

Thursday, June 11 and Friday, June 12, 2015

This 1.5 day workshop provides pharmacists, pharmacy technicians and pharmacy assistants with background theory and hands-on practice in incident analysis (root cause analysis) and prospective risk assessment using failure mode and effects analysis (FMEA)

Day 1:

Incident Analysis - Root Cause Analysis (RCA) for Pharmacy Practice

The RCA portion of this workshop has been assigned 6.5 CEUs by the Ontario College of Pharmacists. The workshop curriculum is derived from the Canadian Incident Analysis Framework.

Program Abstract:

The program begins with an overview of the system approach in the management of error and introduction to human factors engineering principles. Root cause analysis (RCA) is a tool to help investigate adverse events and critical incidents in healthcare, identify and analyze root causes and contributing factors, and develop recommendations. Participants will learn how to conduct an RCA through interactive exercises and group work. The workshop will cover diagramming to support incident analysis, identification of contributing factor, summarizing the findings and developing and implementing recommended actions.

Learning Objectives for RCA:

On completion of the RCA portion of the workshop, participants will be able to:

- 1. Describe the impact of system factors on error potential;
- 2. Apply basic human factors engineering principles in a health care environments
- 3. Describe the importance of each component of the incident management continuum;
- 4. Complete a system-based analysis using a constellation diagram;
- 5. Develop redesign strategies based on systems theory and basic human factors principles; and,
- 6. Apply principles learned to support medication safety activities in their practice setting.

Location:

ISMP Canada 4711 Yonge Street (Procter & Gamble building) Toronto, ON M2N 6K8 Tel: 416-733-3131 Ext. 240

Cost:

\$850 per person, plus applicable taxes

Time:

Day 1: 8:30 am to 4:30 pm Day 2: 8:30 am to 1:00 pm

Audience:

Pharmacists, Pharmacy Technicians, Pharmacy Assistants, Pharmacy Students and Interns

Further Information:

Telephone: 416-733-3131 Ext. 240 Toll Free: 1-866-544-7672 E-mail: education@ismp-canada.org



Thursday, June 11 and Friday, June 12, 2015

Location: ISMP Canada (HIROC Boardroom), 4711 Yonge Street (Procter & Gamble building), Toronto, ON M2N 6K8

AGENDA for Day 1: Thursday, June 11, 2015 (8:30 am - 4:30 pm)

A.M.	8:30 - 9:00	Registration and Continental Breakfast
	9:00 – 9:15	Welcome, Introduction, Goals for the Day
	9:15 – 10:15	 Medication Safety 101 Scope of the problem System approach Impact of human factors engineering principles on error potential and solution development
	10:15 - 10:30	Group activity: applying human factors
	10:30 - 10:45	Break
	10:45 – 11:30	Using the Canadian Incident Analysis Framework: Overview Before the incident Immediate response Prepare for Analysis Analysis Process Part 1: What happened?
	11:30 – 11:45 11:45 – 12:15	Analysis Activity 1: Getting started Analysis Activity 2: Create an incident timeline
P.M.	12:15 - 12:45	Lunch
	12:45 – 1:00	Analysis Process Part 2: How and why it happened
	1:00 – 1:45	Analysis Activity 3: Develop constellation diagram (support identification of contributing factors)
	1:45 – 2:00	Summarize findings and develop actions
	2:00 - 2:15 2:15 - 2:30	Analysis Activity 4: Summarize findings Analysis Activity 5: Develop action and measurement plans
	2:30 - 2:45	Break and Evaluation
	2:45 – 3:00	Follow through and close the loop
	3:00 - 3:15	Analysis Activity 6: Share learning
	3:15 – 3:45	Introduction to Prospective Risk Assessment using FMEA What is FMEA?
	3:45 – 4:15	Everyday FMEA
	4:15 – 4:30	Closing remarks for Day 1



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Day 2:

Prospective Risk Assessment in Pharmacy Practice Using Failure Mode and Effects Analysis (FMEA)

The workshop curriculum is derived from the Canadian Failure Mode and Effects Analysis Framework and a version of the Framework customized for the pharmacy setting by ISMP Canada for the Alberta College of Pharmacists.

