Patrice L. Spath: Sample Course Offerings
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Title: Front Line Tactics that Reduce Patient Care Mistakes

Description: When you thought you'd fixed everything you can fix with new procedures, training and standards, and unintended patient care mistakes are still occurring, where else do you look? This workshop covers simple methodologies for applying error proofing principles at the front lines of health care delivery. Participants will learn how to implement proven patient safety solutions to reduce human errors. Mistake-proofing principles will be explored along with a variety of examples showing how these techniques can be incorporated into are aspects of patient care delivery. Mistake-proofing isn't a magic wand that will instantly remove the problems of the past. But it is a significant step in the right direction in terms of drastically improving the safety of patient care.

Learning Objectives

- Why common strategies for improving the safety of health care processes often fall short.
- How to identify the error-producing factors that are hiding in plain sight.
- Controls or features that can be integrated into patient care activities to prevent or mitigate error occurrence.
- The human side of patient safety and how to correct mistakes at the source without increasing costs.
- Visual control and mistake-proofing methods that have been proven effective at reducing medical mishaps.

Title: Accountability Matters: Reinforcing Patient Safety Responsibilities in a Blame-Free Environment

Description: Patient safety is a shared responsibility between the organization and the individuals working in that organization. Senior leaders and managers are accountable for identifying and removing barriers to safe practices. Individuals are accountable for their actions. Balancing organizational and individual accountability can be challenging. In this workshop, participants learn how to create a shared accountability system that addresses weaknesses in patient care systems and promotes individual responsibility for following safe practices. Adverse event case studies are used throughout the workshop to explore the relationship between organizational and personal accountability to help ensure the right actions are taken following an adverse event. Participants receive an accountability analysis tool that can be used by managers and supervisors to determine the extent of individual responsibility following an adverse event.

Learning Objectives

- Recognize shortcomings in your organization's accountability system that adversely affects patient safety.
- Incorporate patient safety responsibilities into your employee performance management system at all levels.
- Transform counterproductive "blaming" into process and behavior changes that advance patient safety improvements.
- Create a consistent framework for judging individual accountability following an adverse patient incident.
- Promote an environment where the reporting of adverse events is encouraged and individual consequences, both positive and negative, are aligned with patient safety goals.

Title: Making FMEA a More Powerful and Effective Patient Safety Improvement Tool

Failure mode and effects analysis (FMEA) has become a centerpiece in today's proactive patient safety improvement initiatives. Many health care organizations are completing FMEAs because such projects are required by the Joint Commission accreditation standards. However, misconceptions or misapplication can turn FMEA into a laborious project that generates a lot of paper work without sustainable patient safety gains. In this workshop, you'll learn how to enhance the power and benefits of FMEA for your organization by avoiding common pitfalls and concentrating efforts toward the real value of the FMEA process. Participants receive a detailed FMEA Project Template and a FMEA Scoring Grid.

Learning Objectives

- Describe the steps of a failure mode and effects analysis.
- Identify methods for determining the potential failures high-risk patient care processes and measuring the criticality of process failures.
- Identify targeted process improvement strategies that will reduce the likelihood of failures.
- Leverage FMEA projects to achieve organizational priorities.

Title: How to Get Full Value from Your Root Cause Analysis Investigations

Description: Health care facilities spend considerable time improving processes and yet untoward events still happen. Why? Because often process changes are not directed at the latent system failures that are setting people up to make mistakes. In this workshop you'll learn how to determine if the fundamental system deficiencies that precipitated an untoward event have been found and how to develop sustainable corrective actions to prevent similar incidents in the future. You'll also discover why traditional process improvements have failed to eliminate the risk of untoward events and what safeguards are needed to prevent simple errors from causing accidents. Participants will review actual root cause analyses done in other organizations to find out how to improve their organization's event investigation techniques.

Learning Objectives

- Identify the relationship between sentinel event investigations, performance improvement, peer review, and risk management.
- Describe techniques for conducting a more thorough and effective root cause analysis.
- Apply systematic investigation tools that help the health care team discover the causal factors and root causes of untoward events.
- Discover how to identify the management and organizational policies and decisions that create latent failure conditions that increase the likelihood of untoward events.
- Identify strategies for gaining support for RCA projects from all levels within the organization, including physicians.

