Advanced Healthcare Adverse Event Analysis Training Course

21 – 25 June 2027
London

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Ref: 1414_204381 **Date:** 21 – 25 June 2027 **Location:** London **Fees:** 5700 Euro

Overview

Advanced Healthcare Adverse Event Analysis Training Course is a one-week course for healthcare quality, patient-safety, clinical-governance, risk, investigation, analytics, and service functions who leave with an Adverse Event Learning Dossier. Participants connect reporting intake, event classification, fair accountability, evidence control, interviews, timeline reconstruction, contributing-factor analysis, safety-action design, learning dissemination, governance, and effectiveness monitoring. Agile Leaders Training Center presents healthcare adverse event analysis as structured system learning.

Who Should Attend

- Quality and patient-safety functions responsible for event reporting, learning, and improvement
- Clinical-governance functions responsible for oversight, proportional response, and assurance
- Risk functions responsible for event triage, evidence control, and action tracking
- Clinical leadership functions responsible for supporting affected people and service learning
- Investigation functions responsible for interviews, timelines, and contributing-factor analysis
- Analytics and service-management functions responsible for themes, measures, and follow-up

The course assumes participants already support healthcare safety, governance, risk, clinical operations, or investigation work and leaves out introductory patient safety, legal advice, and regulator-specific reporting rules.

Departments and Industries

The course supports departments and industries that report, analyze, govern, and learn from adverse events.

- Hospitals, clinics, and integrated care providers
- Quality, patient safety, and clinical-governance departments
- Risk, assurance, audit, and improvement functions
- Laboratory, diagnostic, pharmacy, and ambulatory networks
- Insurance, care-management, and healthcare support services
- Health technology, medical-device, and clinical service organizations

Learning Objectives

By the end of this course, participants will be able to:

- Build an adverse-event reporting, classification, and response pathway
- Apply fair-accountability principles during event intake and review
- Use evidence, interview, and timeline methods to reconstruct events
- Analyze work systems, root causes, and contributing factors
- Evaluate safety actions for strength, ownership, and measurability
- Build governance, learning, and effectiveness-monitoring records

Course Agenda

Day 1: Reporting and Response Architecture

- Adverse Event Reporting Pathway Map
- Event Classification and Triage Decision Matrix
- Immediate Response and Harm-Control Checklist
- Fair Accountability and Just Culture Decision Guide
- Affected-Person Engagement and Support Plan

Day 2: Evidence and Event Reconstruction

- Time-Sensitive Evidence Preservation Register
- Clinical Record and Digital Audit Trail Review Method
- Supportive Event Interview Plan and Question Set
- Event Timeline Reconstruction Worksheet
- Evidence Gap and Corroboration Matrix

Day 3: System and Contributing-Factor Analysis

- SEIPS Work-System Exploration Map
- Contributing-Factor Classification Framework
- Process Flow and Handoff Analysis Method
- Root-Cause Five-Why and Cause-Tree Analysis
- Finding Validation and Consensus Record

Day 4: Safety Actions and Organizational Learning

- Safety Action Strength and Control Hierarchy Matrix
- Action Ownership and Implementation Record
- Effectiveness Measure and Review Plan
- Thematic Learning and Recurrence Analysis Grid
- Governance Reporting and Learning Dissemination Pack

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Day 5: Adverse Event Analysis Practice

- Exercise: Classify and Triage an Adverse Event
- Exercise: Reconstruct Evidence, Interviews, and Timeline
- Exercise: Analyze Work-System Contributing Factors
- Exercise: Design and Test Safety Actions
- Capstone Exercise: Adverse Event Learning Dossier

Practical Exercises

The course uses suggested activities drawn from medication, diagnostic, procedural, digital, and care-transition events.

- Suggested activity: convert an event notification into a classification, response pathway, evidence register, and engagement plan.
- Suggested activity: reconcile clinical records, audit trails, interviews, observations, and working conditions in an event timeline.
- Suggested activity: map system interactions, distinguish contributing factors from assumptions, and validate findings through consensus.
- Suggested activity: assemble actions, owners, effectiveness measures, thematic learning, and governance reporting in the capstone dossier.

FAQs

Who suits healthcare adverse event analysis training, and what does it assume?

Healthcare adverse event analysis training suits people who already support patient safety, clinical governance, risk, operations, analytics, or investigations and need advanced methods for reporting, evidence, system analysis, action design, and follow-up.

How does advanced adverse event analysis differ from basic root-cause analysis training?

Advanced adverse event analysis connects reporting, proportional response, engagement, evidence preservation, interviews, timelines, work-system analysis, validated findings, action strength, governance, and effectiveness monitoring rather than relying on one causal tool.

What evidence supports healthcare adverse event analysis?

Healthcare adverse event analysis uses time-sensitive records, digital audit trails, equipment information, interviews, observations, process evidence, environmental conditions, and a reconciled timeline while recording gaps and conflicting accounts.

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How should contributing factors be analyzed after an adverse event?

Contributing factors should be analyzed across people, tasks, technology, environment, organization, communication, and care processes, then tested against evidence and discussed through a structured validation and consensus process.

How are safety actions monitored after adverse event analysis?

Safety actions are monitored by defining an owner, implementation evidence, an effectiveness measure, a review point, unintended effects, and a governance route that can strengthen, adapt, or close the action.

Conclusion

The course connects adverse-event reporting, fair response, evidence, reconstruction, system analysis, safety actions, learning, governance, and monitoring. Participants take back an Adverse Event Learning Dossier. The dossier helps their organizations document event evidence, validate findings, assign safety actions, measure effectiveness, share learning, and track recurring themes.