Report of the announced inspection of medication safety at Roscommon University Hospital.

Date of announced inspection:
16 June 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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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 which is available on HIQA’s website: www.hiqa.ie

An announced medication safety inspection was carried out at Roscommon University Hospital by Authorised Persons from HIQA; Dolores Dempsey Ryan, and Nora O’ Mahony. The inspection was carried out on 16 June 2017 between 09:00hrs and 16:30hrs. Interviews were held at the hospital with the following groups of managers and clinical staff:

- Group one: the Chairperson of the Drugs and Therapeutics Committee designate, the Risk Advisor, and the Senior Pharmacist.
- Group two: the General Manager and the Director of Nursing.
Inspectors visited one clinical area, spoke with staff, and reviewed documentation:

- St Coman’s 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 Roscommon University 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.

Roscommon University Hospital (RUH) is a Model 2 hospital within the Saolta University Health Care Group, providing hospital activities including extended day surgery, selected acute medicine, local injuries, and a large range of diagnostic services (including endoscopy, laboratory medicine, point of care testing and radiology), specialist rehabilitation medicine and palliative care.

Roscommon University Hospital had formalised governance arrangements and organisational structures with clear lines of accountability in place to support the safe use of medications. The Drugs and Therapeutics Committee reported to the hospital’s Management Team. The Hospital Management Team was operationally accountable to the Saolta Group Management Executive Council and attended monthly and quarterly Saolta Group meetings as required.

The Drugs and Therapeutics Committee was established in 2012. The Committee was chaired by a Consultant Physician, and co chaired by the Senior Pharmacist. The General Manager was corporately responsible for oversight of medication safety.

The Drugs and Therapeutics Committee was revising its terms of reference that outlined the Committee’s purpose, roles and responsibilities, membership, accountability and reporting relationships, frequency of meetings, declaration of interest and reporting relationships at the time of the inspection. Membership of the Drugs and Therapeutics Committee was multidisciplinary to reflect the fact that medicines management was the responsibility of a number of clinical professional groupings. Membership included clinicians, pharmacists, nurses, the risk advisor, hospital management, and other healthcare professionals who participated in the medication-use process.

The Drugs and Therapeutics Committee was responsible for the governance and oversight of the hospital’s medication management systems and for ensuring its safety. However, on the day of inspection, HIQA found that the leadership,
governance and oversight of medication management systems by the Drugs and Therapeutics Committee needed to be strengthened to further ensure its effectiveness.

A review of the minutes of the Drugs and Therapeutics Committee meetings showed that attendance at meetings was variable. In addition, hospital managers acknowledged that the committee had not consistently met between 2013 and 2015. However, the Drugs and Therapeutics Committee was re-established in 2016. Inspectors noted that the frequency of meetings had improved in 2016 and 2017.

Inspectors found that Roscommon University Hospital had independent governance arrangements in place for medication safety and reported to the Saolta Group’s Drugs and Therapeutics Committee. However, the hospital had no representative on the Galway University Hospitals’ Drugs and Therapeutics Committee to support a collaborative approach to medication safety despite the fact that they shared medication guidelines. This should be a key area for improvement following this inspection where Roscommon University Hospital’s Drugs and Therapeutics Committee should formalise its existing relationship with the Galway University Hospitals’ Drugs Therapeutics Committee to support governance, collaboration and shared learning for medication safety.

For a Drugs and Therapeutics Committee to be effective there must be, a structured drug selection system that is explicit in its methodology, transparent and evidence-based. Inspectors found that Roscommon University Hospital did not have a locally approved hospital formulary in place. The purpose of maintaining a formulary in the hospital is to ensure that appropriate governance exists with the Drugs and Therapeutics Committee around what is approved for use and that in doing so, a proper safety evaluation occurs before medications are introduced into practice at the hospital.

