

ISMP Canada Workshop

Medication safety: Incident analysis (Root Cause Analysis)

Customized for the Long-Term Care Environment

AGENDA

A.M.	8:00 – 9:00	Registration
	9:00 – 9:15	Welcome, Introduction, Goals for the Day
	9:15 – 10:00	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
	10:00 – 10:15	Group activity: <i>applying human factors engineering principles</i>
	10:15 – 10:30	Break
	10:30 – 11:15	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?
	11:15 – 11:45	Analysis Activity 1: <i>Getting started</i>
	11:45 – 12:15	Analysis Activity 2: <i>Develop the timeline</i>
P.M.	12:15 – 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	Group Debrief
	2:30 – 2:45	Break
	2:45 – 3:00	Summarize findings and develop actions
	3:00 – 3:15	Analysis Activity 4: <i>Summarize findings</i>
	3:15 – 3:30	Analysis Activity 5: <i>Develop action and measurement plans</i>
	3:30 – 3:45	Group Debrief
	3:45 – 4:00	Follow through and close the loop
	4:00 – 4:15	Analysis Activity 6: <i>Share learning</i>
	4:15 – 4:30	Summary, Closing Remarks and Evaluation