



ISMP Canada Workshop

Medication safety: Incident analysis and proactive risk assessment

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

Day 1:

Incident Analysis - Root Cause Analysis (RCA)

The Root Causes Analysis (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.¹

Program Abstract:

The program begins with an overview of the system approach in the management of error and introduction to human factors engineering principles. RCA is a tool to help investigate patient safety 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 factors, summarizing 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 healthcare 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.

Audience:

Nurses, physicians, pharmacists, pharmacy directors, risk managers, patient safety officers, medication safety officers, paramedics and other healthcare practitioners

Workshop Level:

Introductory

Location:

ISMP Canada
4711 Yonge Street
(Procter & Gamble building)
Toronto, ON M2N 6K8
Tel: 416-733-3131 Ext. 0

Time:

Day 1: 8:30 a.m. to 4:30 p.m.
Day 2: 8:30 a.m. to 1:00 p.m.

Cost:

\$850 per person, plus applicable taxes

Further Information:

Telephone: 416-733-3131 Ext. 0
Toll Free: 1-866-544-7672
E-mail: education@ismp-canada.org

¹ Incident Analysis Collaborating Parties. Canadian Incident Analysis Framework. Edmonton, AB: Canadian Patient Safety Institute; 2012. Incident Analysis Collaborating Parties are Canadian Patient Safety Institute (CPSI), Institute for Safe Medication Practices Canada, Saskatchewan Health, Patients for Patient Safety Canada (a patient-led program of CPSI), Paula Beard, Carolyn E. Hoffman and Micheline Ste-Marie



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AGENDA for Day 1:

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 <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</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 – 11:45	Analysis Activity 1: <i>Getting started</i>
	11:45 – 12:15	Analysis Activity 2: <i>Develop/Review an incident timeline</i>
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: <i>Develop constellation diagram (support identification of contributing factors)</i>
	1:45 – 2:00	Summarize findings and develop actions
	2:00 – 2:15	Analysis Activity 4: <i>Summarize findings</i>
	2:15 – 2:30	Analysis Activity 5: <i>Develop action and measurement plans</i>
	2:30 – 2:45	Break and Evaluation
	2:45 – 3:00	Follow through and close the loop
	3:00 – 3:15	Analysis Activity 6: <i>Share learning</i>
	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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Day 2:

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

The workshop curriculum is derived from the Canadian Failure Mode and Effects Analysis Framework Version II (2016).

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 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.

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

Audience:

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AGENDA for Day 2:

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