

CPPS CE APPROVAL APPLICATION

- Complete the form below and attach requested program information
- Submit via email to cpps@ihi.org

Only completed applications can be processed. Please submit application information at least 6 weeks prior to your program.

Questions? Contact us at cpps@ihi.org or 617.391.9927

Name of Organization: _____

Mailing Address: _____

Staff Contact: _____ **Job Title:** _____

E-mail Address: _____ **Phone:** _____

Organization/Program website: _____

Was a current CPPS involved in program planning/review? Yes No

If yes, please provide name, credentials, and contact email/phone:

Has your program been approved by other CE providers? Yes No

If yes, please list and include hours approved:

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If approved, would you like your program to be publicly listed on www.cbpps.org? Yes No

If yes, please provide listing details (title, date, registration information and link (if applicable)):

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Submission Requirements:

- Organization/Program information (above)
- Complete table and include supporting documentation (next page)

I hereby verify that the information contained in this application is true and accurate and affirm that my organization has responsibility for control over all aspects of the program(s) to ensure educational objectives and standards are met.

Print Name and Job Title: _____

Signature: _____

Date: ____ ____ ____

CE PROGRAM DOCUMENTATION

Title and Brief Description of Activity	Date of Activity Or Enduring	Content Code (1-5)	CE Hours Requested	Documentation
				<input type="checkbox"/> Agenda/Overview <input type="checkbox"/> Objectives
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CPPS Content Codes

- 1 Culture
- 2 Leadership
- 3 Patient Safety Risks & Solutions
- 4 Measuring & Improving Performance
- 5 Systems Thinking & Design/Human Factors

CPPS Exam Content Outline

I. Culture

A. Assessment of Patient Safety Culture

1. Identify work settings with positive patient safety culture and those in need of improvement
2. Target low-performing domains for improvement
3. Disseminate best practices from high-performing work settings
4. Disseminate culture survey results within all levels of the organization
5. Assist in interpreting culture survey results
6. Apply ongoing proxy measures of patient safety culture (e.g., near-miss reporting, targeted surveys)

B. Raising Awareness

1. Engage healthcare team in patient safety initiatives
2. Provide learning opportunities for the healthcare team about the importance of reporting errors and near misses
3. Provide learning opportunities for the healthcare team about how to report errors and near misses
4. Provide learning opportunities for the healthcare team about the importance of timely disclosure to patients related to adverse events and unexpected outcomes
5. Provide learning opportunities for the healthcare team about the importance of timely apology and transparency related to adverse events
6. Use storytelling to raise awareness of patient safety
7. Evaluate patient safety implications (unintended consequences) of operational changes (e.g., cost-reduction measures)
8. Include consideration of values, language, cultural background, and health literacy level in safety materials, treatment plans, etc.

C. Promoting a Culture of Safety

1. Advocate for the inclusion of the principles and science of patient safety within initiatives
2. Articulate principles of a fair and just culture
3. Disseminate information about patient safety activities on a regular basis
4. Advocate for the involvement of patients and caregivers in decisions about patients' care
5. Promote the involvement of patients and their caregivers in the patient safety team
6. Promote a collaborative work environment in which teams can cross multiple disciplines
7. Facilitate a systems approach to address disruptive behaviors
8. Foster support for healthcare team members involved in adverse events
9. Develop reporting feedback loops for informing individuals and groups about near misses and adverse events

II. Leadership

- A. Align patient safety strategy with organizational mission, vision, values, and goals
- B. Advocate for patient safety as a top priority
- C. Collaborate with key stakeholders to prioritize patient safety efforts
 - 1. Executives
 - 2. Managers
 - 3. Clinicians
 - 4. Frontline staff
- D. Identify key stakeholders for distinct patient safety initiatives
- E. Develop operational plan to improve patient safety
- F. Advocate for resources required to support the operational safety plan
- G. Foster transparent communication throughout the organization
- H. Foster transparent communication with patients and their caregivers
- I. Create opportunities for interdisciplinary patient safety conversations and problem solving
- J. Advocate for integration of patient safety responsibilities into job descriptions and performance evaluation tools
- K. Embed accountability into investigations and system improvement
- L. Promote the application of principles of high reliability at all levels of the organization
- M. Demonstrate the ability to influence decision makers and frontline staff to participate in patient safety initiatives
- N. Use storytelling as a mechanism to engage stakeholders and drive changes
- O. Work within the organization to accomplish process improvement, effectively engage leaders, and influence stakeholders and frontline staff
- P. Provide patient safety content expertise for purposes of maintaining continuous readiness as defined by regulatory bodies
- Q. Promote compliance with requirements related to reporting serious occurrences and reportable events to appropriate organizations
- R. Maintain ongoing working relationships with
 - 1. Clinicians
 - 2. Managers
 - 3. Executives
 - 4. Regulatory agencies
 - 5. Governing body
 - 6. External agencies
 - 7. Patients and their caregivers
 - 8. Frontline staff

