



ISMP Live Virtual Canada Workshop

Medication safety: Incident analysis and proactive risk assessment for Paramedicine

This 1.5 day workshop provides paramedics 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.

Audience:

Paramedics, pharmacy directors, pharmacists, pharmacy technicians, nurses, physicians, risk managers, patient safety officers, medication safety officers, and other health care practitioners

Workshop Level:

Introductory

Requirements to Attend:

Computer with internet connection, speakers, webcam, and microphone. Join us virtually from your own location.

Email education@ismpcanada.ca if you would like to arrange a virtual workshop for your organization.

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