

Failure Mode and Effects Analysis Workshop



E	09.00	Registration
		Welcome and introductions <i>Representative of the healthcare organization</i> <i>Healthcare Quality Quest workshop leader</i>
M		An introduction to FMEA — Benefits of failure mode and effects analysis and ways to look at risks <i>Brief presentation</i>
		How to identify and assess areas of potential avoidable risk to patients — A more focused way to concentrate on minimizing risk <i>Brief presentation</i> <i>Participants identify and rate processes, situations or events that could present avoidable risk to patients</i>
M	10.45	Break
	11.00	How to analyse key systems or processes and find where and how a system or process can fail — Clarifying the right systems or processes and predicting where they could break down <i>Brief presentation</i> <i>Participants analyse systems or processes that could present avoidable risk to patients</i> <i>Participants identify what could go wrong in a system or process</i>
A	12.30	Lunch
	13.30	How to judge the significance of system or process failures — Which failures are the most important to prevent <i>Brief presentation</i> <i>Participants judge the consequence and likelihood of system or process breakdowns, events or situations and find those of 'significant' risk</i>
R		How to find the cause of a breakdown that represents a serious risk to patients — What causes system or process breakdowns <i>Brief presentation</i> <i>Participants use techniques to find root causes of breakdowns in clinical systems or processes</i>
	15.00	Break
G	15.15	How to select the right actions to prevent an incident — Strategies for acting on the findings of analysis <i>Brief presentation</i> <i>Participants decide on actions to implement to eliminate or reduce the possibility of incidents occurring relating to the high-risk area of practice</i>
		Planning the way forward <i>Participants plan how to carry forward the work carried out in the workshop</i>
O	16.30	Workshop evaluation and adjourn
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