Inspectors were provided with an example of where a request for the introduction of a drug was informally discussed at the Drugs and Therapeutics Committee. However, the hospital did not have a process or written criteria in place to formally evaluate the quality and safety of new medicines before introducing them for use. Standard criteria for such decision making should be formalised, defined and consistently implemented by the Drugs and Therapeutics Committee. A formal drug formulary system should be established to limit the choice to essential drugs, minimise the number of drugs to which practitioners must be familiar with and to

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*A formulary is a hospital’s preferred list of medicines that staff can use as a reference document to ensure safe and cost-effective prescribing*
provide adequate time for designing safe processes for the use of new drugs added to the formulary

As Roscommon University Hospital is part of the Saolta Group, and patients would regularly transfer into or out from this hospital to the Galway University Hospitals, the benefits of establishing formal links with the Galway University Hospitals’ Drugs and Therapeutics Committee should therefore be explored. Such a relationship would also potentially facilitate the use of a shared medicines formulary.

Documentation provided to inspectors indicated that a medication safety agenda was being progressed at the hospital, and the hospital had recently developed a preliminary quality improvement plan for medication safety. The hospital should look to further progress its work in this area by devising a formalised written medication safety strategy and plan with clearly defined objectives. In the absence of national guidance in this area, international guidelines which outline best practice in relation to medication safety strategic planning and a quality improvement plan should be considered.9

Reports from the hospital’s Antimicrobial Stewardship Team and the Nurse Prescribers Medicines Review Team were regularly discussed at the Drugs and Therapeutics Committee meetings. However, documentation reviewed by inspectors indicated that while medication safety was an item on the agenda, medications incidents were not routinely reported to this Committee.

Hospital management who spoke with inspectors confirmed that monthly medication incident reports were discussed at the Quality and Safety Committee meetings and this Committee reported into the Hospital Management Team. The hospital reported that key members of the Drugs Therapeutics Committee were also members of the Quality and Safety Committee and the Hospital Management Team and this arrangement supported governance and oversight of medication safety. The hospital had identified that more work was required in the development of a medication plan to progress a medication safety programme within the hospital. In addition, the Drugs and Therapeutics Committee had not evaluated its effectiveness, but reported to inspectors that they planned to produce a quarterly report for the Hospital Management Team.

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 disseminated.10 Hospital staff reported medication incidents and near misses on an electronic reporting system. The hospital inputted
all medication incidents reported within the hospital to the National Incident Management System (NIMS).†

The hospital’s Serious Incident Management Team (SIMT) reviewed serious incidents, which would also be escalated the Saolta Group SIMT. Staff from Roscommon University Hospital attended the Saolta Group SIMT meetings to support shared learning with hospitals within the group. This supported hospital group governance and oversight of serious incidents.

The hospital had an established system for reporting and addressing medication incidents. The Risk Advisor with the Senior Pharmacist reviewed and graded all medication incidents using the Health Service Executive (HSE) risk matrix. Medication incident reports were produced monthly as part of an overarching quality and safety report for the Hospital Management Team.

Inspectors found that ward staff who spoke with inspectors confirmed that they were informed about medication incidents through the hospital information system and at various committee meetings. Nonetheless, hospital managers and ward staff confirmed that near misses were not formally reported, but were addressed at local level on the ward.

HIQA noted a low numbers of medication related incidents reported throughout 2016, relative to other hospitals. As a result of poor reporting, key medication related risks could not be understood, recorded, escalated or mitigated effectively by the hospital. Low numbers of incidents reported does not necessarily mean a low number of incidents occurring. Studies have found a positive association between increased incident reporting rates and measures of safety culture where an increase in incident reporting was indicative of a positive reporting culture within the hospital. The hospital therefore needs to begin to better quantify and report medication related risks through improved reporting. The Drugs and Therapeutics Committee needs to provide leadership, governance and oversight on medication incidents and near misses, and support the implementation of medication safety initiatives.

The hospital reported that the majority of medication incident reports were submitted by nursing staff with limited evidence available to suggest that other healthcare staff were reporting medications incidents. Therefore, inspectors formed the opinion that the culture of reporting medication incidents needs to be broadened out to include other healthcare staff so that safety surveillance is improved, learning is shared, and safety culture is promoted and enhanced across the organisation.

† 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 State Claims Agency (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.\(^1\) Inspectors were informed that the hospital had a process in place to inform patients when medication-related incidents occurred. An example was given to inspectors of where an open disclosure had been made to a patient following a medication incident. Staff were also provided with training on open disclosure.

