Tenth National Conference

A Practical Guide to Reducing Medication Errors
Improving Patient Safety

Wednesday 23 March 2011
Manchester Conference Centre, Manchester

Topics include:
- Keynote address from the Department of Health – Reducing Medication Errors: moving forward
- Patient Safety Interventions that work to reduce Medication Errors: beyond the Patient Safety First campaign
- Reducing the prevalence of Medication Errors in general practice
- Engaging Junior Doctors in patient safety: Medication Errors
- Developing nursing competence for the management and administration of medicines including supporting staff when a Medication Error occurs
- Reducing Medication Errors: Focusing on High Risk Medicines
- Learning from Medication Errors and changing systems to improve practice
- Taking steps to reduce harm from omitted and delayed medicines in practice
- Following the patient journey to improve medicines management and reduce errors from admission to discharge or transfer of care
- Reducing Medication Errors in care homes
- Reducing Medication Errors as a Quality Accounts priority: where to start

Chair and speakers include:

Carol Alstrom,
Workstream Lead, No Needless Medication Errors, The Patient Safety Federation & Chief Nurse, NHS Isle of Wight

Dr Justine Scanlan
Director of Pharmacy Salford Royal Hospitals NHS Trust & Fellow NHS Institute for Innovation and Improvement

Jonathan Mason
Head of Prescribing and Pharmacy Department of Health and Head of Medicines Management City & Hackney Teaching PCT

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A PRACTICAL GUIDE TO
REDDUCING
MEDICATION ERRORS
Improving Patient Safety

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"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, CHIEF EXECUTIVE, NATIONAL PATIENT SAFETY AGENCY

"Incidents involving medicines were the third largest group (nine per cent) of all incidents reported to the RLS, after patient accidents (35 per cent) and treatment / procedure (nine per cent), from a total of 811,746 incidents of all types reported during 2007.”

SAFETY IN DOSES: IMPROVING THE USE OF MEDICINES IN THE NHS, NATIONAL PATIENT SAFETY AGENCY

"Medication errors are any incident where there has been an error in the process of prescribing, dispensing, preparing, administering, monitoring or providing medicines advice, regardless of whether any harm occurred or was possible. This is a broad definition and most errors result in no or low harm.”

SAFETY IN DOSES: IMPROVING THE USE OF MEDICINES IN THE NHS, NATIONAL PATIENT SAFETY AGENCY

Chairled by Carol Alstrom, Workstream Lead, No Needless Medication Errors, The Patient Safety Federation & Chief Nurse, NHS Isle of Wight, this important one day conference will give delegates key updates to reducing medication errors and increasing patient safety. The day will commence with a keynote introduction from Dr Justin Scanlan, Director of Pharmacy Salford Royal Hospitals NHS Trust & Fellow NHS Institute for Innovation and Improvement who will give a national update on Medication Errors, medication safety in terms of QIPP and an update from the NHS Outcomes Framework regarding delivering better outcomes relating to the safer use of medicines. This will be followed with a presentation to discuss moving forward from the Patient Safety First campaign including what medication errors are avoidable, critical success factors in reducing medication errors and monitoring medication errors as a patient safety indicator.

After the break the focus will shift to implementing patient safety interventions to reduce medication errors. Diane Wake Executive Director of Nursing and Operations Royal Liverpool and Broadgreen University Hospitals will discuss developing nursing competence for the management and administration of medicines including supporting staff when a medication error occurs, ensuring frontline staff are competent to calculate doses by improving numeracy skills, education and training frontline staff to reduce medication errors and ending with the importance of supporting individuals following a medication error.

Louise Howard-Baker, Pharmacist Betsi Cadwaladr University Health Board and Programme Manager, Improving Medicines Management 1000 Lives Programme for Wales will follow after the lunch break to discuss reducing medication errors by focusing on high risk medicines including prioritising high alert medications in primary and secondary care, supporting clinical teams to reduce harm from high risk medicines and actions to reduce harm highlighting case studies in practice.