III. Patient Safety Risks & Solutions

A. Risk Identification & Analysis

1. Implement a systematic approach to respond to data sources (e.g., safety alerts, product recalls, industry alerts)
2. Develop a mechanism to report identified risks
3. Perform activities to identify gaps and risks (e.g., failure modes and effects analysis (FMEA), walk-arounds)
4. Review events and near-miss reports
5. Identify vulnerable populations with a high likelihood of patient safety events
6. Perform Root Cause Analysis (RCA)
7. Share findings and action items from safety investigations with frontline staff members and other departments

B. Patient Safety Solutions

1. Evaluate evidence for applicability to a program or initiative
2. Evaluate evidence-based best practices for organizational implementation of
 - a. Bundles
 - b. Simulation
 - c. Checklists
 - d. Team training
 - e. Communication techniques
3. Evaluate technology solutions to promote patient safety in an organization
 - a. Information technology (e.g., EMR, CPOE, decision support)
 - b. Medication safety related technology (e.g., barcoding, pharmacy robots, smart pumps)
4. Monitor patient safety events following the implementation of new technology
5. Investigate how the interface between technology systems may contribute to patient safety events
6. Identify and spread local safety innovations throughout the organization

IV. Measuring & Improving Performance

A. Measurement

1. Identify quantitative patient safety data sources for internal and external reporting
2. Identify qualitative patient safety data sources for internal reporting (e.g., walk-arounds, event reporting, patient feedback, patient and family advisory council)
3. Collect patient safety data
4. Analyze patient safety data using statistical techniques (e.g., statistical process control)
5. Interpret patient safety data
6. Develop credible and understandable reports
7. Present results of data analyses to decision makers

B. Improvement

1. Select an improvement methodology that is relevant to an initiative or project

2. Apply improvement methodologies to promote measurably improved processes
3. Use process, outcome, and balancing measures to monitor and inform system performance
4. Employ project management skills
5. Employ facilitation skills to promote teamwork

V. Systems Thinking & Design / Human Factors

A. Systems Thinking

1. Systematically identify, define, and address patient safety issues
2. Apply systems theory
 - a. Identify relevant system elements (people, tools/technology, tasks, environment, organizations and their interaction)
 - b. Plan for unintended consequences of making changes to identified system elements
3. Apply systems thinking to improve processes
 - a. Identify workflow
 - b. Collaborate with frontline staff and management leaders to identify problems within processes
 - c. Identify barriers to improving processes
 - d. Rank safety concerns and issues (using multiple sources) to prioritize patient safety activities
 - e. Use a ranking system to identify and implement sustainable solutions
 - f. Evaluate the degree to which proposed solutions match root causes
 - g. Design/redesign solutions with help of frontline staff
4. Standardize processes considering potential unintended consequences
Identify normalized deviance (e.g., drift) in processes and systems
5. Recognize rule violations as an indicator of potential system design or performance flaws
6. Differentiate among human error, behavioral choices, and system failures

B. Design / Human Factors

1. Recognize how key components of systems interact to determine safety
 - a. People (health literacy, cultural competency, physical and cognitive limitations)
 - b. Tools, technology, and techniques
 - c. Tasks (clinical and nonclinical)
 - d. Environment
 - e. Organization (including culture, financial decisions, rules, staffing, etc.)
2. Apply principles of high reliability to system design
3. Incorporate regulatory/accreditation requirements in designing process improvement initiatives