Report of the announced inspection of medication safety at the National Maternity Hospital, Dublin.

Date of announced inspection: 12 April 2017
Report of the announced inspection of medication safety at the National Maternity Hospital.
About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent authority established to drive high-quality and safe care for people using our health and social care services in Ireland. HIQA’s role is to develop standards, inspect and review health and social care services and support informed decisions on how services are delivered.

HIQA aims to safeguard people and improve the safety and quality of health and social care services across its full range of functions.

HIQA’s mandate to date extends across a specified range of public, private and voluntary sector services. Reporting to the Minister for Health and the Minister for Children and Youth Affairs, HIQA has statutory responsibility for:

**Setting Standards for Health and Social Services** — developing person-centred standards, based on evidence and best international practice, for health and social care services in Ireland.

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1. Introduction

Medications are the most commonly used intervention in healthcare, and advances in medication usage continue to play a key role in improving patient treatment success. However, where medicines are used, the potential for error, such as in prescribing, administering or monitoring, also exists. While most medication errors do not result in patient harm, medication errors have, in some instances, the potential to result in catastrophic harm or death to patients.

Medication related events were the third most common type of adverse event recorded in the Irish National Adverse Events Study. Medication safety has also been identified internationally as a key focus for improvement in all healthcare settings and it is estimated that on average, at least one medication error per hospital patient occurs each day.

HIQA’s medication safety monitoring programme, which commenced in 2016, aims to examine and positively influence the adoption and implementation of evidence-based practice in public acute hospitals around medication safety. HIQA monitors medication safety against the *National Standards for Safer Better Healthcare* to determine if hospitals have effective arrangements in place to protect patients from harm related to medication use.

An expert advisory group was formed to assist with the development of this medication safety monitoring programme. The advisory group membership included patient representation, alongside members with relevant expertise from across the Irish health service. Specific lines of enquiry were developed to facilitate medication safety monitoring. The lines of enquiry which are aligned to HIQA’s *National Standards for Safer Better Healthcare* are included in Appendix 1 of this report. Further information can be found in a *Guide to the Health Information and Quality Authority’s Medication Safety Monitoring Programme in Public Acute Hospitals 2016* which is available on HIQA’s website: www.hiqa.ie

An announced medication safety inspection was carried out at the National Maternity Hospital by Authorised Persons from HIQA; Dolores Dempsey Ryan, Kathryn Hanly, Kay Sugrue and Noelle Neville. The inspection was carried out on 12 April 2017 between 10:30hrs and 16:00hrs. Interviews were held in the hospital with the following groups of managers and clinical staff:

- Group one: the Chairperson of the Drugs and Therapeutics Committee, the Chief Pharmacist, a clinical pharmacist and the Head of Risk Management.
- Group two: the Clinical Director and the Director of Nursing.

Inspectors visited the following clinical areas and spoke with staff and reviewed documentation in:
- The Neonatal Intensive Care Unit (NICU)
- First Floor Postnatal Ward.

In addition a survey was conducted among outpatients in the Outpatient Department.

HIQA would like to acknowledge the cooperation of staff that facilitated and contributed to this announced inspection, and the patients in the hospital’s Outpatient Department who completed an anonymised questionnaire in relation to prescribed medications.
2. Findings at the National Maternity Hospital

The following sections of this report present the general findings of this announced inspection which are aligned to the inspection lines of inquiry.

2.1 Governance and risk management

**Lines of enquiry:**

- Patient safety is enhanced through an effective medication safety programme underpinned by formalised governance structures and clear accountability arrangements.
- There are arrangements in place to identify report and manage risk related to medication safety throughout the hospital.

The National Maternity Hospital had formalised governance arrangements and organisational structures in place with clear lines of accountability to support the safe use of medications.

The hospital had an established Drugs and Therapeutics Committee that was responsible for the governance and oversight of the hospital’s medication management system and for ensuring its safety. This Committee had agreed terms of reference and reported to the hospital’s Clinical Governance Executive Committee. The Clinical Governance Executive Committee was operationally accountable to the Executive Management Team, and through the Master, reported to the hospital Executive Committee of Governors and the Board of Governors.

