

Reducing Medication Errors in Hospitals National Summit 2016

Tuesday 8 November 2016 Asia House, London

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



Conference Chair

Prof Bryony Dean Franklin

Executive Lead Pharmacist Research & Director

Centre for Medication Safety and Service Quality

Imperial College Healthcare NHS Trust/UCL School of Pharmacy

Supporting Organisation



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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.” Patient Safety Alert, MHRA and NHS England

This Summit aims to bring together clinicians, managers and medication safety officers to understand current national developments, and to debate and discuss key issues and areas they are facing in improving medication safety and reducing medication errors. Following National Update sessions, key areas will focus on reporting of medication incidents, developing the role of the medication safety officer, managing a medication incident, developing a medication error reduction programme, reducing medication errors on the ward, reducing prescribing errors and learning from medication errors and communication of medication errors and safety alerts: getting the message across to frontline staff to learn and improve practice.

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

Prof Bryony Dean Franklin *Executive Lead Pharmacist Research & Director Centre for Medication Safety and Service Quality Imperial College Healthcare NHS Trust/UCL School of Pharmacy*

10.10 Reducing Medication Errors in Practice: Securing Organisational Improvement

Prof Martin Stephens

*Pharmacy Consultant
(Chair Wessex Pharmacy LPN &
Chair & Visiting Professor
University of Portsmouth)*

- how do we avoid being lone voices?
- are we measuring the right things for the right people?
- developing a culture of patient safety from board to ward
- improving reporting and learning systems
- how do we reduce, and monitor the reduction in Medication Errors
- priority areas: where should efforts be focused?

10.40 Medication Errors: setting the benchmark at zero

Dr Alice Osborne

*Consultant Pharmacist
Safe Medication Practice & Medicines Safety Officer Co-Chair
Trust Medicines Safety Forum
Guy's and St Thomas' NHS Foundation Trust
Honorary Clinical Reader in Medicines Safety
School of Biomedical Sciences Kings College London*

- how ambitious should patient safety goals be in relation to medication errors?
our goals of high risk medicines: reduce errors with high risk medicines by 100 per cent that is, to zero and all other medicines: reduce errors with all medicines by 25 per cent every year
- 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

11.10 Questions & answers, followed by tea & coffee at 11.20

11.45 Developing the role of the Medication Safety Officer: Extended Panel Session

Panel Members will give 20 minute presentations discussing the role, what has worked and the challenges they are facing with tips for developing the role in practice – followed by interactive discussion

Joanna Taylor

*Lead Pharmacist – Medication Safety, Risk and Compliance
Central and North West London*

12.40 Medication Errors: zero tolerance in practice

Dr Janine Wright

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

- our goal of 100% high risk medicines and medicines reconciliation compliance and no medication related Never Events
- interventions that work and where to prioritise your efforts
- our experience of implementing zero tolerance in practice

13.10 Questions & answers, followed by lunch 13.15

14.00 Managing a medication incident

Speaker to be announced

- managing a medication incident
- ensuring adherence to the Duty of Candour
- interviewing staff involved in serious incidents
- liaising with patients and families
- recognising trends and patterns in the data
- case studies and examples in practice

14.30 Errors and discrepancies in intravenous infusion practices: a situated study

Prof Ann Blandford

*Professor of Human-Computer Interaction & Director
UCL Institute of Digital Health*

- Normal work, discrepancies and errors
- Work-as-imagined and work-as-done
- Diversity in practices: findings from a point prevalence study
- To DERS or not to DERS: that is the question

15.00 Learning from medication errors and communication of medication errors and safety alerts: Getting the message across to frontline staff and ensuring change

Maddy Woods

*Consultant Nurse
Homerton University Hospital NHS Foundation Trust*

- how do we effectively communicate the learning from medication errors, and safety alerts to frontline staff
- ensuring learning and action plans leads to change in behaviour and practice
- how will we know that a change is an improvement?
- what changes can we make that will result in improvement?
- accountability for action plans and ensuring change happens

15.30 Questions & answers, followed by tea & coffee 15.40

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

Simon Robinson

*Barrister
Accredited Mediator Five Paper Chambers*

- 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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Venue

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A map of the venue will be sent with confirmation of your booking.

Date Tuesday 8 November 2016

Conference Fee

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