### 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.\(^2\) Elements of medication safety were audited at the hospital, but these audits were not aligned to a formalised medication safety strategy. In addition, audit activity throughout the hospital was neither strategically driven by an audit programme nor centrally coordinated.

Documentation reviewed showed that some medication safety-related audits had been undertaken by clinical staff at the hospital which included the following:

- nursing medication audits (October 2016)
- monthly MDA\(^3\) audits
- antimicrobial audits
- nurse prescribing audits
- meropenem usage (April 2017)
- audit of an assessment of antihypertensive usage in the hospital (November 2016)
- medication appropriateness on older persons discharged from the hospital (2012).

Nursing Quality Care-Metrics\(^4\) were monitored across the hospital to review practice around some aspects of medication storage and administration. Inspectors viewed the Nursing Quality Care-Metrics\(^5\) findings and noted that the results relating to medication storage and custody were good. However, more improvement was required with regard to medication prescribing. Ward staff who spoke with inspectors were provided with regular feedback on nursing quality care-metrics.

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\(^1\) The acronym MDA refers to the Misuse of Drugs Acts (MDA). Drugs covered by the MDA include opiate medications.

\(^2\) Metrics are parameters or measures of quantitative assessment used for measurement, and comparison or to track performance.
Inspectors viewed an analysis of proton pump inhibitor** usage among elderly inpatients in relation to unwarranted polypharmacy††. This audit identified that of the 44 inpatient healthcare records reviewed, 12 patients were on proton pump inhibitor with no current indication for continued therapy in accordance with international guidelines. Inspectors noted that no recommendations were made following the analysis to support shared learning or the implementation of a medicines safety improvement initiative.

HIQA found that in the absence of an audit programme and structures to centrally coordinated audits, opportunities were lost to share learning and implement medication safety initiatives to support an effective medication safety programme. 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 senior Hospital Management Team about medication safety at the hospital.

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.

Medication safety quality improvement initiatives were not strategically driven by learning gained from analysis of medication incidents or near misses. Nevertheless, despite this weakness, some good practices were identified during the inspection. For example, interruptions during medication administration rounds are thought to be a prominent causative factor of medication errors.17 Managers told inspectors that, to reduce interruptions red “do not disturb” tabards were worn 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.

Roscommon University Hospital was participating in the Health Service Executive (HSE) Quality Improvement Division venous thromboembolism‡‡ quality improvement collaborative.18 This is a collaborative among multidisciplinary teams in Irish adult acute public and voluntary hospitals who are working together to achieve

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**“Proton pump inhibitor”, is a medicine, which reduces the amount of acid produced in your stomach. It is used for treating acid-related diseases of the stomach and intestine.

†† Polypharmacy is the use of four or more medications by a patient, generally adults aged over 65 years.

‡‡ Thromboembolism is the obstruction of a blood vessel by a blood clot that has become dislodged from another site in the circulation.
appropriate thromboprophylaxis\textsuperscript{55} for their hospital’s inpatients, to reduce the risk of venous thromboembolism and to minimise harm and expenditure associated with unnecessary thromboprophylaxis. Venous Thromboembolic (VTE) events audits had been completed in February and May 2017, which highlighted that the majority of patients had appropriate thromboprophylaxis treatment. The hospital had identified following this audit that they were considering revising the hospital’s medication prescription and administration record to include a risk assessment tool for venous thromboembolism prescribing.

There are currently no agreed national standards outlining requirements for the provision of clinical pharmacy services in Irish hospitals. However, international studies support the role of clinical pharmacists in hospital wards in preventing adverse drug events.\textsuperscript{19,20,21,22,23,24} While efforts were made by the pharmacist to support staff in safe medicines usage, the hospital was not sufficiently resourced to provide a clinical pharmacy service at ward level to prevent, identify, and intercept medication prescribing-related incidents. Inspectors found on the day of inspection that the pharmacy service within the hospital was almost entirely restricted to dispensing. The hospital had an antimicrobial pharmacist one day a week from another hospital to review charts with regard to antimicrobial stewardship. However, the hospital had no pharmacy technician to support a pharmacy service.