Membership of the Drugs and Therapeutics Committee was multidisciplinary to reflect the fact that the safe and effective use of medicines is the responsibility of a number of clinical professional groupings. The Committee was chaired by the Master and composed of physicians, pharmacists, nurses, midwives, administrators, a financial controller and other representative staff who were involved in the medication-use process.

The Drugs and Therapeutics Committee had met four times from March 2016 to February 2017 and aimed to meet at least four times a year. A review of the minutes of this Committee showed that attendance at the meetings was variable. While it was clear to HIQA inspectors that the Drugs and Therapeutics Committee provided active governance oversight of medication practice, the hospital should revisit the membership of the Committee with the aim of ensuring greater attendance from key stakeholders at the Drugs and Therapeutics Committee meetings.

Drugs and Therapeutics Committees should provide the leadership and structure to select appropriate drugs for the formulary, promote rational drug use, and help reduce drug costs to acceptable levels. The Drugs and Therapeutic Committee’s terms of reference stated that the Committee’s responsibilities included making
recommendations on the use of medicines and the addition of new medicines to the drug list. Inspectors were informed that while the hospital had a list of medicines available for use which included a formulary for the Neonatal intensive Care Unit, it did not administer a hospital wide formulary.*

Documentation reviewed during the course of the inspection indicated that discussions had taken place regarding the approval or rejection of new medicines at the Drugs and Therapeutics Committee meetings. However, decisions to add or remove a medication from the formulary were not formalised or guided by a written criteria. A hospital wide medication formulary system should be established to rationalise and effectively risk manage the range of medication therapies available, and provide adequate time for designing safe processes for the use of new medicines added to the formulary, in advance of use in practice.

Medication safety was coordinated by the Chief Pharmacist with the support of the Drugs and Therapeutics Committee, the Senior Hospital Management Team, the Medication Safety Committee and other healthcare staff at the hospital. Medication safety was a standing agenda item for discussion at the Drugs and Therapeutics Committee and formed part of the clinical risk updates at the hospital’s Clinical Governance Executive Committee meetings.

The hospital had reinstated the Medication Safety Committee formerly known as the medication management committee in September 2016. This Committee had clear defined terms of reference and aimed to meet four times a year. The Committee was chaired by the Chief Pharmacist, or by a senior pharmacist if needed. Membership was multidisciplinary to include staff responsible for adult and neonatal medication safety programmes within the hospital. The Medication Safety Committee had a medication work plan for 2017. This plan outlined the key actions to be completed with a lead person assigned to each action.

The Medication Safety Committee had a draft medication safety strategy that was awaiting ratification by the Drugs and Therapeutic Committee and the Clinical Governance Executive Committee. Inspectors viewed the medication safety strategy and noted that while it outlined goals and objectives to be achieved, there was no action plan devised to support the strategy or a named committee identified having oversight for its implementation. This strategic plan should be aligned to the hospital’s strategic plan on patient safety.

The hospital had developed a new incident management system where each hospital’s department’s incidents were recorded. This system was supported by

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* Formulary: a listing of approved medicines for prescription and use in the healthcare organisation.
incident and risk management policies. Incidents were also recorded on the National Incident Management System (NIMS). All clinical incidents were reviewed at the Clinical Risk Department meetings and incidents trends were also reviewed by the Clinical Governance Executive Committee. All high risks were escalated to the hospital’s Executive Management Team and serious incident were escalated to the hospital group. The hospital reported on the day of inspection that they collaborated with the new hospital group structure and other maternity hospitals.

High incident reporting rates are generally associated nationally and internationally with a strong patient safety culture. The hospital’s new risk management database system tracked and trended medication incidents to assess progress and to identify emergent medication safety concerns. A medication incident report for the period from January to March 2017 was provided to inspectors. Inspectors found that while this report categorised medications incidents with regard to for example, prescribing or administration errors, the most frequent medicines incidents were not categorised to support learning or inform quality improvement initiatives. This represents a further opportunity for refinement of this process following this inspection.

