

Root Cause Analysis:

A Follow-up Workshop (half-day)

This workshop is a follow-up to the initial two-day *Patient Safety Tools Training: Root Cause Analysis* workshop. The workshop developers have worked with the Maryland Office of Healthcare Quality to help participants discover how to conduct comprehensive and credible investigations that comply with state regulations and improve the safety of patient care. Actual examples of RCAs done in Maryland hospitals will be used to illustrate the effective use of investigative tools and development of action plans that result in sustainable improvements.

Since 2004, Maryland hospitals have been required to report to the Office of Health Care Quality (OHCQ) any adverse events resulting in patient death or serious disability (Level 1 events). In addition, hospitals must complete a root cause analysis (RCA) and submit a report of this investigation to OHCQ. These investigations must include a thorough analysis of the cause and specific actions to correct areas of concern. In order to help hospitals advance their efforts in patient safety and meet the patient safety regulatory requirements, the Maryland Patient Safety Center has been offering workshops in RCA since 2005.

Learning Objectives:

- Conduct RCAs that improve patient safety and meet regulatory requirements
- Dig deep enough to uncover and correct the root causes of Level 1 adverse events
- Design strong action plans and suitable measures of effectiveness

(*Prerequisite*: previous attendance at 2-day RCA workshop because this is a half-day workshop without time to review the basics and everyone will be expected to have the same level of understanding.)

Agenda

Elements of a credible root cause analysis

- How to use the Office of Health Care Quality RCA evaluation tool to assess the RCA investigation
- Common shortcomings found in RCAs submitted to the Office of Health Care Quality

Have you found the root cause?

- Simple techniques for determining whether you've uncovered the root cause(s) of the event
- How to dig deeper to find and correct latent conditions

Sustainable actions aimed at fixing root causes and latent conditions

- Designing strong actions that control or eliminate identified risks
- What should be measured to determine the effectiveness of actions

Faculty

Patrice L. Spath, Principal, Brown-Spath & Associates, Forest Grove, Oregon

Ms Spath is a widely sought after trainer and consultant whose advice is innovative, up-to-date, and immediately applicable to your unique environment. During the past 20 years, she has presented over 350 educational programs on quality improvement, error reduction and patient safety, case management, clinical paths, and outcomes management. She has authored several books and over 150 journal articles on health care quality topics, and she writes a regular column for *Hospital Peer Review* and *Hospital Case Management*.



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Registration Form

TO REGISTER FOR THIS PROGRAM, YOU MUST HAVE ATTENDED THE PREVIOUS 2-DAY RCA WORKSHOP

Your registration is not complete until you receive a confirmation from the Patient Safety Center. This program is held at MHA headquarters in Elkridge, Maryland

Wednesday, June 17, 2008 (75827)

Registration 8:30 AM, Program 9:00 AM - 1:00 PM

PLEASE PRINT OR TYPE

Please include your e-mail since we will use e-mail to confirm your registration.

Organization Name:		
1. Name:	Degree(s):	
Title:	Badge Name:	
Email Address:	Direct Phone #:	
2. Name:	Degree(s):	·····
Title:	Badge Name:	
Email Address:	Direct Phone #:	

SPECIAL NOTE: Although there is no charge to Maryland healthcare professionals for attendance at these programs, if you register and fail to attend without notifying us 48 hours in advance or finding a substitute, you will be charged a \$50 cancellation fee.

There is a \$75 charge for non-Maryland healthcare professionals to attend this program.

Return Registration Form to:

Robbie Heacock Maryland Patient Safety Center 6820 Deerpath Road Elkridge, MD 21075 rheacock@mhaonline.org

FAX: 410.379.9541