ISMP Canada Workshop

Medication safety: Incident analysis and proactive risk assessment for Emergency Medical Services (EMS)

This 1.5 day workshop provides EMS healthcare practitioners with background theory and hands-on practice in incident analysis (root cause analysis) and proactive risk assessment using failure mode and effects analysis (FMEA)

Day 1: Incident Analysis - Root Cause Analysis (RCA)

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:
In the RCA portion of the workshop, participants will learn:

1. How systems theory and human factors principles impact error potential and solution development;
2. Why it is important to consider the full incident management continuum;
3. How to complete a system-based analysis; and
4. How to redesign systems for safety.

Day 2: Proactive Risk Assessment Using Failure Mode and Effects Analysis (FMEA)

Program Abstract:
Failure Mode and Effects Analysis (FMEA) is a technique used to identify process and problems before they occur. This half-day workshop builds on the principles learned in Day 1, with a change in focus to proactive risk assessment and process redesign. 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.

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

Audience:
Paramedics, pharmacy directors, pharmacists, pharmacy technicians, nurses, physicians, risk managers, patient safety officers, medication safety officers, and other healthcare practitioners

Workshop Level:
Introductory

We Will Come to You – Onsite Training

If you would like ISMP Canada to bring this workshop to your organization please email us at education@ismpcanada.ca

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AGENDA for Day 1

A.M.	**8:30 – 9:00**	**Registration**
	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	***Analysis Activity 1:*** *Getting started*
	11:45 – 12:15	***Analysis Activity 2:*** *Develop/review incident timeline*
P.M.	**12:15 – 12:45**	**Lunch**
	12:45 – 1:00	**Analysis Process Part 2: How and why it happened**
	1:00 – 2:00	***Analysis Activity 3:*** *Develop constellation diagram (support identification of contributing factors)*
	2:00 – 2:15	**Summarize findings and develop actions**
	2:15 – 2:30	***Analysis Activity 4:*** *Summarize findings* ***Analysis Activity 5:*** *Develop action and measurement plans*
	2:30 – 2:45	**Follow through and close the loop**
	2:45 – 3:00	***Analysis Activity 6:*** *Share learning*
	3:00 – 3:15	**Break and Evaluation**
	3:15 – 3:45	**Introduction to Proactive 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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AGENDA for Day 2

A.M.	**8:30 – 8:45**	**Registration**
	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**