The main source of medication error surveillance in the National Maternity Hospital was the voluntary reporting system whereby medical, nursing and pharmacy staff reported medication incidents. However, the practice of reporting medication incidents required improvement particularly with the reporting of near misses. In response, the Medication Safety Committee recently devised a new medication incident reporting form with the view of improving the reporting of medication incidents including near misses.

Medication-related incident reporting facilitates the identification of risk and opportunities for improvement. However, on its own it does not provide a complete picture of all potential sources of risk and patient harm. The National Maternity Hospital used a variety of additional information sources to identify strengths and weaknesses in the hospital medication management system including retrospective chart review (antenatal, postnatal and neonatal charts), direct observation, audit, risk assessment, antimicrobial stewardship, neonatal parenteral nutrition prescription review and staff surveys.

Inspectors were provided with a copy of the pharmacy’s clinical report for April to December 2015, which highlighted that 11,520 patients’ healthcare charts were reviewed and 2,609 pharmacist interventions were provided. These reviews were used to support the planning of medication safety initiatives such as the development of postnatal analgesia guidelines.

† National Incident Management System (NIMS) is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation to the SCA (Section 11 of the National Treasury Management Agency (Amendment) Act, 2000).
Open disclosure occurs when staff in the health and social care service communicate with patients in an open and honest manner when things go wrong with patient care. Inspectors were informed that a significant number of healthcare staff was provided with training on the national open disclosure policy. This was also confirmed by ward staff.

High-risk medicines can cause significant harm when system errors occur. The hospital had identified a list of high-alert medicines used within the organisation including the Neonatal Intensive Care Unit, and was taking appropriate actions to ensure that they were prescribed, dispensed and administered safely. For example, practitioners who work in the delivery unit may administer a variety of high alert medications during the birthing process such as oxytocin (a medicine used to induce and augment labour). Intravenous paracetamol was also listed as a high alert medication for adult patients weighing less than 50 kilograms, and for neonates and infants.

Evidence-based risk reduction strategies were used to reduce unwarranted clinical variation in medication prescribing and administration. These strategies included the development of medication monographs, standardised protocols and dosing regimens for oxytocin, magnesium sulphate, and other high-alert medication infusions. The hospital also introduced some pre-filled syringes, for example for ephedrine, and pre-prepared intravenous magnesium bags, to reduce risk of error when administering medicines. The hospital standardised all the adult emergency resuscitation trolleys across the hospital to reduce risks associated with medication administration.

Inspectors viewed a folder on the wards with information on high risk, high alert medications and a list of sound-alike and look-like drugs (SALADs). Medication alerts were communicated from the pharmacy department to hospital consultants and senior nurse managers through the hospital’s electronic communication system and to non consultant hospital doctors via the Human Resource Department. In addition, the Chief Pharmacist attended the weekly maternal medicines multidisciplinary clinical meetings and provided information on high risk medications and learning from medications incidents as required.

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‡ High-Alert Medications are medicines that bear a heightened risk of causing significant patient harm when they are not used correctly. Errors with these medicines may not be more common than those from other groups but their consequences can be more devastating as they have smaller margins of safety than other medications and therefore warrant particular caution in their handling.
2.2 Audit and evaluation

**Line of enquiry:**
- The effectiveness of medication management systems are systematically monitored and evaluated to ensure they are effective.

Audit represents a key component of all effective clinical governance programmes. It was reported that the hospital had conducted audits to evaluate the safety of medication management systems. Documentation reviewed showed that medication safety-related audits had been undertaken in 2016 by clinical staff at the hospital which included the following:

- Antimicrobial point prevalence survey
- A combined point prevalence survey of antimicrobial prescribing across six maternity hospitals
- Audit of antimicrobial de-escalation on postnatal wards
- Prophylaxis audit§ of the Health Service Executive (HSE) Venous Thromboembolism** (VTE) quality improvement project
- Postnatal analgesia audit
- Audit of synagis usage & criteria for its use
- Anaesthetic emergency medication usage & wastage audit
- Midwifery Quality Care metrics ††
- Neonatal metrics
- Nurse prescribing audits.

