Report of the announced inspection of medication safety at Portiuncula University Hospital, Ballinasloe.

Date of announced inspection: 13 July 2017
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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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Report of the announced inspection of medication safety at Portiuncula University Hospital
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 Portiuncula University Hospital by Authorised Persons from HIQA; Kathryn Hanly, Dolores Dempsey Ryan and Noelle Neville. The inspection was carried out on 13 July 2017 between 9.30hrs 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 and the Chief Pharmacist
- Group two: the Clinical Support Services Director (Deputising for the General Manager), the Director of Nursing and the Director of Midwifery.
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Inspectors visited the following clinical areas, spoke with staff and reviewed documentation:

- St Joseph’s Ward (Medical Ward/ Stroke Unit)
- St Therese’s Ward (Paediatrics)

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

HIQA would like to acknowledge the cooperation of staff who facilitated and contributed to this announced inspection and the hospital outpatients who spoke with inspectors.
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2. Findings at Portiuncula Hospital

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

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.

Portiuncula University Hospital is a Model 3 hospital providing acute surgery, acute medicine and critical care along with Emergency Department and maternity services to adults and children. In addition, the hospital provides a wide range of diagnostic and support services.

The hospital’s Drugs and Therapeutics Committee was re-established in late 2015. The roles and functions of Drugs and Therapeutics Committee were clearly articulated in the Committee’s terms of reference with a stated objective of ensuring rational and appropriate drug therapy.

Membership of the Committee was multidisciplinary and included medical representation from each clinical directorate to reflect the fact that medication management was the responsibility of a number of clinical professional groupings. The Committee was chaired by a Consultant Obstetrician and Gynaecologist who reported positive and supportive engagement from and with Senior Management.

The Drugs and Therapeutics Committee reported to the hospital’s Quality and Safety Governance Group which in turn reported directly to the Hospital Management Team. The Chief Pharmacist, General Manager and Director of Nursing were each members of the Drugs and Therapeutics Committee, the Medication Safety Committee and the Quality and Safety Governance Group which supported communication and oversight of medication safety.

HIQA found that the leadership, governance and oversight of medication safety by the Drugs and Therapeutics Committee needed to be strengthened to further ensure its effectiveness. The Drugs and Therapeutics Committees terms of reference indicated there were two permanent sub-committees of the Drugs and Therapeutics Committee: the Antimicrobial Stewardship sub-committee and the Medication Safety sub-committee. However, a review of the recently updated Medication Safety Committee terms of reference stated that the reporting relationship was through the
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Quality and Safety Governance Group with minutes going to the Drugs and Therapeutics Committee for information. This informal and atypical reporting relationship with the Drugs and Therapeutics Committee was confirmed at interview.

HIQA also found that there was a fragmented approach to the oversight and management of medication incidents reported at the hospital. Inspectors were informed that while medication safety was a standing item on the Drugs and Therapeutics Committee agenda, medication-related incidents and near misses were not routinely reviewed by this committee or the Medication Safety Committee. It was reported that plans were being devised to address this anomaly. Medication errors resulting in patient harm and with patient safety implications were reported however to the hospital’s Quality and Safety Governance Group.

At the time of this inspection, the hospital did not have a formal medication safety programme in place. However, the hospital demonstrated awareness of many of the inherent weaknesses in the existing medication safety systems and had recently acted to address some of the deficiencies identified. A business case had been submitted to hospital management for a medication safety coordinator position.

It was evident that a more structured approach to medication safety at the hospital was beginning to emerge. The Medication Safety Committee had been restructured in December 2016. As a result, Committee membership was expanded to achieve a broader representation from across the hospital. This Committee was chaired by the General Manager. However, a review of the Committee’s terms of reference and quality improvement plan indicated that the stated objective of the Committee was primarily focused on HIQA’s Medication Safety Monitoring programme. The quality improvement plan did not detail the responsible person for each action, due dates or completion dates for each action. It is important that the role and function of the Medication Safety Committee is further developed and enhanced into the future, and not merely a short term reaction in response to regulatory monitoring.

Development of a medication formulary was included in the role of the Drugs and Therapeutics Committee as outlined in the Committee’s terms of reference. However, an up-to-date local approved medication formulary* did not exist in the hospital at the time of this inspection. A formal process for evaluating requests for the supply and evaluation of new medications in the hospital had recently been developed, and approved by the Drugs and Therapeutics Committee. However, this process had yet to be implemented in practice. While HIQA acknowledges that the development of a formulary is a considerable undertaking, arrangements to develop a formulary or drug list in Portiuncula Hospital as identified during this inspection have been slow to progress.

