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ISMP Canada Workshop

Medication safety: Incident analysis (Root Cause Analysis)

This full-day workshop provides healthcare practitioners with background theory and hands-on practice in incident analysis (root cause analysis). 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:

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.

Audience:

Pharmacy directors, pharmacists, pharmacy technicians, nurses, physicians, risk managers, patient safety officers, medication safety officers, and other healthcare practitioners.

Workshop Level:

Introductory



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AGENDA

A.M.	8:30 – 9:00	Registration
	9:00 – 9:15	Welcome, Introduction, Goals for the Day
	9:15 – 10:15	Patient Safety 101 <ul style="list-style-type: none"> • Scope of the problem • System approach • Impact of human factors engineering principles on error potential and solution development
	10:15 – 10:30	Group activity: <i>applying human factors engineering principles</i>
	10:30 – 10:45	Break
	10:45 – 11:30	Using the Canadian Incident Analysis Framework: <ul style="list-style-type: none"> • Overview • Before the incident • Immediate response • Prepare for Analysis • Analysis Process Part 1: What happened?
	11:30 – 12:00	Analysis Activity 1: <i>Getting started</i>
P.M.	12:00 – 12:30	Analysis Activity 2: <i>Develop the timeline</i>
	12:30 – 1:00	Lunch
	1:00 – 1:15	Analysis Process Part 2: How and why it happened
	1:15 – 2:15	Analysis Activity 3: <i>Develop constellation diagram</i>
	2:15 – 2:30	Summarize findings and develop actions
	2:30 – 2:50	Analysis Activity 4: <i>Summarize findings</i>
	2:50 – 3:15	Analysis Activity 5: <i>Develop action and measurement plans</i>
	3:15 – 3:30	Break and Evaluation
	3:30 – 3:45	Follow through and close the loop
	3:45 – 4:00	Analysis Activity 6: <i>Share learning</i>
	4:00 – 4:15	Summary