Topics include

- Reducing harm from High Risk Medicines: An update from the National Patient Safety First Campaign
- Weighing up the risks and benefits of High Risk Medicines
- Involving patients in the management of High Risk Medicines
- Managing High Risk Medicines at and after discharge from hospital
- Improving processes and using risk management tools
- Safely prescribing and administering High Risk Medicines
- Training and educating the multidisciplinary team to ensure patient safety and reduce errors
- Effectively implementing an NPSA alert in practice

PLUS Case Studies

- Improving the reliability and safety of the anticoagulation process in Wales
- Prescribing and administering Patient Controlled Analgesia and Epidurals
- Implementing the NPSA patient safety alert: Promoting safer use of injectable medicines

Chaired by
Dr Gerry Armitage
Senior Research Fellow
Bradford Institute for Health Research
High-alert medications are more likely to be associated with harm than other medications — they cause harm more commonly, the harm they produce is likely to be more serious, and they “have the highest risk of causing injury when misused.” The harm leads not only to patient suffering but also to additional costs associated with the care of these patients.

FRANK FEDERICO, R.PH. DIRECTOR, 5 MILLION LIVES CAMPAIGN INSTITUTE FOR HEALTHCARE IMPROVEMENT

Improving Patient Safety and Reducing Harm from HIGH RISK MEDICINES

THURSDAY 18 NOVEMBER 2010
MANCHESTER CONFERENCE CENTRE
MANCHESTER

Chaired by Dr Gerry Armitage Senior Research Fellow Bradford Institute for Health Research, this one day conference gives an important update on Improving Patient Safety and Reducing Harm from High Risk Medicines, which is one of the Patient Safety First interventions. Delegates will hear an update from the Campaign and an overview of the ‘How to Guide’ for reducing harm from High Risk Medicines.

Prescribing and administering High Risk Medicines safely and effectively is essential for ensuring preventable harm is avoided.

“Unintended errors in the prescription, administration and reconciliation of High Risk Medicines account for a significant proportion of harm caused to patients within the healthcare environment.”

PATIENT SAFETY FIRST, HIGH RISK MEDICINES SEPTEMBER 2008

The conference will offer you an opportunity to hear from a broad range of speakers who will share their knowledge and experience in reducing High Risk Medicines including: involving patients in the safe management of High Risk Medicines, ensuring High Risk Medicines are not omitted or delayed during transfer of care and improving processes using high risk management tools.

Case study presentations will draw on the priority High Risk Medicines including;

- Anticoagulants
- Injectable medicines
- Opiates
- Insulin

These are four out of eight medicines found to be most frequently associated with severe harm and are the medicines that the Patient Safety First intervention addresses.
### Chairman: Dr Gerry Armitage Senior Research Fellow Bradford Institute for Health Research

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<th>Time</th>
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| 10.10  | Reducing harm from High Risk Medicines: an update from the National Patient Safety First campaign | Dr Gerry Armitage  
Senior Research Fellow  
Bradford Institute for Health Research | - minimising the risk of unintended harm to patients from High Risk Medicines  
- an overview of the Patient Safety First ‘How to Guide’ for reducing harm from High Risk Medicines  
- implementing the actions in practice: the impact on patient safety                                                                                                                                 |
| 10.40  | Weighing up the risks and benefits of High Risk Medicines                     | Dr Keith Beard  
Consultant Physician in Geriatric Medicines  
Victoria Infirmary  
Glasgow | - weighing up the risks and benefits of High Risk Medicines  
- considering individual cases and the best interests of patients  
- informing patients of the risk and benefits of High Risk Medicines                                                                                                                                 |
| 11.10  | Questions and answers, followed by coffee and exhibition at 11.20             |                                                                           |                                                                                                                                                                                                       |
| 11.45  | Involving patients in the management of High Risk Medicines                   | Professor DK Theo Raynor  
Professor of Pharmacy Practice  
University of Leeds and  
Director LUTO Research | - involving patients in the safe management of High Risk Medicines: providing comprehensive patient information  
- explaining the risks to patients of particular medicines and supporting informed decision making  
- testing and assessing the quality of patient information                                                                                                                                       |
| 12.15  | Managing High Risk Medicines at and after discharge from hospital            | Andy Fox  
Risk Pharmacist  
Southampton University Hospitals NHS Trust | - ensuring High Risk Medicines are not omitted or delayed during transfer of care  
- reviewing incident reports regularly and auditing omitted or delayed critical medicines for quality and safety improvement  
- working collaboratively between primary and secondary care                                                                                                                                       |
| 12.45  | Questions and answers, followed by lunch and exhibition at 13.00              |                                                                           |                                                                                                                                                                                                       |
| 13.00  | Case Studies: Priority High Risk Medicines                                    |                                                                           |                                                                                                                                                                                                       |
| 14.00  | Improving processes and using risk management tools                           |                                                                           |                                                                                                                                                                                                       |
| 14.30  | Safely prescribing and administering High Risk Medicines                      | Dr Justine Scanlan  
Director of Pharmacy  
Salford Royal Hospitals NHS Trust | - the risk factors associated with the intravenous administration of opiates  
- auditing the prescribing and documentation to PCAs and epidurals to ensure safe practice and reduce risk  
- making improvements in practice: a multidisciplinary approach                                                                                                                                 |
| 15.00  | Questions and answers, followed by tea and exhibition at 15.30                |                                                                           |                                                                                                                                                                                                       |
| 15.30  | Training and educating the multidisciplinary team to ensure patient safety and reduce errors | Gillian Cavell  
Deputy Director of Pharmacy  
Medication Safety Kings College Hospital | - identifying the common risk factors that lead to insulin errors in hospitals  
- making improvements: training and educating the multidisciplinary team  
- measuring and monitoring the improvements to patient safety                                                                                                                                 |
| 16.00  | Effectively implementing an NPSA alert in practice                           | Jane Watson  
Non Medical Prescribing Lead / Medicines Practice Facilitator  
NHS Devon | - promoting safer use of injectable medicines: implementing the NPSA patient safety alert in practice  
- safely prescribing, preparing and administering high risk injectable medicines  
- reducing errors and avoidable patient harm                                                                                                                                                  |
| 16.30  | Questions and answers, followed by close                                       |                                                                           |                                                                                                                                                                                                       |
Improving Patient Safety and Reducing Harm from HIGH RISK MEDICINES
THURSDAY 18 NOVEMBER 2010   MANCHESTER CONFERENCE CENTRE, MANCHESTER

Venue
Manchester Conference Centre, UMIST, Weston Building, Sackville Street, Manchester, M1 3BB. A map of the venue will be sent with confirmation of your booking.

Date
Thursday 18 November 2010.

Conference fee
- £365 + VAT (£428.88) for NHS, social care, private healthcare organisations and universities.
- £300 + VAT (£352.50) for voluntary sector/charities.
- £495 + VAT (£581.63) for commercial organisations.
The fee includes lunch, refreshments and a copy of the conference handbook. VAT at 17.5%.

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A discount of 15% is available to all but the first delegate from the same organisation, booked at the same time, for the same conference.

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A refund, less a 20% administration fee, will be made if cancellations are received, in writing, at least 4 weeks before the conference. We regret that any cancellation after this time cannot be refunded, and that refunds for failure to attend the conference cannot be made, but substitute delegates are welcome at any time.

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