

A PRACTICAL GUIDE TO REDUCING MEDICATION ERRORS

Implementing good medicines
management practice and
patient safety interventions

Thursday 7 October 2010
Cavendish Conference Centre, London



Topics include:

- The Quality-Productivity Challenge: reducing medication errors, learning from national reporting
- Reducing Medication Errors: moving forward
- Reducing medication errors: progress beyond the Patient Safety First Campaign
- Following the patient journey to improve medicines management and reduce errors from admission to discharge or transfer of care
- Reducing the prevalence of medication errors in general practice
- Ensuring frontline staff are competent to administer medicines
- Learning from medication errors and changing systems to improve practice
- Evaluating the impact of various technologies designed to reduce medication errors
- Taking steps to reduce harm from omitted and delayed medicines in practice
- Implementing risk management tools to reduce medication errors in practice
- Improving reporting through positive feedback on incidents

Chair and speakers include:

Tom Gray

Chief Pharmacist Derby Hospital
NHS Foundation Trust and
SHA Lead NHS East Midlands

Martin Stephens

National Clinical Director
for Hospital Pharmacy
Department of Health

Steve Brown

Director of Pharmacy University
Hospitals Bristol NHS Foundation
Trust and Associate Director
Medicines Management
NHS South West; Core Team
Member Patient Safety First
Campaign for England

A PRACTICAL GUIDE TO REDUCING MEDICATION ERRORS

Implementing good medicines management practice
and patient safety interventions



Thursday 7 October 2010 Cavendish Conference Centre, London

“Incidents involving medicines were the third largest group (nine per cent) of all incidents reported to the RLS.”

‘SAFETY IN DOSES’ NATIONAL PATIENT SAFETY AGENCY 2009

“Millions of medicines are prescribed in the community and in hospitals across England and Wales each day – the majority of these are delivered correctly and do exactly what they are meant to do. However when an incident does occur, it is vital we learn from this to ensure patients are not harmed.”

MARTIN FLETCHER NPSA
CHIEF EXECUTIVE ‘TACKLING MEDICATION INCIDENTS AND INCREASING PATIENT SAFETY’ – THURSDAY 3 SEPTEMBER 2009

Chaired by **Tom Gray** Chief Pharmacist Derby Hospital NHS Foundation Trust and **SHA Lead** NHS East Midlands this important one day conference will give delegates key updates to reducing medication errors and increasing patient safety. **Martin Stephens** National Clinical Director for Hospital Pharmacy Department of Health will follow the Chairman’s welcome and introduction with a keynote address on moving forward: the future for reducing medication errors and delivering safe medication practice. This will be followed by a key update following the Patient Safety First campaign and its progress. Issues to be addressed include how changing the culture can help set the benchmark to zero, critical success factor in reducing medication errors and monitoring medication errors as a patient safety indicator.

“There are risks to the safety of patients when they are prescribed medicines, particularly after leaving hospital. Incidents involving medication, such as prescribing errors and failures to review medication after discharge, were the fourth most commonly reported to the National Patient Safety Agency during 2008. One study estimates around 4% of all hospital admissions are due to preventable medicine-related issues.”

CARE QUALITY COMMISSION ‘NHS MUST DO MORE TO PREVENT HARM TO PATIENTS FROM PRESCRIBED MEDICINES AFTER LEAVING HOSPITAL’ 27 OCTOBER 2009

The day will continue by focussing on developing a multidisciplinary/multiagency approach to reducing medication errors across the pathway from admission to discharge, and implementing patient safety interventions to reduce medication errors including **Petra Brown** Chief Pharmacist Manchester Mental Health and Social Care Trust who will talk about learning from medication errors and changing systems to improve practice. Petra and colleagues were winners of the Better Safety in Medicines category of the Patient Safety Awards 2010.

10.00 Chair's welcome and introduction

- The Quality-Productivity Challenge: reducing medication errors, learning from national reporting'

10.15 Keynote address – Reducing Medication Errors: moving forward

Martin Stephens

*National Clinical Director for Hospital Pharmacy
Department of Health*

- moving forward: the future for reducing medication errors and delivering safe medication practice

10.40 Reducing medication errors: progress beyond the Patient Safety First Campaign

Steve Brown

*Director of Pharmacy University Hospitals Bristol
NHS Foundation Trust and Associate Director Medicines
Management NHS South West; Core Team Member
Patient Safety First Campaign for England*

- reducing medication errors: national and local progress
- what is avoidable: changing the culture to set the benchmark to zero
- critical success factors in reducing medication errors
- monitoring medication errors as a patient safety indicator

11.10 Questions and answers, followed by coffee and exhibition at 11.20

FOCUS: DEVELOPING A MULTIDISCIPLINARY/MULTIAGENCY APPROACH TO REDUCING MEDICATION ERRORS ACROSS THE PATIENT JOURNEY

11.50 Following the patient journey to improve medicines management and reduce errors from admission to discharge or transfer of care

Cheryl Crocker

*Deputy Director of Nursing and Quality
East Midlands Ambulance Service*

- identifying key areas in the patients journey when action needs to be taken to improve medication safety and reduce errors
- managing medicines at and after discharge or transfer of care
- working with primary and community care to prevent medication errors at and after discharge or transfer of care
- the role of the ambulance service in medicines management and reducing errors

12.15 Reducing the prevalence of medication errors in general practice

Professor Tony Avery

*Head of Division of Primary Care
University of Nottingham*

- assessing the prevalence of medication errors in general practice
- good practice and interventions to reduce medication errors in general practice
- monitoring and reviewing patient medications and ensuring patients are educated about their medication