Medicines reconciliation is a formal, systematic process for obtaining a current and accurate list of medicines that the patient was taking when admitted to the hospital, and reconciling this medicines list against the patient’s medicines prescribed at admission, transfer and discharge.\textsuperscript{25,26,27,28} Inspectors were informed that formalised medication reconciliation was not routinely carried out in the hospital. The hospital had an informal process in place where patients had their medications checked by a medical prescriber and nursing staff on admission. Nurses checked prescriptions prior to discharge against the patient’s medicines prescription and administration record. However, the effectiveness of this process had not been audited, and no training program was in place to support staff in performing formalised medication reconciliation.

High-risk medicines can cause significant harm when system errors occur.\textsuperscript{6} The hospital had a list of high-alert medicines \textsuperscript{***} used within the organisation, and was taking appropriate actions to ensure that high-risk medicines were stored safely.

\textsuperscript{55}Thromboprophylaxis is the prevention of clots forming in the veins.

\textsuperscript{***}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.
Evidence-based risk reduction strategies were implemented to reduce unwarranted clinical variation in medication prescribing and administration of high alert drugs. These included the introduction of:

- a red high alert insulin box stored in a fridge marked ‘stop potential error’ that clinical staff were required to double check before administering insulin
- insulin labels to indicate that insulin was for single patient use only
- a label “please see insulin drug sheet” as a prompt to ensure that medicines recorded on the subcutaneous insulin prescription and administration record would be administered to avoid a medication omission
- pre-prepared potassium bags to reduce the risks associated with administering these medicines.

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. This is particularly relevant for those patients who are taking multiple medications.

Roscommon University Hospital had systems in place to support the provision of patient information and education in relation to medication usage. Hospital managers and ward staff told inspectors that doctors and nurses offered counselling to patients on prescribed medication before discharge. Patient information leaflets were available to patients. In addition, clinical nurse specialists provided education and support to patients, for example, around the management of diabetes mellitus. A Senior Pharmacist confirmed to inspectors that they were not involved in counselling patients with regard to prescribed medication.

As part of the HIQA inspection, HIQA requested that a small sample of hospital outpatients attending the Outpatient Department complete an anonymised questionnaire in relation to prescribed medications. Fifteen patients who had been inpatients in Roscommon University Hospital within the past year, and who were prescribed regular medications completed the questionnaire. Of the 15 patients surveyed, 11 patients had been prescribed new medicines and one patient had not been prescribed any new medicines. Of these 11 patients:
Eleven of the patients said that while in hospital, a staff member had explained the purpose of new medication in a way that they could completely understand.

Seven of the patients said that prior to discharge from hospital, a staff member told them about all possible medication side effects to look out for following discharge home.

Seven of the patients said that they received complete instruction on how to take their medications at home.

It is acknowledged that the sample size of patients who completed the anonymised questionnaire was small, and therefore was not representative of all recently discharged patients taking prescribed medication. However, patient education is an integral component of the safe, effective and cost-effective use of medications. This patient questionnaire did provide some baseline information about outpatient’s understanding of medications and may be used as a focus for further 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 Quality and Safety Committee and the Hospital Management Team approved all medication-related policies, procedures and guidelines prior to implementation. Documentation provided to inspectors indicated that policies were also an item for discussion at the Drugs and Therapeutics Committee meetings.

Inspectors observed that up to date versions of medication management policies, protocols and guidelines were available to staff in clinical areas through a controlled electronic document management system.

Roscommon University Hospital had access to Galway University Hospitals’ medication guidelines through a folder on their computer desktop at ward level. However, the use of these guidelines had not been formally approved by the Drugs and Therapeutics Committee.
Inspectors found that the clinical area visited had access to printed copies of Galway University Hospital’s intravenous drug administration guides. Inspectors were informed at interview that Roscommon University Hospital linked in with the pharmacy department in Galway University Hospitals to stock the same medicines for example, intravenous medicines. This meant that when patients were transferred across both hospital sites that medicines were available for use.

Other decision support tools available to clinical staff included:

- British National Formulary in print and electronic format
- GAPP (Galway Antimicrobial Prescribing Policy/Guidelines)
- Antimicrobial Guidelines available as an application for smart phones
- Intravenous administration monographs for adults.

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’s laboratory and radiology results on computers in clinical areas across the hospital.

