

REDUCING MEDICATION ERRORS 2008

FIFTH ANNUAL CONFERENCE

Tuesday 7 October 2008 76 Portland Place London

Topics include:

- Improving medications safety in practice: moving forward
- The patient perspective
- Proactive approaches to improving safety, identifying risks and medication errors: lessons from a Safer Patients Initiative pilot site
- Undertaking an Failure Mode Effects Analysis (FMEA)
- Reducing errors in the frontline: a framework for double checking
- Undertaking a Root Cause Analysis
- Supporting clinicians who make a medication error and managing poor medication
- Reducing medication errors and improving outcomes when patients are transferred between care settings
- Update from the National Patient Safety Agency

PLUS workshops:

- Prescribing practice: competence and performance
- Patient safety trigger tools and side effects
- Reducing medication errors in primary care
- Medicolegal risk and medication errors

Keynote Speakers:

Professor Bryony Dean Franklin
Director Centre for Medication Safety and Service Quality, Imperial College Healthcare NHS Trust and The School of Pharmacy, University of London

Steve Brown

Medicines Advisor NHS South West & Member, The NHS Patient Safety Campaign Core Team & Director of Pharmacy, United Bristol Healthcare NHS Trust

Margaret Murphy

Steering Group Member, Patients for Patient Safety World Alliance for Patient Safety, WHO



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“At the moment we are simply too slow to act to ensure that other patients are not harmed by the same sources of risk.”

SAFETY FIRST, THE DEPARTMENT OF HEALTH

Chaired by **Professor Bryony Dean Franklin**, the conference provides an important update on the latest developments in improving patient safety and reducing medication errors including updates on the implications of the NHS Next Stage Review and the Pharmacy White Paper.

Following keynote introductions on improving medication safety in practice and the patient perspective, the conference explores the practical issues around identifying, understanding and preventing the reoccurrence of medication errors, from proactive approaches to medication safety to understanding the psychological framework for errors and undertaking a Failure Mode Effects Analysis (FMEA).

A series of workshops covering prescribing competence, patient safety trigger tools and side effects, medication errors in primary care and medicolegal risk provide the opportunity for more interactive learning.

The conference closes by examining how medication errors can be reduced when patients are transferred between care settings and the impact of NPSA alerts in practice.

Feedback from delegates who attended the previous Reducing Medication Errors event:

“Very good, enlightening and provided many good and simple examples that can be taken back to our own area”

LEADERSHIP FACILITATOR, NHS FIFE

“Good practical advice – good forum to share good practice”

PRACTICE TRAINER, SALFORD ROYAL NHS FOUNDATION TRUST

“Very valuable. Lots of info to take away to improve practice within organisation”

SENIOR REGISTERED NURSE, ST ELIZABETH HOSPICE

“I feel reassured that the current (local) medicines management programme is on right track. Motivating, enlightening and informative. Relevant to current practice”

WARD MANAGER, PORTSMOUTH HOSPITALS NHS TRUST

OPENING SESSIONS

Chairman: Professor Bryony Dean Franklin *Director Centre for Medication Safety and Service Quality, Imperial College Healthcare NHS Trust and The School of Pharmacy, University of London*

10.00 **Chairman's Introduction: reducing medication errors**

10.15 **Improving medication safety in practice**

Steve Brown

*Medicines Advisor NHS South West and
Member The NHS Patient Safety Campaign Core Team and
Director of Pharmacy United Bristol Healthcare NHS Trust*

- reducing medication errors: national and local issues
- moving forward: implications of the NHS Next Stage Review and the Pharmacy White Paper
- critical success factors in reducing medication errors

CONFERENCE

STREAM A: IDENTIFYING, UNDERSTANDING AND PREVENTING THE REOCCURRENCE OF MEDICATION ERRORS

11.50 **Proactive approaches to improving safety, identifying risks and medication errors: lessons from a Safer Patients Initiative Pilot Site**

Cathy Howe

*Head of Clinical Governance
with Lead for Medication
Safety Conwy & Denbighshire NHS Trust*

- proactive approaches to reducing medication safety
- changing perceptions around "acceptable" levels of harm and "normal" complications
- the role of SPC charts in empowering change in frontline staff
- developments from Conwy & Denbighshire

12.15 **Working on medication safety in hospitals: evaluation of an improvement approach**

Prof Johan Hellings

*Chief Executive Officer
Hospital East Limburg, Belgium and
Visiting Professor Hasselt University*

- undertaking a baseline assessment of avoidable medication errors in your organisation: using trigger tools and chart review
- an improvement project focusing on medication safety in four hospitals: working on education and training, knowledge, reporting and error prevention
- measuring improvements and the impact of a "no nonsense improvement approach"

12.40 **Practical tools: undertaking a Failure Mode Effects Analysis (FMEA)**

Gordon Thomson

*Principal Clinical Pharmacist
NHS Tayside*

- Failure Mode Effects Analysis explained
- a walkthrough an FMEA for a high risk medication process
- identifying what could go wrong and developing safeguards
- a brief update from the Scottish Patient Safety Alliance

13.05 Questions and answers, followed by lunch and exhibition at 13.15

14.00 **Reducing medication errors in the frontline: a framework for double checking**

Gerry Armitage

*Senior Research Fellow
Bradford Institute for Health Research*

- identifying problems in the double checking process
- understanding the psychological framework for errors
- investigating errors of omission
- a framework for double checking

