



**LEE MEMORIAL HEALTH SYSTEM  
BOARD OF DIRECTORS**

**Healthcare Performance Improvement (HPI)  
Board Educational Workshop**

**Thursday, October 22, 2009**

**9:00 a.m. – 12:00 p.m.**

**FineMark National Bank and Trust  
12681 Creekside Lane, Ft. Myers, FL 33919**

**AGENDA**

1. **CALL TO ORDER** by Richard Akin, Board Chairman
2. **Workshop Objective:**
  - Improve patient care (safety, clinical quality, cost, and time) through applying best practices from high reliability organizations.
3. **Practical Scenarios for Interactive Learning**
  - Define reliability, and describe how reliability can be measured and expressed.
  - Describe, using Reason's Swiss Cheese Effect, how human error and latent system weaknesses combine to cause loss events in health care.
  - Describe, using Cook and Wood's Sharp-End Model, how culture can shape behavior and prevent human error that contributes to loss events.
  - Know, and be able to provide examples for each of, the five (5) behavior-shaping factors of reliable systems: structure, protocol, culture, process, and intuitive environment.
  - Know, and be able to apply in the context of Patient Safety Culture, the three steps to culture change.
  - Describe the process for selecting Patient Safety Culture behaviors for a hospital or a service line or a single unit.
  - Be able to identify safety behaviors, and describe the use of each behavior, for each of the three (3) human error types in the Generic Error Modeling System (GEMS).
  - Be able to identify Leader behaviors, and describe the use of each behavior, for high reliability organizations.
4. **ADJOURNMENT**



## **The Science of High Reliability: Building Safer Health Care**

### **Course Description**

Errors, delays, and waste are the results of inefficient and poorly designed systems. High reliability is the study of human performance in complex systems and includes: systems thinking, analysis of serious safety events, techniques to minimize the probability of errors and tactics to move your people to a culture where patient safety is at the core of your business. This workshop delivers skills and competencies in patient safety and high reliability organizations. Board members will learn about how to achieve high team performance at the bedside and in the C-suite.

### **Objectives**

This is a 3.0 hour educational program for reliability concepts in healthcare applications. The terminal objective of the program is to improve patient care (safety, clinical quality, cost, and time) through applying best practices from High Reliability Organizations. The workshop will contain practical scenarios for interactive learning.

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2. Describe, using Reason's Swiss Cheese Effect, how human error and latent system weaknesses combine to cause loss events in health care.
3. Describe, using Cook and Wood's Sharp-End Model, how culture can shape behavior and prevent human error that contributes to loss events.
4. Know, and be able to provide examples for each of, the five (5) behavior-shaping factors of reliable systems: structure, protocol, culture, process, and intuitive environment.
5. Know, and be able to apply in the context of Patient Safety Culture, the three steps to culture change.
6. Describe the process for selecting Patient Safety Culture behaviors for a hospital or a service line or a single unit.
7. Be able to identify safety behaviors, and describe the use of each behavior, for each of the three (3) human error types in the Generic Error Modeling System (GEMS).
8. Be able to identify Leader behaviors, and describe the use of each behavior, for high reliability organizations.

Handout packs, including a reading and reference list for ongoing learning will be provided at the workshop.