

A Practical Guide to Reducing Medication Errors

Improving Patient Safety: Towards Zero Tolerance

Wednesday 1 July 2015 Manchester Conference Centre, Manchester

10% Card payments discount**
15% Group booking discount**



Chaired by

Dr David Gerrett

Senior Pharmacist, Medication Safety Team

NHS England

Supporting Organisations



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"it's a learning curve for everybody to ensure patients are receiving harm free care"

Ahmed Ameer Medication Safety Officer NHS England January 2015

"Progress has been made over the last decade to detect, report and learn from patient safety incidents, but further improvements are needed to increase the number of incident reports, improve data quality and maximise what is learned from medication errors....Medication errors are any patient safety incidents where there has been an error in the process of prescribing, preparing, dispensing, administering, monitoring or providing advice on medicines. These Patient Safety Incidents can be divided into two categories; errors of commission or errors of omission. The former include, for example, wrong medicine or wrong dose. The latter include, for example, omitted dose or a failure to monitor, such as international normalised ratio for anticoagulant therapy."

Patient Safety Alert, MHRA and NHS England March 2014

This conference will focus on reducing medication errors and improving patient care with a focus on a zero tolerance approach. The day will begin with national developments in reducing medication errors from NHS England including the effective implementation of the National Patient Safety Alert on improving medication error incident reporting and learning released in 2014, and the developing role of the Medication Safety Officer. The day will continue to look at reducing harm through medication errors using the national medication safety thermometer and the importance of involving patients in reducing medication errors.

A focus area of the conference is on developing a zero tolerance approach to medication errors – a strategy that has worked effectively for reducing infection rates, and pressure ulcer rates across the NHS. This area of the programme will look at zero tolerance prescribing, how to set the benchmark at zero, improving the quality of junior doctor prescribing and developing and assessing competence and safety in medicines administration on the wards.

The conference will continue with case study based sessions on areas including improving incident reporting and learning from incidents, reducing harm from missed doses, omitted and delayed medicines, and focusing on high risk drugs. A final interactive session will provide a step by step guide to incident investigation and root cause analysis of medication safety incidents.

100% of delegates at our last conference on Reducing Medication Errors would recommend the conference to a colleague.

Follow the conference on Twitter #MedicationErrors

10.10 Chairman's Introduction: Reducing Medication Errors: National Update

David Gerrett

Senior Pharmacist, Medication Safety Team
NHS England

- the development of the National Medication Safety Network
- improving the number, quality, timeliness of reports
- maximising local learning and actions
- improving adherence to the Patient Safety Alert on improving medication error incident reporting and learning
- developing the role of the medication safety officer

10.40 Effective Prescribing Insight for the Future: Engaging Prescribers & Reducing Junior Doctor Medication Error

Dr Rakesh Patel

Specialist Registrar in Nephrology
Leicester General Hospital
and NIHR Academic
Clinical Lecturer in Medical Education University of Leicester

- a 'multifaceted educational intervention' to increase the skills, knowledge and competence of junior doctors to avoid prescribing errors
- ensuring junior doctors retain conscious control while problem-solving and decision-making when prescribing complex medications
- Increasing engagement of clinicians in the patient safety agenda

11.10 Question and answers, followed by coffee and exhibition

11.50 Zero Tolerance to Medication Errors: setting the benchmark at zero

Dr Janine Wright

Consultant Gastroenterologist
and Safer Medication Work Stream Clinical Lead
North Middlesex University Hospital NHS Trust

- how ambitious should patient safety goals be in relation to Medication Errors? Our goal of 100% high risk medicines and medicines reconciliation compliance and no medication related Never Events
- establishing a baseline for medication errors to enable progress to be tracked
- high risk drugs: where to prioritise medication error reduction programmes
- focusing on the medication errors that cause the most harm to patients
- accountability for delivery of patient safety improvement targets with relation to medication errors

12.20 Strategies for Reducing Medication Errors and Associated Harm Reduction

Shiraz Haider

Chief Pharmacist
Lincolnshire Partnership NHS Foundation Trust

- how ambitious should patient safety goals be in relation to Medication Errors?
- changing the top-down culture and supporting staff
- our direct experience of reducing medication errors and harm in mental health in both secondary and primary care

12.50 Question and answers, followed by lunch and exhibition

14.00 Developing and assessing competence and safety in Medicines Administration on the wards

Alan Pollard

Chief Pharmacist
Birmingham Women's NHS Foundation Trust

- developing and assessing competence in medicines administration on the wards
- the role of self administration of medicines on medication errors
- developing nurse prescribing competence and audit
- reducing medication errors on the ward

14.30 Learning from patients to reduce medication error

Nicola Davey

Trustee & Pharmacist
Clinical Human Factors Group

- learning from patients and involving patients to reduce medication errors
- using staff and patient stories to inspire the team to improve
- engaging patients to self manage medications

15.00 Investigating Medication Prescribing Accuracy for Critical Error Types: the iMPACT tool

Sarah Thomas or Representative

Research Pharmacist
University Hospitals Birmingham NHS Foundation Trust

- 80 high risk/frequent prescribing errors that are amenable to clinical decision support have been identified using a consensus technique with 20 expert pharmacists and physicians
- iMPACT is an electronic audit tool that collects data on the occurrence of the 80 errors in general medicine
- iMPACT also facilitates the collection of data on the prescription documentation process (for example, whether there is any information missing).
- The audit tool is intended to be used to assess the rate of error before and after the implementation of electronic prescribing
- the tool is freely available to NHS Hospitals

15.30 Question and answers, followed by tea

16.00 EXTENDED SESSION: Incident Investigation & Root Cause Analysis of Medication Errors

Suzanne

Crouch Director of Training
Sologic

- a step by step guide to undertaking an incident investigation and RCA for medication error
- systems and good practice for medication errors incident reporting
- tools and techniques for effective Root Cause Analysis

17.00 Question and answers, followed by close

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Venue

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

Date Wednesday 1 July 2015

Conference Fee

- ☐ £365 + VAT (£438.00) for NHS, Social care, private healthcare organisations and universities.
- ☐ £300 + VAT (£360.00) for voluntary sector / charities.
- ☐ £495 + VAT (£594.00) for commercial organisations.

The fee includes lunch, refreshments and a copy of the conference handbook. VAT at 20%.

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