Title: Advancing Innovation & Sustainable Improvements in Patient Safety

Description: All healthcare organizations want to reduce errors and improve patient safety. Unfortunately, many struggle to attain, let alone sustain, higher levels of performance. Why don't redesigned work processes make patient care safer? What's keeping people from adopting safe practices? Delivering safe patient care that is sustainable over the long-term requires more than project teams and employee training. To deliver safe and reliable healthcare services process owners must use effective motivational strategies and innovative mistake-proofing techniques. In this workshop you will learn how to harness the power of people to make lasting improvements in patient safety. By the end of the day, participants will have an action plan for re-vitalizing patient safety initiatives in their own organization.

Learning Objectives

- Recognize and correct the root cause of less than successful safety improvement initiatives
- Identify specific changes that are needed to create fail-safe processes
- Overcome the system and people barriers that typically derail improvement efforts
- Define optimal solutions for resolving patient safety performance problems
- Use behavior-based strategies to strengthen adherence to safe practices
- Create an action plan for achieving your organization's safety improvement objectives

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Title: A Manager's Guide to Training Frontline Staff in Patient Safety

Description: Mistake-proofing isn't a magic wand that will instantly remove the problems of the past. But it is a significant step in the right direction in terms of drastically improving the safety of patient care. This workshop covers simple methodologies for applying error proofing principles at the front lines of health care delivery. Participants will learn how to coach caregivers in proven patient safety solutions to reduce human errors. Mistake-proofing principles will be explored along with a variety of examples showing how these techniques can

be taught to caregivers in all aspects of patient care delivery. *In addition to an extensive handout, participants will receive take-home electronic versions of the various teaching aids.*

Learning Objectives

- Why common patient safety improvement education strategies often fall short.
- How to identify the error-producing factors that are hiding in plain sight.
- Visual control and mistake-proofing methods that have been proven effective at reducing medical mishaps.
- Practical training materials and exercises that can be used to teach caregivers how to mistake-proof high risk activities.
- How to train physicians and employees to correct mistakes at the source without increasing workload or costs.

Title: Engaging Patients and Family in Quality and Patient Safety

Description:

The goal of the CMS initiative, *Partnership for Patients*, is to enhance the relationship between health care professionals and their patients and families. It is a key part of providing high quality, safe patient care. To achieve this goal, the organization's administrative team and managers must lead the way toward creating partnership opportunities for patients and family members. Successful involvement of consumers in quality and patient safety requires changes in organizational policies and the attitudes and actions of all stakeholders, including caregivers. Improving communication with patients, listening to their concerns, and facilitating active partnerships should be a major element in an organization's quality and patient safety improvement strategy.

Learning Objectives

- Discuss how engaging patients and family as active members of the healthcare team can help improve patient satisfaction, reduce adverse events, and improve quality
- Explain what the administrative team and managers must do to advance patient and family involvement in quality and safety improvement efforts.
- Identify successful strategies for involving patients and family members in your organization's quality and safety improvement initiatives at all levels
- Describe proven techniques for engaging patients and family members in the health care experience.
- Discuss how to create partnerships with patients and family without increasing the risk of lawsuits or over-burdening staff
- Identify how to overcome common roadblocks to successful partnerships with patients and family

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Title: Navigating the Speed Bumps in Your Quality and Safety Improvement Journey

Learning Objectives

- Recognize common potholes in achieving long term patient quality and safety improvements.
- Identify how frontline caregivers and managers can help sustain the gains.
- Describe tactics for overcoming the cultural and communication challenges.
- Use performance data to smooth the speed bumps in the improvement journey.

Title: Joint Commission's Peer Review Requirements: What Hospitals Must do to Comply

Description:

The role of medical staff peer review in hospital improvement efforts has been strengthened by Joint Commission standards requiring ongoing and focused professional practice evaluations. To meet these more stringent requirements the medical staff must define performance expectations and privilege-specific performance triggers and rules/regulations and bylaws must be revised. For the quality department and medical staff services, changes in data collection and reporting systems will be needed. In this workshop participants will discover how to transform their existing peer review process into an efficient system that complies with the Joint Commission standards.