

CPPS CE APPROVAL APPLICATION

- Complete the form below and attach requested program information
- Pay the applicable fee online [here](#)
- Submit via email to cpps@ihi.org

Only completed applications with payment 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: _____

Program title: _____

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:

If approved, would you like your program to be publicly listed on ihi.org/cpps? Yes No

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

Submission Requirements:

- Organization/Program information (above)
- Complete table and include supporting documentation (next page)
- Online payment ([https://my.ihi.org/portal/content/CPPS Accreditation Fee.aspx](https://my.ihi.org/portal/content/CPPS%20Accreditation%20Fee.aspx))

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 Content Outline

I. Culture

A. Assessment of Patient Safety Culture

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

B. Raising Awareness

1. Engage healthcare team in patient safety initiatives
2. Provide learning opportunities for the healthcare team about:
 - a. the value and process of reporting safety incidents.
 - b. the importance of timely disclosure to patients related to adverse events and unexpected outcomes.
 - c. the importance of transparency and timely apology.
3. Address patient safety implications associated with operational changes (e.g., cost-reduction measures)
4. Include consideration of values, language, cultural background, and health literacy level in safety materials, treatment plans, etc.
5. Provide formal and informal education to staff and leadership on applying patient safety principles

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. Ensure the involvement of patients and caregivers in the patients' healthcare decisions
5. Promote the involvement of patients and caregivers in the patient safety team
6. Promote a collaborative work environment that includes all who support patient care
7. Facilitate a systems approach to address disruptive workplace behaviors
8. Foster organizational support for healthcare team members involved in adverse events

9. Develop reporting feedback loops for informing individuals and groups about unsafe conditions, near misses, and incidents

II. Leadership

- A. Align patient safety strategy with organizational mission, vision, values, and goals
- B. Advocate for patient safety as a top priority
- C. Identify key stakeholders for distinct patient safety initiatives
- D. Develop operational plan to improve patient safety
- E. Advocate for resources required to support the operational safety plan
- F. Foster transparent communication:
 1. throughout the organization.
 2. with patients and their caregivers.
- G. Create opportunities for interdisciplinary patient safety conversations and problem solving
- H. Integrate patient safety responsibilities into job descriptions, competencies, and performance evaluation tools
- I. Embed accountability into investigations and system improvement
- J. Promote the application of principles of high reliability at all levels of the organization
- K. Demonstrate the ability to influence decision makers and direct care providers to participate in patient safety initiatives
- L. Use storytelling as a mechanism to engage stakeholders and drive change
- M. Work within the organization to accomplish process improvement, effectively engage leaders, and influence stakeholders and direct care providers
- N. Provide patient safety content expertise for continuous regulatory readiness
- O. Promote compliance with requirements related to reporting serious occurrences and reportable events to appropriate organizations
- P. Develop approaches that address the different priorities and perspectives of diverse stakeholders
- Q. Collaborate with key stakeholders to prioritize patient safety efforts, including:
 1. executives
 2. managers
 3. clinicians
 4. direct care providers
 5. governing body
 6. patients and their caregivers
 7. accrediting agencies
 8. regulatory agencies

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 hazards
3. Perform activities to identify gaps and risks (e.g., failure modes and effects analysis (FMEA), walk-arounds)
4. Review reports of unsafe conditions, near-misses, and incidents
5. Ensure support is provided for staff affected by safety-related adverse events
6. Identify vulnerable populations with a high likelihood of patient safety events (e.g., diabetes, extremes of age, potential for addiction)
7. Perform Root Cause Analysis (RCA)
8. Share findings and action items from safety investigations with direct care providers and other departments
9. Recognize the risks of workplace physical and psychological violence involving:
 - a. patients
 - b. staff / care providers
 - c. families

B. Patient Safety Solutions

1. Perform critical evaluation of evidence for applicability to a program or initiative
2. Evaluate evidence-based best practices for organizational implementation of:
 - a. bundled care processes
 - b. simulation
 - c. clinical decision tools (e.g., checklists, algorithms, care pathways)
 - d. team training
 - e. communication techniques (e.g., to transfer patient care, escalate concerns)
3. Evaluate technology solutions to promote patient safety:
 - a. information technology (e.g., EMR, CPOE, decision support, apps, augmented / artificial intelligence, monitoring technology)
 - b. medication safety-related technology (e.g., barcoding, pharmacy robots, technology-informed infusion devices)
4. Monitor patient safety outcomes following the implementation of new or modified technology
5. Investigate how the interface between technology systems may contribute to patient safety events

6. Investigate how the interface between technology and users may contribute to patient safety events
7. Identify and disseminate local safety innovations throughout the organization
8. Evaluate risks associated with existing, modified, or new technology systems

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 (e.g., walk-arounds, event reporting, patient feedback, patient and family advisory council)
3. Collect patient safety data
4. Manage patient safety data
5. Analyze patient safety data using statistical techniques (e.g., statistical process control)
6. Interpret patient safety data
7. Develop credible and understandable reports
8. Present results of data analyses to stakeholders
9. Evaluate feedback from standards organizations (e.g., for regulators, accreditation, and ratings, etc.)

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 evaluate system performance
4. Employ project management skills to manage the work of improvement
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. Identify normalized deviance (e.g., drift) in processes and systems
3. Recognize rule violations as an indicator of potential system design or performance flaws
4. Differentiate among human error, behavioral choices, and system failures
5. Apply systems theory
 - a. Identify relevant system elements (people, tools/technology, tasks, environment, organizations and their interaction)
 - b. Plan for unintended consequences of change
6. Apply systems thinking to improve processes
 - a. Identify workflows

- b. Understand workflows
- c. Collaborate with direct care providers and management leaders to identify problems with processes
- d. Identify barriers to improving processes
- e. Use a ranking system to prioritize patient safety concerns
- f. Use a ranking system to prioritize sustainable solutions
- g. Evaluate the degree to which proposed solutions match root causes
- h. Evaluate the strength of interventions, such as training, forcing functions, policy
- i. Design/redesign solutions with the help of stakeholders (e.g., patients, direct care providers, management)
- j. Consider potential unintended consequences when standardizing processes
- k. Implement sustainable solutions
- l. Evaluate sustainable solutions

B. Design / Human Factors

1. Recognize how key components of systems interact to determine safety:
 - a. people (e.g., health literacy, cultural competency, physical and cognitive abilities)
 - 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 and resilience to system design
3. Incorporate regulatory/accreditation requirements in designing process improvement initiatives
4. Identify and address factors that negatively impact human performance (e.g., limitations of memory, time constraints, multi-tasking, interruptions, stress, fatigue and lack of sleep, the detrimental effect of shift work, ergonomics).
5. Identify and enhance factors that support human performance (e.g., pattern identification, anticipation of outcomes, critical thinking, teamwork).