

Monitoring & Reducing Medication Errors & Harm in Hospitals National Summit 2018

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

Thursday 6 December 2018 The Studio Conference Centre Manchester



Speakers include

Ash Soni OBE
President
Royal Pharmaceutical Society

Professor Philip Routledge CBE
Clinical Director
All Wales Therapeutics and
Toxicology Centre

Prof Rachel Elliott
Professor of Health Economics
University of Manchester

Supporting Organisations



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Follow the conference on Twitter #MedicationErrors

"A study has revealed an estimated 237 million medication errors occur in the NHS in England every year, and avoidable adverse drug reactions (ADRs) cause hundreds of deaths....Of the total estimated 237 million medication errors that occur, the researchers found that almost three in four are unlikely to result in harm to patients, but there is very little information on the harm that actually happens due to medication errors." University of York 2018

"We are seeing 4 to 5 deaths every single day because of errors in prescription or dispensing or the monitoring of medications"
Former Health Secretary Jeremy Hunt speaking to BBC, Friday 23rd March 2018

"Unsafe medication practices and medication errors are a leading cause of injury and avoidable harm in health care systems across the world." Medication without Harm, World Health Organisation

"Medication errors occur when weak medication systems and/or human factors such as fatigue, poor environmental conditions or staff shortages affect prescribing, transcribing, dispensing, administration and monitoring practices, which can then result in severe harm, disability and even death." Medication without Harm, World Health Organisation

This timely Summit in line with the WHO Medication without Harm programme, aims to bring together clinicians, managers, medication safety officers and leads to understand current national developments, and to debate and discuss key issues and areas they are facing in improving and monitoring medication safety, and reducing medication errors and harm in hospitals. Following National Update sessions, the day will focus on effective reporting of medication incidents, monitoring medication errors and harm, managing a medication incident investigation and ensuring change occurs, supporting staff, reducing medication errors in practice, developing a medication error reduction programme. The programme will include case studies focusing on reducing and monitoring medication errors involving high risk drugs and also relating to older people. There will also be focus on using eprescribing systems to optimise medication safety and monitor error and harm.

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

SUPPLIER SHOWCASE - The day also features a pre conference supplier showcase where suppliers will be demonstrating their systems and how they can support your organization to deliver digital imaging in practice.

Benefits of attending. This conference will enable you to:

- Network with colleagues who are working to reduce medication errors
- Understand how you can effectively monitor medication error and harm using metrics and indicators
- Improve your skills in the reporting, investigation and learning from medication errors
- Effectively manage a medication incident and ensure change occurs
- Proactively reduce medication errors before they occur
- Reflect on lessons from medication incidents involving high risk drugs
- Understand how to work with staff to reduce prescribing errors and improve prescribing competence
- Identify key strategies reducing medication error and harm in older people
- Developing your skills in root cause analysis and investigation of incidents
- Self assess and reflect on your own practice
- Gain CPD accreditation points contributing to professional development and revalidation evidence

10.00 Chairman's Introduction

Ash Soni OBE *President, Royal Pharmaceutical Society*

10.10 Medication without Harm Update: The WHO Global Initiative aiming to reduce the level of severe, avoidable harm related to medications by 50% over the next five years

Professor Philip Routledge CBE

Clinical Director

All Wales Therapeutics and Toxicology Centre

- the Global Challenge on Medication Safety: actions for improvement
- meeting the goal to reduce the level of severe, avoidable harm related to medications by 50% over 5 years, globally
- improvements that can be made at each stage of the medication process, including prescribing, dispensing, administering, monitoring and use
- defining key interventions and research priorities for reducing medication-related harm

10.40 Medication Errors & Medication Related Harm: National Findings

Prof Rachel Elliott

Professor of Health Economics

University of Manchester

- the findings of the short life working group on Medication Related Harm
- what is the current scale of medication errors in the UK?

11.05 New Measures to Reduce Medication Harm: National Update

Paul Brown

Clinical Specialist

NHS Digital

- new measures to reduce medication errors
- how can we proactively reduce medication errors before they occur
- developing indicators to quantify which prescribing practices have a higher risk of harm
- how do we reduce, and monitor the reduction in Medication Errors: new metrics
- priority areas: where should efforts be focused?

11.35 *Questions & answers, followed by tea & coffee at 11.40*

11.55 Measuring and monitoring medication harm in your service

Speaker to be advised

- establishing a baseline for medication errors to enable progress to be tracked
- measuring medication error and harm at the point of care
- monitoring medication errors and medication harm
- focusing on the medication errors that cause the most harm to patients
- what have we learnt from the safety thermometer?
- hospital focused medication harm indicators: looking to the future

12.25 Optimising Electronic Prescribing to reduce & Monitor Medication Errors & Medication Harm

Speaker to be advised

- advancing eprescribing explained
- embedding an electronic prescribing system to drive changes in clinical practice
- what does an optimized HePMA system look like and how do we get there?
- the potential for new medication errors with electronic systems: issues to be aware of and error mitigation
- how can we use eprescribing to monitor medication errors, omitted doses and medicines

12.55 *Questions and answers, followed by Lunch and exhibition*

13.50 Demonstrating, Improving & Monitoring Prescribing Competence

Speaker to be advised

- practical tools to reduce prescribing errors
- improving pharmacists' feedback to clinicians on their prescribing errors
- improving prescribing competence: the National Framework
- non medical prescribing: issues and common errors
- improving identification of prescribers
- how can you monitor prescribing competence?
- case study examples

14.20 EXTENDED SESSION: Managing and investigating a medication incident: ensuring change occurs

Speaker to be advised

- managing a medication incident
- supporting staff who make a medication error
- effectively communicating the learning from medication errors, and safety alerts to frontline staff
- implications of the revised NHS Improvement Serious Incident Framework
- ensuring learning and action plans leads to change in behaviour and practice

15.00 Reducing & Monitoring Medication Errors involving High Risk Drugs

Speaker to be advised

- high risk drugs: never events & where to prioritize medication error reduction programmes
- focusing on the medication errors that cause the most harm to patients
- our experience and developments

15.30 *Questions & answers, followed by tea & coffee 15.40*

16.00 Reducing & Monitoring Medication Errors in Older People

Speaker to be advised

- "Researchers at the University of York found that "Errors were more likely to occur in older people and in patients with multiple conditions and using many medicines."*
- medication errors in older people: current issues
 - how do we effectively identify medication related harm in older people
 - reducing polypharmacy and managing comorbidity: stopping medicines safely
 - our experience

16.30 EXTENDED SESSION: Developing your skills in root cause analysis and investigation of medication errors

Mike O'Connell

*Legal Services Practitioner, recently retired Head of Legal Services
Mid Yorkshire Hospitals NHS Trust*

- a step by step guide to carrying out a root cause analysis of a Medication incident
- principles of effective RCA investigation
- learning from investigations and ensuring change occurs
- case studies in practice
- links between incidents and litigation

17.15 *Questions & answers, followed by Close*

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The PDF will be emailed out after the conference, please fill in the 'Your Details' section above, ensuring your email address is clear and the 'Payment' section..

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

Venue

The Studio Conference Centre, The Hive, 51 Lever Street, Manchester, M1 1FN. A map of the venue will be sent with confirmation of your booking.

Date Thursday 6 December 2018

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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