Medication safety alerts were managed through the Pharmacy Department and alerts were circulated to healthcare staff through the hospital information system.

### 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. The hospital did not have a formalised education programme for clinical staff linked to an overall medication safety strategy. However, inspectors were informed that non consultant hospital doctors received induction training which included medication safety. Inspectors were informed that non-consultant hospital doctors attended regular weekly teaching sessions and journal club presentations.

Nursing staff attended induction training on intravenous drug administration and completed the Health Service Executive medication management online training programme. Inspectors viewed nurse-training records at ward level relating to

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††† Non-consultant hospital doctor (NCHD) is a term used in Ireland to describe qualified medical practitioners who work under the (direct or nominal) supervision of a consultant in a particular speciality.
Health Service Executive medication management online training programme, medication management policy, anaphylaxis training, and noted that a number of nurses had attended these medication-training programmes.

Documentation provided to inspectors indicated that induction training for both doctors and nurses had been well attended.

Inspectors viewed a ‘Newsletter RUH Nursing News’ produced by Nurse Practice Development Department. Newsletters were produced quarterly and they provided up-to-date information on such items as education session, new policies, nursing metrics, haemovigilance news and study days.

‡‡‡ Haemovigilance is a set of surveillance procedures covering the whole transfusion chain (from the collection of blood and its components to the follow-up of recipients.)
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 hospital had a Drugs and Therapeutics Committee in place that was responsible for the governance and oversight of the hospital’s medication management systems and for ensuring its safety. However, on the day of inspection, HIQA found that the leadership, governance and oversight of medication management systems by the Drugs and Therapeutics Committee needed to be strengthened to ensure medication safety.

On the day of the inspection, Roscommon University Hospital did not have a defined medication safety programme with clear objectives underpinned by a written strategy. HIQA recommends that, following this inspection an agreed written medication strategy or plan, targeted on the basis of risk, should be developed and implemented by the hospital, and shared with the wider Saolta Group. In the absence of national guidance in this area, international guidelines which outline best practice in relation to medication safety governance and improvement are available, and should be considered by staff responsible for patient safety in the hospital setting.

Inspectors found that Roscommon University Hospital had no formulary in place to ensure that appropriate governance exists with the Drugs and Therapeutics Committee around what medicines are approved for use and that in doing so, a proper safety evaluation occurs before medications are introduced into practice at the hospital. As Roscommon University Hospital formed part of the Saolta Group, the hospital should have a representative on the Galway University Hospitals’ Drugs and Therapeutics Committee to support governance arrangements for medication safety and collaborate to develop a formulary. Collaboration within the hospital group in relation to medication safety would provide a valuable opportunity to share learning, experience and resources.

Roscommon University Hospital had a process in place to check medication when a patient was admitted. However, medication reconciliation was not formalised in the hospital. Inspectors found on the day of inspection that the pharmacy service within the hospital was almost entirely restricted to dispensing, and therefore unable to provide clinical services such as medicines reconciliation. HIQA found that in most hospitals inspected so far through this medication safety-monitoring programme, the
clinical pharmacy service provided the main portion of medicines reconciliation function.

The level of reporting of medication related incidents and near misses at Roscommon University Hospital were low. The hospital therefore needs to begin to better quantify and report medication related risks through improved reporting by all healthcare staff.

Auditing of medication-related incidents was not centrally coordinated or strategically driven at the hospital. HIQA found that in the absence of an audit programme and structures to centrally coordinated audits, opportunities were lost to share learning and implement medication safety initiatives to support an effective medication safety programme. 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 senior Hospital Management Team about medication safety at the hospital.

Inspectors found that the hospital had implemented some quality improvement initiatives to reduce medication errors and had developed a number of medication policies. However, to generate more widespread change, the hospital should adopt a broader approach to medication safety, which includes greater collaboration with other hospitals in the Saolta group, rather than focusing on specific, circumscribed safety initiatives.

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 Roscommon 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 Group structure, to share good practice pertaining to medication safety and to develop and implement policies and practices for medication management.
4. References


25. Health Information and Quality Authority. Guidance for health and social care providers. Principles of good practice in medication reconciliation. Dublin:


### 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>
</tr>
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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>
</tr>
</tbody>
</table>
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