*Local formulary is defined as list of medicines approved for use within a healthcare organisation
Portiuncula University Hospital was also represented in the recently formed Saolta Hospitals Group Drugs and Therapeutics Committee. This Committee was set up with the aim of facilitating shared learning and ensuring adoption of appropriate standards on all aspects of drugs and therapeutic use across the hospital group. A review of this Committee was outside the scope of this inspection. However, formation of this Committee suggests that there was collaboration about medication management at hospital group level and has the potential to provide a valuable opportunity to share learning, experience and resources.

**Risk management**

The main source of medication error data in the hospital was the voluntary reporting system. Medication incidents were reported via an electronic risk management system which generated trend reports. Three monthly medication incident summary reports for the period from September to December 2016 were provided to inspectors for review. Sub-categorisation and risk rating of the medications incidents was evident. Medication incidents were graded using the National Coordinating Council for Medication Error Reporting and Prevention (NCCMERP) Medication Error Index to categorise incidents in terms of patient harm (Appendix 2). The index considered factors such as whether the error reached the patient and, if the patient was harmed, to what degree. The type of incident/near miss was also recorded. The most frequently occurring type was omitted/missed drug/dose. Medications involved in incidents were also classified by British National Formulary categories. The most frequently occurring category was cardiovascular. However, HIQA noted that incidents were not categorised according to drug class or directorate/ward in which medication incident/near miss occurred. This represents a lost opportunity for learning and identifying key areas for improvement.

During the documentation review, HIQA inspectors reviewed the list of reported medication-related incidents between January and June 2017. Inspectors identified that anticoagulant medications were implicated in a significant percentage of overall medication incidents reported. The most frequent drugs implicated in reports were direct acting oral anticoagulant medications, which were involved in approximately one in five of the total incidents reported. It is recommended that medication incidents reports should be analysed and synthesised in greater detail to reveal trends in incident reports. Such information is key to the implementation of proactive medication safety initiatives.

Reporting in itself does not improve safety. Reporting of incidents is of little value unless the data collected are analysed and recommendations are disseminated.

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† Medications used to treat or prevent blood clots.
However, staff informed inspectors that they did not routinely receive updates on medication errors that have occurred within the hospital.

HIQA was also informed that medication-related incidents and near misses were under reported at the hospital. Higher incident reporting rates both demonstrate and promote an improved culture of safety.\(^7\) Approximately 90 percent of reports were submitted by clinical pharmacists with limited evidence available to suggest that medical and nursing staff were reporting medications incidents. The absence of a clinical pharmacy service in the Women’s and Children’s Directorate, which included the paediatric and maternity wards also meant there was likely underreporting in these areas. As a result key medication related risks in these areas could not be understood, recorded, escalated or mitigated effectively. Therefore, the culture of reporting medication incidents needs to be broadened out to include other healthcare staff, rather than reliance on clinical pharmacists, so that safety surveillance is improved, learning is shared, and safety culture is promoted and enhanced across the organisation.

All hospitals covered by the Clinical Indemnity Scheme (CIS) have a statutory requirement to report all adverse clinical events and “near misses” via the National Incident Management System (NIMS)\(^6\). Medication incidents were graded using the Health Service Executive (HSE) risk matrix.\(^8\) Serious medication incidents reported were inputted to the National Incident Management System (NIMS)\(^5\).

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.\(^9\) Inspectors were informed that the hospital had a process in place to promptly inform patients when medication-related incidents occurred.

### 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 involves a cyclical approach to planning, standard selection, measuring performance leading to improvement in practice and sustaining that change.\(^10\) While elements of medication safety were audited at the hospital, these audits were not aligned to a formalised medication safety strategy.

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\(^{6}\) 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).
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Audits relating to medication management were limited and strongly weighted towards antimicrobial stewardship. It was explained that there was limited auditing capacity due to reduced staffing resources in the hospital which meant that many of the quality improvement initiatives implemented had not yet been audited. Nevertheless, the inspection team was provided with examples of recent medication management audit activities which included, for example:

- an audit on assessing risk and prophylactic treatment of venous thromboembolism in pregnant patients
- an audit to determine the rate of omitted and delayed doses of time critical medicines
- nurse prescribing audits
- an audit of prescription errors in the paediatric unit.

