

# Managing the risk of medication errors: a multi-disciplinary continuing professional development programme

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## What was done?

- ▶ A regional multi-disciplinary Continuing Professional Development (CPD) programme was developed, dealing with the **risk management of medication errors**

## Why was it done?

- ▶ Every year in France, **10,000 preventable deaths** and more than **130,000 preventable hospitalisations** are related to drug misuse
- ▶ This issue is a **priority** of the national health strategy

## How was it done?

### 13-member regional working group:

- ▶ Hospital pharmacists
- ▶ Quality managers
- ▶ Regional drug observatory
- ▶ Regional health quality network

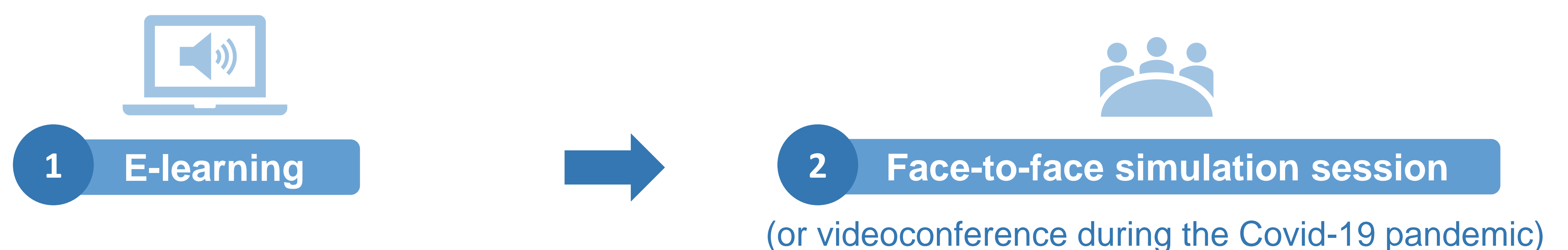
**Submission of the programme to the National CPD Agency**





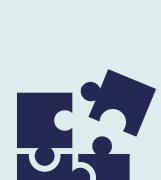
**Acceptation** as a continuing education measure  
**National orientation:** "control of risks associated with healthcare acts and pathways"

## What has been achieved?

**Target audience**  **Any health professional involved in the medication circuit in a health or medico-social institution:**  
 ▶ physicians, pharmacists, residents, nurses, pharmacy technicians...

### A training in 2 parts



<b>What?</b> 	<b>Theoretical aspects</b>	<b>Apply a posteriori risk management by analysing a fictional adverse event</b> (medication error)
<b>How long?</b> 	1 month → <b>2h30</b> of personal work	<b>3h</b>
<b>What format?</b> 	<b>Slide presentation with voice commentary</b>	<b>Workshops</b> ✓ 15 learners ✓ 2 hospital trainers: pharmacist and health quality professional
<b>What about?</b> 	<ul style="list-style-type: none"> <li>✓ <b>Medication errors:</b> definitions, key figures, reporting</li> <li>✓ <b>Risk management principles</b></li> <li>✓ Focus on <b>a priori</b> and <b>a posteriori</b> risk management</li> </ul>	<ul style="list-style-type: none"> <li>✓ Never events</li> <li>✓ Drug reconciliation</li> <li>✓ City-hospital link</li> <li>✓ Lack of communication</li> <li>✓ Human factors</li> </ul>
<b>Pedagogical tools?</b> 	Concrete <b>examples of medication errors</b> throughout the presentation	<b>Serious card game, simulation, group work, role-playing game, paper-board</b>



**Questionnaires** completed **before, during and after** the training, to evaluate:

- learners' **satisfaction**
- impact of the training on their **knowledge** and **skills**

## What next?

- ▶ This regional training will promote the **link between actors** from different institutions and the **multi-disciplinary** approach around the management of the risks of medication errors
- ▶ In addition, we provide an **awareness kit on medication errors reporting**, including a customisable slide show and a quiz, which allows short sessions to be conducted in any health facility (<http://www.omedit-normandie.fr/boite-a-outils/erreurs-medicamenteuses/erreurs-medicamenteuses,4115,5188.html>)