Maryland Patient Safety Center presents:

Patient Safety Tools Training:

Failure Modes and Effects Analysis

Friday, December 16, 2020 • 8:30 am – 3:30 pm

LIVE VIRTUAL TRAINING VIA ZOOM

Maryland Patient Safety Center
410.540.9210
6820 Deerpath Road
Elkridge, Maryland 21075

Program Overview

Healthcare is a tremendously complex combination of process flow, technology and behaviors. The inherent complexity creates many opportunities for a failure or breakdown in our systems, equipment, or behaviors. Each opportunity for failure creates a risk of potential harm to the patient, staff, and organization. As healthcare workers, we have a responsibility to keep our patients, ourselves, and our organizations safe. Failure Modes and Effects Analysis (FMEA) is a proven effective tool utilized to make good risk-based decisions which is a key part of providing safe, quality care.

Who Should Attend

Medical directors, senior executives, managers, patient safety officers, performance improvement directors, staff educators, risk managers, unit supervisors, and others responsible for proactive patient safety improvement projects in any type of healthcare organization.

Program Fee: Non-members: $299
Maryland Patient Safety Center members: Free

About the Speaker:

Fe Nieves-Khouw, MSN, RN, CPHQ

Fe Nieves-Khouw MSN, RN, CPHQ previously held the position of interim vice president and chief nursing officer at Laurel Regional Hospital, a facility of University of Maryland Medical System Capital Region Health. Fe has a passion for, and many years of experience in healthcare quality and safety. She was Director of Quality and Safety at the University of Maryland Medical Center and at Mercy Medical Center. She was the Director of Quality and Regulatory Affairs at Laurel Regional Hospital before she became its interim chief nursing officer. Fe is an experienced educator and consultant and has spent many years as a nursing leader and manager. Prior to these roles, Fe was an advance practice nurse in Behavioral Health with knowledge and skills honed in both mental health and juvenile justice systems.

Learning Objectives

- Discuss the key drivers for the use of failure mode and effect analysis in healthcare
- Identify clinical processes that maximize the benefits of failure mode and effects analysis
- Identify best practice steps of a failure mode and effects analysis
- Prioritize risks identified by failure mode analysis for improvement
- Describe key factors that contribute to a successful FMEA process
- Initiate a plan for communicating and handing off top high risk processes to the appropriate team for improvement

To register: www.MarylandPatientSafety.org

Questions regarding this program or the Maryland Patient Safety Center:
Contact Lorie Catsos at 410-540-9210 or lcatsos@marylandpatientsafety.org