



## **Advanced Never Events Prevention and Systems Assurance Training Course**

20 – 24 June 2027  
Manama



## Advanced Never Events Prevention and Systems Assurance Training Course

**Ref:** 1522\_212418 **Date:** 20 – 24 June 2027 **Location:** Manama **Fees:** 4700 Euro

### Overview

Advanced Never Events Prevention and Systems Assurance Training Course is a one-week course for patient safety, clinical governance, quality, risk, clinical, pharmacy, surgical, and operational leaders, who leave with a Never Events Prevention and Assurance Pack. The course connects strong systemic barriers, human factors, high-risk process controls, incident response, causal analysis, corrective action, learning, audit, dashboards, and governance. Agile Leaders Training Center presents never events prevention as a test of barrier reliability and organizational learning rather than individual blame.

### Who Should Attend

- Functions responsible for patient safety and clinical governance
- Teams responsible for healthcare quality and enterprise risk
- Clinical leaders responsible for nursing, medical, pharmacy, and surgical services
- Personnel responsible for incident investigation and systems learning
- Operational managers responsible for high-risk care processes
- Assurance functions responsible for audit, dashboards, and corrective action

The course assumes participants oversee safety systems, high-risk processes, incidents, or assurance and leaves out clinical qualification, introductory patient safety, and legal advice.

### Departments and Industries

The course supports departments and organizations responsible for preventing serious avoidable incidents and assuring safety barriers.

- Hospitals and ambulatory healthcare services
- Clinical governance and patient safety departments
- Pharmacy, medication management, and transfusion services
- Surgical, procedural, and diagnostic services
- Healthcare risk, quality, and internal audit functions
- Health education and public service organizations

### Learning Objectives

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



- Analyze never event pathways and barrier weaknesses
- Apply human factors and hierarchy-of-controls reasoning
- Build safeguards for surgery, medication, devices, and specimens
- Use causal analysis to design corrective actions
- Evaluate action reliability through audit and dashboards
- Prioritize governance escalation and organizational learning

## **Course Agenda**

### **Day 1: Never Event Risk Systems**

- Never Event Definition and Classification Decision Map
- High-Risk Process and Failure Pathway Model
- Human Factors and Workload Analysis Canvas
- Safety Culture and Just Response Discussion Guide
- Board-to-Frontline Accountability Map

### **Day 2: Strong Systemic Barriers**

- Hierarchy of Controls Barrier Selection Matrix
- Barrier Strength and Dependency Assessment
- Wrong-Site and Retained-Item Safeguard Map
- Medication Route and Dose Control Checklist
- Device, Specimen, and Identification Error-Proofing Plan

### **Day 3: Incident Response and Analysis**

- Immediate Safety and Escalation Response Protocol
- Evidence Preservation and Timeline Reconstruction Tool
- Systems-Based Causal Analysis Diagram
- Contributory Factors and Control Gap Register
- Patient, Family, and Staff Communication Plan

### **Day 4: Corrective Action and Assurance**

- Corrective Action Strength Scoring Grid
- Action Owner and Milestone Assurance Tracker
- Never Event Leading and Lagging Indicator Dashboard
- Barrier Audit and Field Verification Schedule
- Learning Dissemination and Governance Review Charter

## Day 5: Never Events Prevention Practice

- Suggested Exercise: Failure Pathway and Barrier Review
- Suggested Exercise: High-Risk Safeguard Reliability Test
- Suggested Exercise: Causal Analysis and Action Design
- Suggested Exercise: Assurance Dashboard and Escalation Review
- Capstone Exercise: Never Events Prevention and Assurance Pack

## Practical Exercises

The course uses suggested activities based on fictional surgical, medication, diagnostic, and ambulatory safety incidents.

- Suggested activity: map a high-risk process, failure pathways, existing barriers, dependencies, and control owners.
- Suggested activity: compare behavioral checks with elimination, substitution, engineering, and system-supported controls.
- Suggested activity: analyze an incident timeline and convert causal findings into stronger corrective actions.
- Suggested activity: build an assurance dashboard connecting barrier tests, overdue actions, escalation, and governance review.

## FAQs

### Who suits advanced never events prevention training, and what does it assume?

Safety, governance, quality, risk, clinical, pharmacy, surgical, and operational leaders suit the training; it assumes responsibility for safety systems or high-risk processes and excludes clinical credentialing and introductory safety instruction.

### How does never events prevention differ from general patient safety training?

Never events prevention concentrates on clearly recognizable serious incidents, strong systemic barriers, error-proofing, immediate response, causal analysis, corrective-action strength, and evidence that controls remain reliable.

### What makes a strong systemic barrier for never events prevention?

A strong systemic barrier removes, substitutes, physically restricts, or technically controls a hazard with limited dependence on memory, vigilance, or unsupported checking and includes ownership, testing, maintenance, and escalation.



## **How should healthcare organizations assure corrective actions after a never event?**

Organizations should assign owners, define completion and effectiveness evidence, test barriers in practice, monitor leading and lagging indicators, escalate overdue or weak actions, and review sustained performance through governance structures.

### **Conclusion**

Participants leave with a Never Events Prevention and Assurance Pack containing process maps, barrier assessments, safeguard checklists, investigation tools, action scoring, audit schedules, dashboards, and governance controls. The pack shifts attention from procedural completion to barrier reliability. It gives leaders traceable evidence for prevention, response, learning, and sustained corrective action.