

# Healthcare Series

## The FMEA for Healthcare

### Systematic Incident Prevention and Control Method

#### Course Overview

Failure mode and effects analysis (FMEA) is a proactive tool, technique and quality method that enables the identification and prevention of process or product errors before they occur. FMEA can help identify and eliminate concerns early in the development of a process or new service delivery. FMEA is a systematic way to examine a process prospectively for possible ways in which failure can occur, and then to redesign the process so that the new model eliminates the possibility of failure.

#### Course Objectives

1. To provide a comprehensive coverage of FMEA techniques and exercises that enable the participants grasp the essential skills of this proactive safety management approach.
2. To share practical valuable experience with successful examples in Hong Kong Healthcare sectors

#### Who Should Attend?

1. Clinical professionals, physicians, nurses
2. Allied health professionals
3. Quality & Safety and other supporting professionals



SSI 六式碼學會  
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Your Partner for Growth

## FMEA for Healthcare

### 醫療領域FMEA工作坊

- ✓ **預防性質量管理**  
學習FMEA工具，提前識別和消除潛在錯誤，提升醫療服務的安全性和質量。
- ✓ **實踐導向**  
通過實際案例和演練，參與者將獲得寶貴的實踐經驗，能夠在日常工作中即時應用所學知識。
- ✓ **提升職業競爭力**  
完成工作坊後，學員將能有效應用FMEA方法，增強職業能力，為患者安全和醫療質量做出更大貢獻。

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## Key Takeaways

1. Anticipate & Prevent Errors: Shift from a reactive "incident reporting" culture to a proactive "prevention" mindset.
2. Quantify Clinical Risk: Master the Risk Priority Number (RPN) system to objectively rank and prioritize safety concerns.
3. Redesign High-Risk Workflows: Acquire the tools to architect safer processes that eliminate failure modes at the source.
4. Drive Team-Based Solutions: Learn to facilitate multidisciplinary teams to solve complex, cross-departmental safety challenges.
5. Evidence-Based Implementation: Apply proven methodologies used in Hong Kong's leading healthcare sectors to ensure sustainable clinical improvements.

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## Contents

### A: Foundation & Process Visualization

1. Strategic Team Formation: Selecting high-risk clinical processes and assembling high-impact multidisciplinary teams.
2. Workflow Architecture: Mastering process diagramming to expose hidden vulnerabilities in the current service delivery model.

### B: The Risk Quantification Framework

1. Failure Mode Identification: Brainstorming critical factors and potential breaking points within the system.
2. The Scoring Matrix: Evaluating risk through three critical lenses.
  - Severity: Impact of the failure on patient safety.
  - Occurrence: Probability of the failure happening.
  - Detection: Effectiveness of current controls in catching the error.
3. Risk Prioritization: Calculating and analyzing the Risk Priority Number (RPN) to focus resources where they matter most.

### C: Root Cause & Process Redesign

1. Contributing Factor Analysis: Identifying the "why" behind failure modes and auditing current control methods.
2. Iterative Redesign: Developing a "New Model" process designed for error-resilience.

### D: Implementation & Sustained Control

1. The Control Plan: Developing robust protocols to prevent the return of identified risks.
2. Analysis & Testing: Validating the new process through rigorous testing before full-scale rollout.
3. Monitoring & Presentation: Establishing KPIs to monitor the improved process and presenting findings to stakeholders.

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## Corporate Training

If you are interested in organizing corporate training, please do not hesitate to contact us for further information and to discuss customized solutions that align with your needs

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### Contact us

For registration of the above course, please complete the e-application form. Our course administrator will contact you shortly

For enquiries, please contact us at (852) 2581 2771