Nursing and Midwifery Quality Care-Metrics** were monitored across the hospital to review practice around aspects of medication storage and administration. Inspectors viewed the Nursing Quality Care-Metrics findings and noted that the results relating to controlled drugs, medication storage, custody and administration were good. However, there were consistently less than satisfactory findings in relation to observations around medication prescribing.

Overall, inspectors concluded that the hospital had conducted a number of audits relating to medication management. In order to enhance the current approach taken, the hospital would benefit from taking more structured approach to the planning of audit in the area of medication safety aligned to a formal medication safety strategy with dedicated resources.

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.

As previously highlighted, medication safety quality improvement initiatives were not strategically driven by learning gained from analysis of medication incidents or near misses. Nevertheless, despite this weakness, a number of good practices were identified during the inspection. For example, the hospital’s medication prescription and administration record for adult patients had been revised to include designated sections for communication of medication issues, documenting medication

** Metrics are parameters or measures of quantitative assessment used for measurement and comparison or to track performance.
reconciliation, venous thromboembolism risk assessment and prescribing antimicrobials and infusions.

Clinical staff told inspectors that adult and paediatric inpatient wards and the Pharmacy Department operated a daily '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 incidents.

As part of the Productive Ward™†† quality improvement initiative medication storage at ward level was reviewed and standardised to ensure generic A to Z storage of medication on all wards. In addition, the hospital had installed electronic access controls into the clinical rooms and on medication storage cupboards. This ensured that only authorised staff could access the medications contained within them. Every time the cabinets were opened the event was automatically logged via the audit trail facility. The hospital had also installed an automated medication supply system in the Emergency Department. This system facilitated management of medication in a secure automated dispensing cabinet.

Additional practices to enhance medication safety in the hospital were identified during this inspection. The hospital had adopted the Institute of Safe Medication Practices high-alert medications list. High-alert medications are medicines that bear a heightened risk of causing significant patient harm when they are not used correctly. The acronym ‘A PINCH’ which grouped medications into categories was used to facilitate education and to raise awareness of high risk medications. Following an audit to determine the rate of omitted and delayed doses of time critical medicines, the hospital had also identified a local list of critical medicines where timeliness of administration is crucial.‡‡ The hospital promoted medication safety awareness of high-alert and time critical medications through in service education.

Interruptions during medication administration rounds are thought to be a prominent causative factor of medication errors. To reduce interruptions, a trial of red “do not disturb” tabards was carried by nursing staff while administering medications. This intervention was designed to draw attention to the fact that the medication round was in progress, and that nurses should not be interrupted while administering medications. However, inspectors were informed that the effectiveness of this initiative had not been evaluated and the initiative had not been rolled out to other clinical areas.

†† The Productive Ward: Releasing Time to Care™ is a quality improvement initiative designed and licensed by the UK National Health Service Institute for Innovation and Improvement to drive forward improvements in health services through redesigning and streamlining the way staff and services deliver care with an emphasis on patient safety.

‡‡ Time critical medicines are those where the omission or delay is likely to cause the most harm.
Clinical pharmacy services

The hospital had resourced all inpatient adult wards with a designated clinical pharmacist. There are currently no agreed national standards outlining requirements for the provision of clinical pharmacy services in hospitals. International studies support the role of clinical pharmacists in hospital wards in preventing adverse drug events. Clinical pharmacists reviewed inpatient medication prescription charts to prevent, identify, and intercept medication prescribing-related incidents. Clinical Pharmacists also played a key role in communicating with the multidisciplinary team with regard to drug therapy and inpatient counselling and education. This service was provided on a Monday to Friday basis.

It was reported that due to resource deficiencies, clinical pharmacy provision was not standardised practice across all clinical areas in the hospital. The Women’s and Children’s Directorate, which included the paediatric and maternity wards, did not have a dedicated clinical pharmacy service. However, inspectors were informed that a pharmacist attended the day ward when necessary to oversee the setting up of aseptically compounded IV infusions only.