Inspectors viewed the anaesthetic emergency medication usage and wastage audit and noted that the use of pre-filled syringes had clearly reduced medication administration errors.

Adult and neonatal patient healthcare records were audited on a monthly basis as part of the national quality care midwifery metrics programme and this audit included the auditing of medication prescription and administration kardex. In addition, staff at the hospital had recently completed a patient safety climate survey to look at the hospital’s patient safety culture and identify areas for improvement, which has yet to be analysed.

§ A prophylactic is a medication or a treatment designed and used to prevent a disease from occurring.

** Thromboembolism describes the obstruction of a blood vessel by a blood clot that has become dislodged from another site in the circulation.

†† Metrics are parameters or measures of quantitative assessment used for measurement and comparison or to track performance.
The National Maternity Hospital had a Risk and Audit Committee which was a sub-committee of the Executive Committee of Governors. This Committee was responsible for the management of clinical and corporate risk and for the audit programme. Although, the hospital had identified a number of audits for competition in 2017, there was no overall strategic audit plan in place. Current arrangements regarding a strategic audit plan should be strengthened and formalised to provide assurance to the senior hospital management team about medication safety at the hospital. The audit plan needs to implement and aligned to a formalised medication safety strategy.

2.3 Medication safety support structures and initiatives

**Line of enquiry:**
- Hospitals develop effective processes to promote medication safety that are implemented and supported by clear and up-to-date policies, procedures and or protocols.

The hospital had implemented a number of quality improvement initiatives aimed at optimising medication safety. For example, a red and white stripe allergy wrist band was introduced to identify a patient with a medication allergy.

The hospital had also introduced a ‘My Medicine’ leaflet to encourage a patient to keep a record of their up-to-date medications. Patients were asked to bring the leaflet with them when attending their hospital antenatal appointments. This leaflet was devised as a quality improvement initiative in response to a near miss where a patient was reluctant to disclose the medication they were taking which could have potentially caused a drug interaction. The ‘My Medicine’ leaflet was also designed to support medication reconciliation and reduce medication errors.

Additional practices to enhance medication safety in the hospital were identified during this inspection. These included the introduction of a:

- medication information folder with up to date drug monographs and protocols
- new incident management database system
- drug compatibility chart
- ‘My Medicines’ leaflet
- the red allergy wrist band
- safety pause
- anaphylaxis packs
- sound alike-look alike-drugs (SALADS)
- pharmacy near miss-error log.

The National Maternity Hospital was also participating in the Health Service Executive (HSE) Quality Improvement Division venous thromboembolism quality improvement collaborative. This is a improvement collaborative among multidisciplinary teams in Irish adult acute public and voluntary hospitals who are working together to achieve appropriate thromboprophylaxis for their hospital’s inpatients, to reduce the risk of venous thromboembolism and to minimise harm and expenditure associated with unnecessary thromboprophylaxis.

Hospital managers told inspectors that wards operated a ‘safety pause’ system whereby staff communicated information about patient safety issues at the ward shift handover. This included relaying information about medication risks and medication incident trends. Clinical pharmacists used this forum to provide medication information sessions to ward staff as required. The aim of the medication safety information session was to increase communication between the multidisciplinary team, to educate staff on specific topics relating to medication, to highlight areas for improvement. Ward staff provided inspectors with an example of a medication incident relating to post natal analgesia and this incident had been discussed at the ‘safety pause’ at shift handover.

The hospital had resourced the clinical areas such as the neonatal unit, ante-natal and post-natal wards, gynaecology ward and the maternal medicines clinics with a clinical pharmacist service. There are currently no agreed national standards outlining requirements for the provision of clinical pharmacy services in hospitals. However, international studies support the role of clinical pharmacists in hospital wards in preventing adverse drug events.