12.40 Ensuring frontline staff are competent to administer medicines

Paul Warburton

Senior Lecturer Edge Hill University

- ensuring frontline staff are competent to calculate doses: improving numeracy skills
- education and training frontline staff to reduce medication errors
- supporting staff following a medication error

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

FOCUS: IMPLEMENTING PATIENT SAFETY INTERVENTIONS TO REDUCE MEDICATION ERRORS

14.10 Learning from medication errors and changing systems to improve practice

Petra Brown

*Chief Pharmacist
Manchester Mental Health and Social Care Trust
Petra Brown and colleagues were winners of the Better Safety
in Medicines category of the Patient Safety Awards 2010*

- improving medication incident reporting and capturing pharmacist interventions
- learning from medication errors through incident scrutiny meetings, mandatory training, e-learning and newsletters
- changing systems to improve medication practice: developments at Manchester Mental Health and Social Care Trust

14.35 Evaluating the impact of various technologies designed to reduce medication errors

Professor Bryony Dean Franklin

*Executive Lead Pharmacist (Research) and Director
Centre for Medication Safety and Service Quality,
Imperial College Healthcare NHS Trust and
The School of Pharmacy University of London*

- the technologies available to reduce medication errors and their impact
- learning from overseas and the future for implementing new systems in the UK
- understanding human factor issues in medication errors and how technology can help eliminate human error
- an update on e-prescribing

15.00 Taking steps to reduce harm from omitted and delayed medicines in practice

Dr Alistair McIntyre

*Consultant Physician, Gastroenterologist and Hepatologist
Buckinghamshire Hospitals NHS Trust*

- identifying critical medicines where timeliness of administration is crucial
- understanding what to do when a medicine has been omitted or delay: having guidance and procedures in place
- reviewing and improving systems for the supply of time critical medicines within and out-of-hours to minimize risks

15.25 Questions and answers, followed by tea and exhibition at 15.35

16.00 Implementing risk management tools to reduce medication errors in practice

Keith Weeks

*Reader in Health Professional Education
Faculty of Health Sport and Science
University of Glamorgan with Paul Spark
Principle Pharmacist Cardiff and Vale University Health Board*

- an overview of the various risk management tools available to reduce medications errors in practice
- using the Global Trigger Tool (GTT) in practice to reduce harm from medication errors
- the impact on patient safety and the number of serious medication errors

16.30 Improving reporting through positive feedback on incidents

Alice Osborne

*Research and Development Pharmacist
Guy's and St Thomas' NHS Foundation Trust*

- identifying when adverse drug incidents or near misses have occurred
- improving reporting and sharing the learning from incidents
- developing an integrated approach: tips and advice

17.00 Questions and answers, Close



▶ How to book	Fax the booking form to 020 8547 2300	Through our website at: www.healthcare-events.co.uk	Post this form to Healthcare Events 2 Acre Road, Kingston, Surrey KT2 6EF
----------------------	--	--	--

▶ Your details (Please complete a new form for each delegate. Photocopies are acceptable)

Dr Mr Mrs Ms (Please circle)

First name

Surname

Job Title

Department

Organisation

Address

Postcode

Telephone

Fax

Email

*Please write your address clearly as confirmation will be sent by e-mail.
If you prefer confirmation by post please tick this box.
Please also ensure you complete your full postal address details for our records.*

Please specify any special dietary or access requirements

This form must be signed by the delegate or an authorised person before we can accept the booking
(By signing this form, you are accepting the terms and conditions below)

Name

Signature

Date

▶ Payment

By cheque A cheque for _____ is enclosed
Please make cheques payable to: Healthcare Events Ltd. Cheques can be £ or Euros (1 Euro = £0.90)

By invoice Please send an invoice to

Name (IN BLOCK CAPITALS)

Organisation

Address

Postcode

Purchase order number if applicable

By BACS

For payments in £: Sort Code 16-22-24 Account No. 10111198
For payments in Euros: Sort Code 16-10-90 Account No. 10048291

Please send your BACS remittance form as confirmation of payment

Your BACS reference _____

By credit card Please debit my Visa/Mastercard/Switch **All sections must be completed**

Cardholder's name

Card No. _____

Valid from _____ Expiry date _____

Issue No. (Switch only) _____

Card security code _____ (This is the last three digits of the number printed on the back of your card)

Signature

Card billing address

For office use only

Conference documentation I cannot attend the conference but would like to receive a CD containing the conference handbook material, which includes speaker slides, at £69 each.

The CD will be sent out after the conference, please fill in the 'Your Details' section above for delivery, and the 'Payment' section.

Venue
Cavendish Conference Centre, 22 Duchess Mews, London, W1G 9DT. A map of the venue will be sent with confirmation of your booking.

Date
Thursday 7 October 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%.

Group rates
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.

Terms and conditions
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.

Accommodation
On confirmation of your booking you will receive details of accommodation.

Confirmation of booking
All bookings will be confirmed by email, unless stated otherwise. Please contact us if you have not received confirmation 7–10 days after submitting your booking.

Exhibition
If you are interested in exhibiting at this event, please contact Gemma Belford on 020 8541 1399 or email gemma@healthcare-events.co.uk

Credits
The conference is accredited by the Royal College of Physicians, London and College of Pharmacy Practice Accreditation applied for.

For more information contact Healthcare Events on **020 8541 1399** or email **jayne@healthcare-events.co.uk**

The information you provide will be held on the Healthcare Events' database and may be used to update you with details of other events that we organise. If you DO NOT wish to receive this information, please tick this box

We occasionally release your details to companies sponsoring or exhibiting at our events. If you DO NOT wish to receive information from these companies, please tick this box

Healthcare Events reserve the right to make changes to speakers and programmes without prior notice. © Healthcare Events Ltd 2010.