

A Practical Guide to Reducing

Medication Errors

Improving Patient Safety: Towards Zero Tolerance

Friday 27 November 2015 ICO Conference Centre, London

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



Chair and Speakers Include:

Helen Gordon

Chief Executive

Royal Pharmaceutical Society

Fiona Culley

Managing Director

Culley Associates Ltd

Supporting Organisation



Association for Prescribers



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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

"Whatever the financial cost of mistakes we must never forget the real and lasting impact that a serious patient safety incident has on all of those involved" Dave Branford, chair of the English Pharmacy Board at the Royal Pharmaceutical Society, Nov 2014

"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.

The conference will continue with case study based sessions on areas including improving incident reporting and learning from incidents, reducing medication errors in high risk specialties, learning from patients and developing and assessing competence and safety in prescribing and Medicines Administration on the wards. 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

10.00 Chair's Introduction: Reducing Medication Errors: National Update

Helen Gordon

Chief Executive

Royal Pharmaceutical Society

- 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
- omitted medicines and medication errors
- developing the role of the medication safety officer

10.30 Reducing Medication Errors in Practice: Improving reporting and learning systems

Professor Liz Kay

Clinical Director of Pharmacy

Leeds Teaching Hospitals NHS Foundation Trust

& Council Member, General Pharmaceutical Council

- how do we reduce, and monitor the reduction in Medication Errors in an NHS Trust
- priority areas: where should efforts be focused?
- improving reporting and learning systems
- what are the root causes of medication error: our experience and learning

11.00 Questions & answers, followed by coffee & exhibitions 11.15

11.50 Zero tolerance prescribing and zero harm

Gillian Cavell

Consultant Pharmacist in Medication Safety

Kings College Hospital

- how ambitious should patient safety goals be in relation to Medication Errors?
- why we have taken a zero tolerance approach to prescribing errors
- changing the culture and supporting staff to refuse inadequate prescriptions
- the impact on prescription and administration errors
- the role of the Medication Safety Officer in delivering zero harm

12.20 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

12.50 Questions & answers, followed by lunch & exhibitions 13.00

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

Fiona Culley

*Managing Director,
Culley Associates Ltd*

- developing and assessing competence in medicines administration
- improving frontline staff training and education in prescribing and administration
- ensuring staff understand their roles with regard to medication error reporting
- reducing medication errors
- the role of the Care Quality Commission in monitoring and reducing medication errors

14.30 Learning from Patients to reduce Medication Error

Nicola Davey

Trustee

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 Reducing Medication Errors in high risk areas - Case Study: Critical Care

Andreas Fischer

Specialist Pharmacist, Critical Care

Royal Brompton and Harefield NHS Foundation Trust

- reducing medication errors in high risk specialties
- the role of electronic prescribing in reducing medication errors: consideration, challenges and potential for new errors
- our experience in Critical Care

15.30 Questions & answers, followed by coffee & exhibitions 15.40

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

Hilary Merrett

*Independent Consultant, Quality & Safety & Editor Clinical Risk
Quality & Safety Consulting*

- 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 Questions & answers, followed close 17.10

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Conference Registration

Download

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Organisation

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For more information contact Healthcare Conferences UK on **01932 429933** or email **jayne@hc-uk.org.uk**

Venue

ICO Conference Centre, 22 Berners Street, London, W1T 3DD. A map of the venue will be sent with confirmation of your booking.

Date Friday 27 November 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.
☐ £300 + VAT (£360.00) for IHM members.

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

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