The limited and incomplete clinical pharmacy cover in areas treating high risk patients in the Paediatric Unit and Special Care Baby Unit was of concern to HIQA. International evidence on medication errors indicates that a small error in dose of medication given to children has a greater risk of harm compared to the adult population. Published studies also indicate babies in the Special Care Baby Units (SCBU) are more likely to experience a medication error than other hospitalised patients and to experience more harm when a medication error does occur.

A business case for clinical pharmacy had been developed and submitted for approval of funding. Inspectors were informed that risks in relation to clinical pharmacy service deficiencies had been recorded on the hospital’s executive risk register and escalated to Saolta Hospital Group management. However, there was no defined plan or timeframe in which this issue would be addressed. This should be reviewed by the hospital and hospital group following this inspection.

Medication reconciliation

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. The hospital had established a formal structured pharmacy-led medication reconciliation service in adult inpatient wards at both admission and discharge in line with recommended

Clinical pharmacy describes the activity of pharmacy teams in ward and clinic settings.
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Clinical pharmacists on adult inpatient wards collected gold standard pre-admission medication lists*** and documented this in the designated section of the hospital's medication prescription and administration record. Patient's pre-admission medications were verified by a Clinical Pharmacist using two information sources, one of which was always the patient or their carer and these were then compared to the patient's hospital medication prescription chart. A significant proportion of reported medication errors were detected and corrected by clinical pharmacists during the medication reconciliation process. To improve communication between the clinical pharmacists and medical staff, an alert sticker was designed and implemented as a communication tool and inserted into patients' medical notes which inspectors viewed.

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.

Establishing and maintaining a strong patient-centred approach is key for reducing medication errors. A well-informed patient and/or family can help prevent medication errors by hospital staff and is less likely to make medication errors at home. Adherence to the medication regimen is another goal achieved through patient education.

Portiuncula University Hospital had systems in place to support the provision of information and education to patients in relation to medication. Patient information leaflets were available to adult and paediatric patients. Senior managers told inspectors that there was a multidisciplinary approach to patient information and education. Inspectors were informed that pharmacists offered counselling to patients prescribed anticoagulant medication before discharge. In addition, clinical nurse specialists provided education and support to patients, for example, around the management of respiratory disease and diabetes mellitus.

As part of this inspection, HIQA asked the hospital to administer an anonymised questionnaire in relation to prescribed medications to a small sample of hospital patients attending the Outpatient Department. The questionnaire was completed by nine patients who had been inpatients in Portiuncula University Hospital within the last year and who were prescribed regular medications. Of the nine patients surveyed, eight patients had been prescribed regular medications. Of these eight patients:

*** A standardised method of collecting and documenting an accurate current list of prescribed and non-prescribed medication for an individual patient using as many sources of information as possible.
five said that a staff member had explained the purpose of new medications in a way that they could completely understand
five said that a staff member had told them about all possible medication side effects to look out for following discharge home
six of the patients said that they received complete 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.

Up to date medication policies, procedures, protocols and guidelines were readily available to staff through the hospital’s controlled document management system. These included a medication management policy and an intravenous medication administration policy.

Healthcare staff require 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’s diagnostic results on computers in clinical areas across the hospital.

Additional sources of medication information were readily available to staff involved in medication use including;

- the British National Formulary in print and electronic formats,
- A-Z reconstitution and administration guidelines for intravenous medication
- Galway Antimicrobial Prescribing Policy/Guidelines (GAPP)
  - Antimicrobial Guidelines available as an application for smart phones.

The paediatric service used nationally approved protocols obtained through the National Network for Paediatric Services.
There was an established system in place to respond to guidance, alerts, recalls and recommendations issued by regulatory bodies in relation to medication safety. Such information was communicated to relevant heads of department.

**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.

Staff education can effectively augment error prevention when combined with other strategies that strengthen the medication-use system.28

The hospital did not have a formalised education programme for clinical staff linked to an overall medication safety strategy. However, inspectors were informed that medication safety was included in induction programmes for all new clinical staff. New nurses in the paediatric unit are supervised during their first month on the unit. The Pharmacy Department had also developed a prescribing and drug administration standards booklet. This booklet included information on prescribing and administration in the medication prescription and administration record, information on medications that looked and sounded similar, allergy assessment, delayed drug administration high-alert drugs, outpatient/discharge prescriptions and what to do if the drug chart is not completed correctly.

Nursing staff also completed the HSELanD online Medication Management training programme.29 Nursing staff were required to undertake anaphylaxis training to facilitate the administration of first dose antimicrobial medications.