At the National Maternity Hospital, clinical pharmacists reviewed inpatient medication prescription charts to prevent, identify, and intercept medication prescribing-related incidents in most of the clinical areas. The hospital also devised a ‘My Medicines’ leaflet for patients to keep a record of their medicines and this practice was introduced to support medication reconciliation. However, medication reconciliation was not formalised or supported by a medication reconciliation policy or audit. Medication reconciliation at time of admission is a systematic process conducted by an appropriately trained individual, to obtain an accurate and complete list of all medications that a patient was taking prior to admission.

‡‡ Clinical pharmacy describes the activity of pharmacy teams in ward and clinic settings.
2.4 Person-centred care

Line of enquiry:
- Patients and/or carers are informed about the benefits and associated risks of prescribed medications in a way that is accessible and understandable.

Patients should be well informed about any medications they are prescribed and any possible side-effects. The National Maternity Hospital had systems in place to support the provision of patient information and education in relation to medication. Inspectors were informed that clinical midwife specialists such as the diabetic nurse specialist provided education to patients including information on prescribed medicines as required. In addition, the hospital also had a number of nurse prescribers to support medication prescribing and who provided education to patients on medicines prescribed. Inspectors were informed that parents were provided with medication information in the Neonatal Intensive Care Unit (NICU) regarding the medications their infants were prescribed.

As part of this inspection, HIQA asked a small sample of patients attending the hospital’s Outpatient Department to complete an anonymised questionnaire in relation to prescribed medications. The questionnaire was completed by nine people who had been inpatients in the National Maternity Hospital within the past year and who were prescribed regular medications. Of the nine patients surveyed:

- All patients said that while in hospital, a staff member had explained the purpose of new medication in a way that they could understand.

- Five patients said that prior to discharge from hospital, a staff member told them about possible medication side effects to look out for following discharge home while four patients said they were partially informed about medication side effects.

- All patients said that they received instruction on how to take their medications at home.

It is acknowledged that this was a small sample of patients who completed the anonymised questionnaire in relation to prescribed medications at the hospital’s Outpatient Department, and therefore was not representative of all recently discharged patients taking prescribed medication. The information did however, provide some information about outpatient’s understanding of medications and could be expanded upon and used to identify opportunities for improvement.
2.5 Policies procedures and guidelines and access to information

Lines of enquiry:

- Hospitals develop effective processes for medication management that are implemented and supported by clear and up to date policies, procedures and/or protocols.
- Essential information supporting the safe use of medicines is readily available in a user friendly format and is adhered to when prescribing, dispensing and administering medications.

The hospital had a Guideline Committee that had developed a number of multidisciplinary policies, procedures, protocols and guidelines to support safe medication management systems within the hospital. This Committee reported into the Clinical Governance Executive Committee. Inspectors observed that up to date versions of medication policies, procedures, protocols and guidelines were readily available to staff in clinical areas through a controlled electronic document management system. Inspectors were informed that the hospital shared its policies and protocols with other maternity hospitals within the hospital group to support the standardisation of medication practices.

Healthcare professionals reported that they had ready access to patient information, relevant to the safe use of medications, at the point of clinical decision making. Inspectors observed that decision support tools were available to staff in clinical areas. These included up to date versions of the *British National Formulary* (in areas caring for adults) and the *British National Formulary for Children* (in the Neonatal ICU). A list of medications for approved for prescription and use at the hospital was also available from the pharmacy to clinical staff. The use of mobile technology gave prescribers easy access to antimicrobial guidelines at the point of prescribing. Each clinical area had access to a folder containing printed copies of intravenous medication administration protocols and monographs which inspectors viewed. Allergy posters were displayed on the wards detailing information on drug allergies.

Clinical pharmacy staff provided key information about medications to medical, nursing and other staff, as well as to patients. Clinical pharmacists also developed protocols and engaged with the multidisciplinary team in managing medication use within the hospital. Nurses in the Neonatal Intensive Care Unit reported they could contact the Clinical Pharmacist during office hours from Monday to Friday for information regarding appropriate medication use.

