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

1 **E-learning** → 2 **Face-to-face simulation session**

(or videoconference during the Covid-19 pandemic)

	1 E-learning	2 Face-to-face simulation session
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?	✓ **Medication errors**: definitions, key figures, reporting ✓ **Risk management principles** ✓ Focus on ***a priori*** and ***a posteriori*** risk management	✓ 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)

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