Training on medication safety issues and prescribing was also provided by pharmacists to clinicians during ‘Grand Rounds’†††.

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††† 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.
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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.

Current structures and systems to support medication safety at Portiuncula University Hospital need to be strengthened. The hospital’s Drugs and Therapeutics Committee was re-established in late 2015. However, HIQA found that medication incidents were not discussed by this Committee. This meant that there was poor governance oversight of medication incidents by the Drugs and Therapeutics Committee.

The hospital had restructured the Medication Safety Committee in December 2016. However, this Committee had not established formal communication links with the Drugs and Therapeutics Committee. In addition, HIQA found that the hospital did not have a formal medication safety programme in place, which was underpinned by an overarching medication safety strategy, prioritised on the basis of identified risk. The role and function of both the Drugs and Therapeutics Committee and the Medication Safety Committee should be refocused, with assurance arrangements in place to assess that medication management processes are safe, that patient safety is managed effectively and, when appropriate, risk is raised to a higher level. The hospital should look to further progress its work in this area by devising a formalised medication safety strategy with clearly defined objectives, prioritised on the basis of identified risk. In the absence of national guidance in this area, international guidelines which outline best practice in relation to medication safety strategic planning and quality improvement should be considered.

There also remains scope for improvement in working to promote a more effective culture of medication adverse incident reporting as part of a wider approach to the development of a more comprehensive medication safety programme in the hospital. The hospital should endeavour to track and trend medication incidents reported and improve learning mechanisms to staff following medicines incident reporting to ensure that lessons are learnt and staff can see actions have been taken.

The aim of clinical governance is to accomplish continuous quality improvement and is designed to consolidate fragmented approaches to quality improvement. Medication safety quality improvement initiatives were not strategically driven by learning gained from analysis of medication incidents or near misses. While there were some structures and systems in place clinically to support medication safety,
the hospital needs to embrace a wider approach to medication safety rather than focusing on specific, circumscribed safety initiatives.

Audit facilitates decision making regarding medication safety quality improvement initiatives and ensures that the accountable person can be confident that medication safety is being managed effectively and thus be able to make a judgment on the level of risk to patients. Current arrangements with regard to medication safety audit should be strengthened to ensure that there is a more systematic approach to audit selection and dissemination of audit findings throughout the hospital to provide assurance to the Hospital Management Team about medication safety at the hospital.

It is noted that while there is a clinical pharmacy service in place, it was not fully comprehensive – at the time of the inspection the Emergency Department, paediatric and maternity wards did not have a dedicated clinical pharmacy service. This represents a significant risk. It is recommended that an evaluation occurs with respect to the clinical pharmacy services to examine the possibility that in the very short term, existing resources might be better targeted towards the provision of an inpatient clinical pharmacy service to high risk areas from a medication safety perspective such as maternity and paediatric services. In addition, the hospital needs to review the appropriateness of appointing a medication safety pharmacist position in light of current clinical general pharmacy service limitations within the maternal and children’s directorate.

Following this report, the hospital must focus its efforts to address the risks and findings identified in this report, and work to ensure that the necessary arrangements are in place to protect patients from the risk of medication-related harm.

It is recommended that this report is shared with senior managers, clinicians and other relevant staff at Portiuncula University Hospital to highlight both what has been achieved by the hospital in implementing medication safety activities to date, and to foster further collective progression from this time point. The hospital should continue to collaborate further within the Saolta hospital group structure, to share good practice pertaining to medication safety and to develop and implement policies and practices for medication management.
4. References


29. Health Service Executive. HSELanD. Available online from: http://www.hseland.ie/dash/Account/Login

## 5. Appendices

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

<table>
<thead>
<tr>
<th>Area to be explored</th>
<th>Line of enquiry</th>
<th>National Standards for Safer Better Healthcare</th>
</tr>
</thead>
<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>
</tr>
</tbody>
</table>

Definitions

Harm
Impairment of the physical, emotional, or psychological function or structure of the body and/or pain resulting there from.

Monitoring
To observe or record relevant physiological or psychological signs.

Intervention
May include change in therapy or active medical/surgical treatment.

Intervention Necessary to Sustain Life
Includes cardiovascular and respiratory support (e.g., CPR, defibrillation, intubation, etc.)
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