Staff in the Neonatal Intensive Care Unit (NICU) had access to a local formulary containing 70 intravenous medication administration monographs. This information was reviewed and controlled by the Pharmacy Department. Inspectors were
informed that the formulary facilitated easy access to advice on the safe and accurate administration of medications to neonates. To reduce possible adverse drug reactions and toxicity, and to avoid precipitation and occlusion of infusion lines in neonates, the clinical pharmacist had also developed a drug compatibility chart for use in the NICU. In addition, the NICU had developed a number of safety checklists including bedside NICU and neonatal high dependency safety checklists. Staff reported that the checklists were useful tools to improve patient safety in the NICU. The hospital had also designed a NICU pre-intubation safety checklist to improve teamwork and communication.

Healthcare staff required access to complete and accurate patient information, relevant to the safe use of medications, at the point of clinical decision making to help ensure patient safety. Clinical staff had access to patient laboratory and radiology results on computers in clinical areas across the hospital.

2.6 Training and education

**Line of enquiry:**
- Safe prescribing and drug administration practices are supported by mandatory and practical training on medication management for relevant staff.

The hospital had implemented a medication safety training programme for staff with medication management responsibilities. The hospital completed a training needs assessment for midwives and nurses. New midwives and nurse employees completed a competency orientation record booklet which included training on policy, procedure and medications. All nursing and midwifery staff due to commence employment in the hospital also completed an intravenous medication workshop and were required to complete the Health Service Executive medication management online training programme. In addition, anaphylaxis training was also provided to staff administering medications. The hospital reported that 100% of pharmacist, nursing, and midwifery staff and 97% of non consultant hospital doctors were provided with medication induction training.

Skills and drills workshop training which included medication information was provided every three months to members of the multidisciplinary teams to mitigate risks associated with obstetric emergencies. The hospital had recently introduced leadership crisis situation workshop training for members of the multidisciplinary teams and had set up a new online training system for staff. In addition, a regular pharmacy staff journal club was in place in the Neonatal Intensive Care Unit where

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55 A journal club has been defined as an educational meeting in which a group of individuals discuss current articles, providing a forum for a collective effort to keep up with the literature.
the clinical pharmacist attended to provide information on issues such as medication safety initiatives.

The hospital had a medication safety week starting in November 2016 where clinical pharmacists provided information sessions to all clinical staff on quality improvement initiatives such as ‘My Medicines’ leaflet and the red allergy wrist band. Information sessions were also provided on medication reconciliation, high risk medicines, and included information provided each morning of the medication safety week by specialist midwifery lead staff.

The hospital reported that ‘one minute’ tutorials involving a one slide-one minute presentation had been designed for multidisciplinary participation in the provision of education. In addition, Grand Rounds*** allowed the provision of medication information education sessions to doctors and the multidisciplinary team.

The hospital was preparing to implement the Maternal and Newborn Clinical Management System, an Electronic Health Record (EHR) for all women and babies who access the Maternity Services. It was also reported that there was collaboration during the implementation phase between the Pharmacy Departments in maternity hospitals nationally. The new system was due to be implemented in the National Maternity Hospital in November 2017.

***Grand rounds are formal meetings where physicians and other clinical support and administrative staff discuss the clinical case of one or more patients. Grand rounds originated as part of medical training.
3. Conclusion

Medications represent the primary measure for treatment intervention in hospitalised patients. Error associated with medication usage constitutes one of the major causes of patient harm in hospital. Medication-related events were the third most common type of adverse event recorded in the recently published Irish National Adverse Events Study. Medication safety should therefore be a priority area for all acute hospitals as they seek to ensure a high quality and safe service for patients.

The National Maternity Hospital had established governance arrangements in place, with systems and processes to support medication safety practices in the hospital. The medication safety agenda was prioritised at organisational level by the Chief Pharmacist with the support of the Drugs and Therapeutics Committee, the Senior Hospital Management Team, the Medication Safety Committee and other healthcare staff at the hospital. Inspectors found however that the hospital did not have a hospital wide drug formulary in place, and this represents a further opportunity for improvement following this inspection. A hospital wide drug formulary system should be established to manage the risk associated with the introduction of new medicines in particular.

