

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



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



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>)