Medication without harm - how will New Zealand rise to The Challenge?

Medication Safety regional workshop (Hamilton)

31 October 2017

Hotel Novotel Tainui, 7 Alma St, Hamilton

Time	Session	Presenter
9:00am	Registration opens	
9:30am	**Mihi, waiata and karakia** **Opening address**	 **Dr Doug Stephenson**, Clinical Director, Quality & Patient Safety, Waikato DHB
9:45am	**The Challenge of medication safety for New Zealand**	**Health Quality & Safety Commission**
9:50am	**A patient's story**	Presented by **Charlotte Foley**, Quality and Risk Facilitator Clinical Support and MH&AS Services, Lakes DHB
10:00am	**Designing medication processes for humans**	**Dr Michael Hamilton**, Physician Lead and Medication Safety Specialist, Institute for Safe Medication Practices Canada (ISMP Canada) This discussion will explore how humans work and interact with the medication process, and point out vulnerabilities in both the way we think and behave as health care workers, as well as in the design of the health delivery systems in which we work. These weaknesses are a common source of mistakes in medication use but have the potential to be engineered out of the system. Participants will be able to: • Define human factors/ergonomics/clinical engineering in the context of health care and medication processes • Explain a number of human limitations and how they relate to health care delivery • Understand the Hierarchy of Effectiveness and how it can be applied to health care system design • Identify human factor related vulnerabilities in their own work contexts
10:45am	***Morning tea***	
11:10am	**Designing medication processes for humans** (continued)	**Dr Michael Hamilton**

11:55am	**Rapid fire sessions** (15 minutes each) **Local medication safety initiatives**	2 x local presenters
12.25pm	***Lunch***	
1:15pm	**Case study approach: the interdisciplinary nature of adverse medicine events - medicines safety is everyone's business** ISMP Canada reviews hundreds of medication incident reports annually in their weekly Analysis Rounds. This discussion will provide insight on how these cases are selected, as well as explain the incident analysis framework we most commonly use to review these incidents. Actual medication incident cases will be used to identify safety issues and to highlight the role that all health care workers play in medication safety. Participants will be able to: • Explain a screening mechanism for safety incidents • Explain an incident analysis framework at a high level • Use case presentations as a tool for learning and understanding issues in medication safety	**Dr Michael Hamilton**
2:45pm	**Medication treatment safety** ACC provides cover for injuries caused by treatment, including harm from medication. Information on treatment injuries including claims for medication adverse events, medication errors and trends over time will be presented, along with an overview of ACC-supported initiatives to improve medication safety.	**Dr Peter Jansen**, Senior Medical Advisor, ACC
3:15pm	**The importance of Pharmacovigilance** Addressing both pharmacovigilance and medication error data is necessary for safe patient care. Various jurisdictions address these issues in different ways, but no matter the mechanisms, strong cooperation, robust analysis, and impactful information are necessary for safe medication use.	**Dr Michael Hamilton**
3:30pm	**The Medication Error Reporting Programme (MERP): strengthening pharmacovigilance in NZ** An overview of the findings from the MERP will be presented, along with how its operation complements a national pharmacovigilance service to contribute to improving medication safety in NZ.	**Dr Michael Tatley**, Director, New Zealand Pharmacovigilance Centre, University of Otago
3:50pm	**Close**	**Dr Doug Stephenson**
4:00pm	***Workshop ends***	