Prevention of medication errors is dependent on the presence of a well-organised reporting system, supported by a culture of openness around reporting, and greater awareness amongst staff of the systemic nature of many of these errors. Healthcare staff were aware that their hospital had a medication incident reporting system. However, further scope for improvement in the degree of near miss error reporting was identified by the hospital with the development of a new risk medication form to support medication incident reporting.

Important lessons can be learned from analysis of medication-related incidents and near misses. Reporting of incidents is of little value unless the data collected are analysed and recommendations are disseminated. The hospital had developed a new risk management database where medication incidents were tracked and trended to assess progress and to identify emergent medication safety concerns. In addition, inspectors found that the hospital had also implemented a number of quality improvement initiatives to reduce medication errors and had developed a number of medication policies.

A clinical pharmacy service was provided across the hospital. Although this service included the provision of expert advice to prescribers and reviewing inpatient medication prescription charts, medication reconciliation was not formalised or supported by a medication reconciliation policy or audit.

Audit represents a key component of all effective clinical governance programmes. While the National Maternity Hospital had completed a number of audits, the
hospital’s current arrangements regarding a strategic audit plan should be strengthened and formalised to provide assurance to the senior hospital management team about medication safety at the hospital. The strategic audit plan needs to be implemented and aligned to a formalised medication safety strategy.¹²

The hospital reported on the day of inspection that it collaborated with the new hospital group structure and other maternity hospitals. This should be continued to share good practice pertaining to medication safety and to develop and implement policies and practices for medication management.

Following this report, hospital management and staff should continue to build upon the various measures already in place to promote safe use of medicines, through the development and enactment of a medium to long-term medication safety strategy that sets out a clear vision for medication safety across the hospital.
4. References


9. Abstoss KM, Shaw BE, Owens TA, Juno JL, Commiskey EL, Niedner MF. Increasing medication error reporting rates while reducing harm through


## 5. Appendices

### Appendix 1: Medication safety monitoring programme Phase One: Lines of Enquiry and associated National Standard for Safer Better Healthcare

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<th>Area to be explored</th>
<th>Line of enquiry</th>
<th>National Standards for Safer Better Healthcare</th>
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<tbody>
<tr>
<td>Clear lines of accountability and responsibility for medication safety</td>
<td>Patient safety is enhanced through an effective medication safety programme underpinned by formalised governance structures and clear accountability arrangements.</td>
<td>3.1, 5.1, 5.2, 5.4, 5.5, 5.6, 5.8, 5.9, 5.10, 7.1</td>
</tr>
<tr>
<td>Patient involvement in service delivery</td>
<td>Patients and or carers are informed about the benefits and associated risks of prescribed medicines in a way that is accessible and understandable.</td>
<td>1.4, 1.5, 1.7, 3.1, 4.1</td>
</tr>
<tr>
<td>Policies procedures and guidelines</td>
<td>Hospitals develop effective processes to promote medication safety that are implemented and supported by clear and up-to-date policies, procedures and or protocols.</td>
<td>2.1, 3.1, 3.2, 3.3, 3.5, 3.6, 3.7, 5.8, 5.11, 8.1</td>
</tr>
<tr>
<td>Risk management</td>
<td>There are arrangements in place to identify, report and manage risk related to medication safety throughout the hospital.</td>
<td>3.1, 3.2, 3.3, 3.5, 3.6, 3.7, 5.8, 5.10, 5.11, 8.1</td>
</tr>
<tr>
<td>Audit and evaluation</td>
<td>The effectiveness of medication management systems are systematically monitored and evaluated to ensure they are effective.</td>
<td>2.8, 3.1, 5.8, 8.1</td>
</tr>
<tr>
<td>Education and training</td>
<td>Safe prescribing and drug administration practices are supported by mandatory and practical training on medication management for relevant staff.</td>
<td>6.2, 6.3</td>
</tr>
<tr>
<td>Access to information</td>
<td>Essential information of the safe use of medications is readily available in a user-friendly format and is adhered to when prescribing, dispensing and administering medications.</td>
<td>2.5, 8.1</td>
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</tbody>
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Report of the unannounced inspection of medication safety at the National Maternity Hospital Hospital
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