Program Abstract:

Failure Mode and Effects Analysis (FMEA) is a technique used to identify process and product problems before they occur. This half-day workshop builds on the principles learned in Day 1, with a change in focus to prospective risk assessment and process redesign. The workshop curriculum is customized for the pharmacy practice environment.

Through interactive group work, participants will learn how to diagram a process, how to identify potential failures, and how to redesign processes with consideration of human factors principles to decrease the likelihood of a failure impacting a patient.

FMEA is a team-based, structured process. It is forward-looking, in contrast to the retrospective approach of incident analysis and techniques such as root cause analysis. FMEA is based on the premise that all systems and processes contain embedded system failures.

Learning Objectives for FMEA:

On completion of the FMEA portion of the workshop, participants will be able to:

- 1. Identify processes suitable for analysis using FMEA;
- 2. Describe the steps required to complete an FMEA;
- 3. Map out a process and identify potential failure modes;
- 4. Develop redesign strategies based on systems theory and basic human factors principles; and
- 5. Apply principles learned to support medication safety activities in their practice setting

Location:

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Cost:

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Time:

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Audience:

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AGENDA for Day 2: Friday, June 12, 2015 (8:30 am - 1:00 pm)

A.M.	8:30 - 8:45	Continental breakfast
	8:45 – 9:00	Review from Day 1
	9:00 – 9:15	Conducting an FMEA FMEA Step 1: Select a process to analyze and assemble a team FMEA Step 2: Diagram the process and sub-process(es)
	9:15 – 9:45	FMEA Activity 1 – Step 1 and Step 2
	9:45 – 10:00	FMEA Step 3: Brainstorm potential failure modes
	10:00 - 10:30	FMEA Activity 2 – Step 3
	10:30 - 10:45	Break
	10:45 – 11:00	FMEA Step 4: Identify the effects and causes of the failure modes FMEA Step 5: Prioritize the failure modes
	11:00 - 11:45	FMEA Activity 3: Step 4 FMEA Activity 4: Step 5
	11:45 – 12:00	FMEA Step 6: Redesign the process(es) FMEA Step 7: Analyze and test the changes Introduction to FMEA Step 8
P.M.	12:00 - 12:30	FMEA Activity 5 – Steps 6 and 7
	12:30 - 12:45	Putting it all together – applying RCA and FMEA in your practice setting
	12:45 – 1:00	Debrief, Evaluation, Closing Remarks





ISMP Canada Workshop

Medication Safety for Pharmacy Practice: Incident Analysis and Prospective Risk Assessment Using Root Cause Analysis (RCA) and Failure Mode and Effects Analysis (FMEA)

Thursday, June 11 (8:30 am - 4:30 pm) and	
Friday, June 12, 2015 (8:30 am- 1:00 pm)	

Location: ISMP Canada, 4711 Yonge Street, (HIROC Boardroom) Toronto, ON

The RCA portion of this workshop has been assigned 6.5 CEUs by the Ontario College of Pharmacists.

How to Register

	Fax:	416-733-1146
		Attn: Alice Ho
I	Mail:	ISMP Canada
		4711 Yonge Street, Suite 501
		Toronto, ON M2N 6K8
		Attn: Alice Ho
Co	Contact:	Alice Ho,
		Administrative Assistant
		Phone: 416-733-3131 ext. 240
		Email: aho@ismp-canada.org

REGISTRATION INFORMATION (Please print clearly)

First Name:		Last Name:
Company Name:		
Mailing Address:	Business:	
	Home:	
City:	Pi	rovince: Postal Code:
Telephone:	Fa	ax:
Email (to be used	for registration confirmation	n):
	ration Fee \$850 per perso \$ 960.50	on* plus applicable taxes * ISMP Canada reserves the right to cancel or re-schedule the workshop if minimum enrolment is not reached
Method of Pay	ment Payment must acco	ompany registration. Please make cheques payable to "ISMP Canada".
□ Cheque □	VISA [®] D Mastercard [®]	
Name of Cardholo	der:	
Credit Card #:		Expiry Date:

Signature:

GST Registration #898242219



Cancellation Policy:

Cancellation requests must be submitted in writing to ISMP Canada at least **7 days** prior to the workshop and are subject to a \$75 cancellation fee. Registration can be transferred to an alternate attendee.