A Logic Model for ISMP Canada

ISMP Canada's activities for provincial, territorial and pan-Canadian medication safety including the Canadian Medication Incident Reporting and Prevention System

ismp CANADA

CONTROL

DEGREE OF INFLUENCE

INFLUENCE

Activities

- Support for, and collection of, medication incident data
- Analysis and development of evidence-based interventions/solutions
- Creating, updating and maintaining programs and tools promoting safe medication practices
- Supporting adoption of safe medication practices through knowledge dissemination and knowledge translation
- Promoting and supporting consultation and collaboration

Outputs

Support for, and collection of, medication incident data

- Individual Practitioner Reporting Program
- Consumer Reporting Program
- Community Pharmacy Reporting Program
- Review of data collected in the National System for Incident Reporting (NSIR)
- Support for provincial incident reporting programs

Analysis and development of evidence-based interventions/solutions

- Prioritization of incidents using the analysis framework and prioritization matrix
- Incident analyses
- Cluster analyses of aggregate data
- Root Cause Analyses (RCAs)
- Consultation with experts
- Collaborative and coordinated research projects
- Collaborative intervention projects

Creating, updating and maintaining programs and tools promoting safe medication practices

- Medication Safety Self-Assessment (MSSA) programs
- Failure Mode and Effects Analysis (FMEA) framework
- Incident Analysis Framework (with Canadian Patient Safety Institute, Saskatchewan Health, and Patients for Patient Safety Canada)
- Medication Reconciliation Support
- Co-development of guidance documents

Supporting adoption of safe medication practices through knowledge dissemination and knowledge translation

- Safety Bulletins, alerts, newsletters for consumers and bulletins for health care practitioners
- Inform standards and guidance
- Articles in peer-reviewed journals
- Provide expert consultations (e.g. Coroner Offices)
- Present learning at partner conferences
- Social media/networking (e.g., Twitter, Facebook, Email)
- Collaborative educational programs
- Media communication efforts
- RCA, FMEA, and "best possible medication history" (BPMH) workshops
- Webinars/presentations/elearning modules
- Train-the-Trainer programs
- Online educational materials for consumers and health care practitioners
- Educational materials on ISMP Canada website
- Responses to email and telephone queries
- Pan-Canadian medication safety network

Promoting and supporting consultation and collaboration

- Identification of potential partners
- Memoranda of understanding/ partnering agreements
- Collaborative KT projects
- Leverage partnerships/action plans for greater impact
- Dissemination/ implementation plans
- Provincial, national and international levels

Immediate Outcomes

- Increased use of mechanisms for reporting medication incidents by health care organizations, professionals, and consumers
- Generation of feasible recommendations, safety solutions, and selected evidence-based interventions
- Increased awareness and understanding of medication safety issues and evidence-based safety practices
- Increased recognition of ISMP Canada as a key partner in medication safety by national, provincial, and territorial health system stakeholders

↔ Broadening reach of ISMP Canada activities

↔ Increased integration of efforts to promote safe medication practices

↔ Increased implementation of evidence- and system-based medication safety practice improvements based on ISMP Canada recommendations/safety solutions/other activities

Intermediate Outcomes

Reduction in and prevention of harmful medication incidents in Canada

Ultimate Outcome

- Improved quality of care and patient outcomes
- Reduced costs associated with harmful medication incidents and increased sustainability of the health care system

Zero Preventable Harm From Medications

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