The final session concludes with a focus on reducing medication errors across the patient pathway including at discharge, in care homes and a session focused on primary care delivered by Jonathan Mason, Head of Prescribing and Pharmacy Department of Health and Head of Medicines Management City & Hackney Teaching PCT

Visit our website www.healthcare-events.co.uk or tel 020 8541 1399  fax 020 8547 2300
Chair: Carol Alström, Workstream Lead, No Needless Medication Errors, The Patient Safety Federation & Chief Nurse, NHS Isle of Wight

10.00 Chair’s welcome and introduction

10.10 Keynote address – Reducing Medication Errors: moving forward
Dr Justine Scanlan
Director of Pharmacy Salford Royal Hospitals NHS Trust & Fellow NHS Institute for Innovation and Improvement
- Reducing Medication Errors: National Update
- Medication Safety within the QIPP agenda
- delivering better outcomes relating to the safer use of medicines: an update from the NHS Outcomes Framework

10.40 Patient Safety Interventions that work to reduce Medication Errors: beyond the Patient Safety First Campaign
Omar Ali
Formulary Development Pharmacist
Surrey and Sussex Healthcare NHS Trust
with Michael Wilson Chief Executive
- 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: IMPLEMENTING PATIENT SAFETY INTERVENTIONS TO REDUCE MEDICATION ERRORS

11.50 Reducing Medication Errors as a Quality Accounts Priority: where to start
Shiraz Haider Chief Pharmacist with Ann Hunt Director of Operations
Lincolnshire Partnership NHS Foundation Trust
- why we have prioritised the reduction of Medication Errors as a Quality Accounts priority
- establishing a baseline for Medication Errors to enable progress to be tracked
- managing medicines management risk and reporting

12.15 Engaging Junior Doctors in patient safety: Medication Errors
Shree Datta
Chair The Junior Doctors Committee, The British Medical Association
- training and educating junior doctors in medication safety
- what can be done to support Junior Doctors

12.30 Developing nursing competence for the management and administration of medicines including supporting staff when a Medication Error occurs
Diane Wake
Executive Director of Nursing and Operations
Royal Liverpool and Broadgreen University Hospitals
- ensuring frontline staff are competent to calculate doses: improving numeracy skills
- education and training frontline staff to reduce Medication Errors
- supporting individuals following a Medication Error

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

14.00 Reducing Medication Errors: focusing on High Risk Medicines
Louise Howard-Baker
Clinical Director of Pharmacy and Medicines Management, Betsi Cadwaladr University Health Board and Programme Manager, Improving Medicines Management
1000 Lives Programme for Wales
- prioritising high alert medications in primary and secondary care
- supporting clinical teams to reduce harm from high risk medicines
- actions to reduce harm: case studies in practice

14.25 Learning from Medication Errors and changing systems to improve practice
Dr Chris Green
Director of Pharmacy and Medicines Management
Countess of Chester Hospital NHS Foundation Trust
- improving medication incident reporting and capturing pharmacist interventions
- learning from Medication Errors through incident scrutiny meetings, mandatory training, e-learning and newsletters
- improving reporting on actual and near miss drug incidents: sharing the learning through feedback
- changing systems to improve medication practice: developments in the Countess of Chester

14.50 Taking steps to reduce harm from omitted and delayed medicines in practice
Dr David Rosser
Executive Medical Director
University Hospital Birmingham NHS Foundation Trust
- identifying critical medicines where timeliness of administration is crucial
- real time alerting when medicines have been omitted or delayed
- 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 minimise risks

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

FOCUS: REDUCING MEDICATION ERRORS ACROSS THE PATIENT JOURNEY

15.30 Following the patient journey to improve medicines management and reduce errors from admission to discharge or transfer of care
Reena Chauhan
Senior Pharmacist – Governance and Patient Safety
Derby Hospitals NHS Foundation Trust
- 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 across boundaries to prevent medication errors at and after discharge or transfer of care
- promoting safe medicines use across NHS East Midlands

16.00 Reducing Medication Errors in care homes
Prof Irene Gray
Director of Care, Southern Cross Healthcare PLC
- improving medicines management in care homes
- managing complex medication regimes
- working in partnership to demonstrate improvements: responding to the DH Alert

16.25 Reducing the prevalence of Medication Errors in primary care
Jonathan Mason,
Head of Prescribing and Pharmacy Department of Health and Head of Medicines Management
City & Hackney Teacher PCT
- assessing the prevalence of medication errors in general practice
- good practice and interventions to reduce medication errors in general practice
- improving concordance through the monitoring and review of patient medications and ensuring patients are educated about their medication

16.50 Questions and answers, followed by close