14.30 **Investigating medication errors: undertaking a root cause analysis**

Jeff McIlwain

*Consultant, Clinical Risk Management
St Helen's & Knowsley NHS Trust*

- root cause analysis explained
- identifying contributory factors
- report writing
- developing and implementing an action plan to prevent reoccurrence

15.00 **Supporting clinicians who make a medication error and managing poor performance**

Chris Caldwell

*Assistant Director of Nursing for Education and Advancement
Great Ormond Street Hospital for Children NHS Trust*

- supporting clinicians and patients when a medication error occurs
- when do mistakes become poor performance? Ensuring a consistent and fair approach that avoids blame and manages poor performance
- initiating change and ensuring competence through training, education and review

15.30 Questions and answers, followed by tea and exhibition at 15.40

RETURN TO MAIN STREAM

FINAL JOINT SESSION: IMPROVING MEDICATION

16.00 **Reducing medication errors and improving clinical outcomes when patients are transferred between care settings**

Margaret Ledger Scott

*Clinical Director Medicines Management and
Chief Pharmacist
Co Durham & Darlington NHS Foundation Trust*

- reducing medication errors when patients are transferred or discharged
- developing a patient booklet to give the patient control over the information regarding their disease management and medication
- the impact on medication errors, hospital admissions and clinical outcomes

10.50 Medication safety: the patient perspective

Margaret Murphy

*Steering Group Member, Patients for Patient Safety
World Alliance for Patient Safety, WHO*

- ensuring patients are fully informed about their medication to improve compliance and safety
- shared decision making: ensuring patients understand risk v benefit
- involving patients as partners: key issues and tips for success

11.20 Question and answers, followed by coffee and exhibition at 11.30

SPLITS

STREAM B: WORKSHOPS

WORKSHOP 1: Prescribing practice: competence and performance

11.45 Developing and assuring prescribing competence

Barbara Stuttle CBE

*Chair The Association for Nurse Prescribing,
Executive Nurse South West Essex Primary Care Trust and
National Clinical Lead for Nursing NHS Connecting for Health*

- competence development for new prescribers
- ensuring prescribing safety in extended roles
- ensuring and assessing prescribing competence

Measuring and improving prescribing performance

Dr Jill Loader

*Associate Director, Medicines Management
NHS South West*

- monitoring prescribing behaviour and performance at trust level: the use of high level prescribing performance indicators
- understanding and analyzing variations in prescribing across organizations
- delivering large scale changes in prescribing behaviour and using prescribing performance within commissioning

Followed by interactive discussion

WORKSHOP 2: Patient safety trigger tools and side effects

12.35 Developing trigger tools to reduce adverse drug incidents

Workshop led by: Gerry Armitage

Senior Research Fellow Bradford Institute for Health Research

With Philip Moore

*Lead pharmacist, Project Development/Elderly and Critical Care
Bradford Teaching Hospital NHS Foundation Trust*

- using trigger tools to identify when adverse drug incidents have occurred
- identifying medications that indicate an adverse drug incident has occurred
- developing consensus: delegates at the workshop will discuss key triggers and appraise options for trigger tools

13.15 Lunch and exhibition

WORKSHOP 3: Medicolegal Risk and Medication Errors

14.00 Medicolegal risk and medication errors

Workshop led by: Dr Carol Seymour

*MedicoLegal Advisor
The Medical Protection Society*

This workshop will cover Medicolegal issues with regard to medication errors including:

- lessons from recent claims and cases
- tips for frontline staff and pharmacists
- an interactive session for delegates to question the MPS over medicolegal risk and challenges they are facing in practice

Followed by interactive discussion

WORKSHOP 4: Reducing medication errors in primary care

14.45 Reducing medication errors in primary care

Workshop Led by: Prof Tony Avery

*Head of Division, Primary Care, GP & Partner and
Professor of Primary Care University of Nottingham*

- improving medication safety and reducing medication errors in primary care
- improving safety at the interface between organizations
- investigating drug related problems in general practice
- exploring relationships between GPs and Pharmacists
- communicating and engaging GPs to improve medication safety

15.30 Questions and answers, followed by tea and exhibition at 15.40

FOR FINAL JOINT SESSIONS

SAFETY BETWEEN ORGANISATIONS

16.30 A whole system approach: an update from the NPSA

Prof David Cousins

*Head of Safe Medication Practice
The National Patient Safety Agency*

- an update from the NPSA
- using foresight in practice to identify, respond and recover from initial indications that a patient safety incident could occur: foresight training
- the impact of the NPSA alerts in practice

17.00 Questions and answers, followed by close



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Workshop 2: Patient safety trigger tools and side effects

Workshop 3: Medicolegal Risk and Medication Errors

Workshop 4: Reducing medication errors in primary care

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Handbooks ordered up until two months after the conference will be supplied as a hardcopy in an A4 ring binder, those ordered after this time will be posted as a PDF document on CD.*

Venue
76 Portland Place, London, W1B 1NT. A map of the venue will be sent with confirmation of your booking.

Date
Tuesday 7 October 2008.

Conference fee

£340 + VAT (£399.50) for NHS, social care and private healthcare organisations.

£290 + VAT (£340.75) for voluntary sector/charities.

£475 + VAT (£558.13) for commercial organisations.

£290+VAT (£340.75) for IHM members.

The fee includes lunch, refreshments and a copy of the conference handbook.

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Credits
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