OUTLINE

Through the teachings of real-life scenarios, expert Cyndi Zarbano, MSN, BSN, CCRN, CEN, PCCN, CMSRN, CLNC, will walk you step-by-step through the following topics to transform your nursing practice.

Insight from a Legal Nurse Consultant

What the current data says . . . will amaze you! Consequences of unsafe practice

- Patient injury or death
- Loss of trust
- Corrective action Understanding what that means
- Suspended license
- Loss of license
- Litigation

Types of Medication Errors

- Commission
- Omission

Med Error Contributors: Identify Safety Precautions for YOUR Practice

Ineffective communication Experience level – Beginner vs. expert Interruptions and distractions Shift length, patient acuity and workload System errors: Lack of safety nets Similar drug names

Failure to follow policies or guidelines

- Taking short cuts
- Ordering: Electronic, written, verbal
- Order processing: Pharmacy review
- Beyond the 8 Rights of Medication Administration

Review actual cases of medication errors: What went wrong?

Drug Calculation Errors: A Deadly Mistake!

Common errors and how to avoid them

- Mathematical calculations
- Metric vs. imperial system
- Units of measure and conversions

Tools and policies to avoid making math errors

The tragic and deadly stories...

Identify the Greatest Risk Potential for Errors

High risk medications - Insulins, opioids, anticoagulants, etc.

Drip titration

Predict high risk patients for adverse reactions Must-know insights on reversal agents

Reporting ADEs

Barriers to reporting
Internal reporting system

- Just Culture
- Professional accountability
- Incident reports learning from past experiences

Minimize the Risk of Making a Life-Threatening Mistake: Individual and Systems Approaches

Time management tools

Think critically

Facility safety nets

Electronic tools

Use the safety tools available

- Institute for Healthcare Improvement
- Agency for Healthcare Research and
 Ouality
- Institute for Safe Medication Practices (ISMP)

Be a STAR! An easy philosophy to guide your safe, medication administration practice

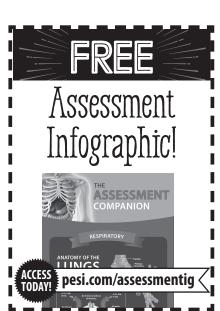
OBJECTIVES

- 1. Compare the major categories of adverse drug events (ADEs).
- 2. Evaluate the barriers to and benefits of reporting ADEs.
- 3. Solve medication dosage calculations.
- 4. Analyze actual medication errors to avoid the pitfalls.
- 5. Demonstrate how available tools and strategies can assist with error prevention and safe medication use
- 6. Develop new skills to predict high risk medication error scenarios.

CANCELLATION POLICY: If you contact us before the event date, you can exchange for a certificate to attend another seminar, or receive a tuition refund less a \$30 cancel fee. Substitutions are permitted at any time.



Target Audience: Nurses • Nurse Practitioners • Nurse Educators • Legal Nurse Consultants
Pharmacists • Risk Management • Paralegals • Attorneys



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Medication Error Prevention Training

30+ Best Practices to Minimize the Risk of Making a Life-Threatening Mistake

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Featuring Legal Nurse Consultant and Expert

Cyndi Zarbano, MSN, BSN, CCRN, CEN, PCCN, CMSRN, CLNC

Medication Error Prevention Training

30+ Best Practices to Minimize the Risk of Making a Life-Threatening Mistake

- Predict high risk patients for med error & adverse drug reaction potential
- Must-know insights on reversal agents
- 3 steps to dramatically reduce medication dosing tragedies
- Protect your nursing license & prevent corrective action risks
- Prevent deadly insulin, opioid and anticoagulant errors

Carle Place, NY

Wednesday, December 11, 2019

Yonkers, NY

Thursday, December 12, 2019

Manhattan, NY

Friday, December 13, 2019





Medication Error Prevention Training

30+ Best Practices to Minimize the Risk of Making a Life-Threatening Mistake

A seasoned nurse had drawn up the right dose of a drug hundreds of times in her career.

But once...she made a life-changing error. A patient died, she was suspended, and then fired from a profession she loved.

Patient safety is a sacred bond. For nurses, keeping patients safe is the top priority. But long shifts, high acuities, confusing dosing calculations, an ever-changing list of drug interactions, and similar drug names create an environment where even the most competent clinician can make a serious medication mistake.

Are you confident that you have the tools you need to avoid making a headline error?

This program will give you all the resources you need to fulfill this critical aspect of your job and dramatically reduce your risk of making a life changing error. Join Cyndi Zarbano as she shares with you what she has learned working with the Board of Nursing in five states consulting and educating nurses who have received corrective action and suspension related to their medication errors!

SPEAKER

Cvndi Zarbano, MSN, BSN, CCRN, CEN, PCCN, CMSRN, CLNC,

has been a nurse for more than 25 years and a legal nurse consultant (LNC) for 12. Many of her cases in the last decade have been consulting and educating nurses who have gotten into trouble with the board of nursing and helping them complete their corrective action stipulations. Medications errors and patient injury are a common cause of corrective action, license suspension and loss of license.

Cyndi's clinical area of expertise has been in various intensive care/critical care roles, currently working for Mayo in Minnesota. She has been a national seminar speaker for over ten years speaking to diverse healthcare audiences throughout the country. During her presentations, she has earned the reputation of keeping attendees engaged with the use of current clinical knowledge, fascinating legal stories, and the interjection of nursing humor to keep it fun.

Speaker Disclosure:

Financial: Cyndi Zarbano is the owner of Clinical Review Consultants. She receives a speaking honorarium from PESI, Inc.

Non-financial: Cyndi Zarbano has no relevant non-financial relationships to disclose.



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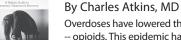
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7:30 Registration/Morning Coffee & Tea

8:00 Program begins

11:50-1:00 Lunch (on your own)

4:00 Program ends

There will be two 15-min breaks (mid-morning & mid-afternoon). Actual lunch and break start times are at the discretion of the speaker. A more detailed schedule is available upon request.

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