Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of the announced inspection of medication safety at St. Luke's Hospital, Rathgar, Dublin.

Date of announced inspection:

21 June 2017

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.

Regulation — Registering and inspecting designated centres.

Monitoring Children's Services — Monitoring and inspecting children's social services.

Monitoring Healthcare Safety and Quality — Monitoring the safety and quality of health services and investigating as necessary serious concerns about the health and welfare of people who use these services.

Health Technology Assessment — Providing advice that enables the best outcome for people who use our health service and the best use of resources by evaluating the clinical effectiveness and cost effectiveness of drugs, equipment, diagnostic techniques and health promotion and protection activities.

Health Information — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information about the delivery and performance of Ireland's health and social care services.

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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.[1] 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.[2]

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* [3] 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* [4] which is available on HIQA's website: www.hiqa.ie

An announced medication safety inspection was carried out at St Luke's Hospital by Authorised Persons from HIQA; Kathryn Hanly and Kay Sugrue. The inspection was carried out on 21 June 2017 between 10.30hrs and 15.30hrs. Interviews were held in the hospital with the following groups of managers and clinical staff:

- Group one: the Chairperson of the Drugs and Therapeutics Advisory Committee, the Clinical Lead and Chairperson of the Clinical Risk Management Committee, the Chief Pharmacist, and the Director of Quality Patient Safety and Risk.
- Group Two: the Network Director and the Assistant Director of Nursing.

Inspectors visited the following clinical area and spoke with staff and reviewed documentation:

- D Ward

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 patients in the hospital's Outpatient Department who completed an anonymised questionnaire in relation to prescribed medications.

2. Findings at St Luke's Hospital, Rathgar, Dublin

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.

St Luke's Hospital Rathgar is part of the St Luke's Radiation Oncology Network incorporating St Luke's Radiation Oncology Centre at Beaumont Hospital and St Luke's Radiation Oncology Centre at St James's Hospital.

An announced medication safety inspection was undertaken in St Luke's Hospital, Rathgar. The hospital comprised of:

- in-patient acute wards B and D
- day unit
- five day unit (Oaklands Lodge)

A Transitional Care Unit* was also located within St Luke's Hospital, comprising wards A and C. These wards facilitated patients transferred from Tallaght and St James's Hospital following completion of their acute phase of treatment. A review of the governance arrangements for wards A and C was not within the scope of this inspection. However, discussion regarding the governance arrangements for wards A and C as described on the day of the inspection will be further detailed at the end of section 2.1.

St Luke's Hospital had a Drugs and Therapeutics Advisory Committee that had recently updated its terms of reference which outlined the Committee's aims, responsibilities, reporting relationships, membership and frequency of meetings. However, a review of the terms of reference indicated that the level of activity of the Drugs and Therapeutics Advisory Committee fell short of that expected.[5] For example, medication safety was not a standing item on the Drugs and Therapeutics Advisory Committee meeting agendas. An effective drugs and therapeutics committee should have ongoing oversight of the medication management and safety system within a hospital.[5] Inspectors were informed that the scope and function of

* Transitional care refers to the coordination and continuity of health care during a movement from one healthcare setting to either another or to home.

the Committee was under review with medication safety to be added as a standing agenda item on the agenda.

The Committee was chaired by a Consultant Oncologist and was further composed of a multidisciplinary membership with broad representation from staff who participated in the medication-use process.[5] However, the Committee did not have a representative from general practice or a community pharmacist.

The Drugs and Therapeutics Advisory Committee and the Clinical Risk Management Committee had independent responsibility for various elements of medication use within the hospital. The Clinical Risk Management Committee was responsible for analysis and correction of reported clinical incidents and near misses including medication errors and near misses. The main focus of the Drugs and Therapeutics Advisory Committee was on formulary[†] management. Other issues discussed included issues relating to nurse prescribing, restricted antimicrobials, financial oversight and some medicines management such as recalls, shortages and alerts. There was no reference to matters relating to medication safety in the minutes viewed by inspectors. Both committees reported quarterly to the Quality, Risk and Patient Safety Management Committee, which in turn provided a monthly report to the Network Executive Management Team.

Evaluation of medicines, with a view to adding or deleting them from the formulary, is an important function of a Drugs and Therapeutics Committee.[5] The Drugs and Therapeutics Advisory Committee reported that they had recently established a formal process for the review of new medication requests. The purpose of maintaining a hospital formulary is to ensure that appropriate governance exists 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.[6] The Committee objectively appraised, evaluated, and selected medications for addition to the formulary. Inspectors were also given examples of when the Committee had taken steps to reduce unnecessary duplication of the same basic medication type, entity or product. Optimising the number of medications and products available from the pharmacy can produce safer patient care and financial benefits.[7] However, inspectors were informed that there was no process in place for regular review of the formulary. It is important that the formulary management processes are sustained and improved into the future, and not merely a short term reaction in response to regulatory monitoring. Inspectors were informed that the hospital planned to address this anomaly in the future.

All medicines must undergo clinical trials before they are granted a licence in Ireland, or in Europe.[8] However, the Drugs and Therapeutics Advisory Committee

[†] A formulary is a hospitals continually updated approved list of medicines that staff can use as a reference document to ensure safe and cost-effective prescribing.

was not formally notified of clinical trials involving medication occurring within the hospital. It is recommended that Drugs and Therapeutics Committees should have a role in assessing the risks of clinical trials to the hospital other than the ethical considerations.[5] Inspectors were informed that the hospital Drugs and Therapeutics Advisory Committee was reviewing this anomaly and intended to extend their remit, as one of the objectives of their recently developed 2017 to 2018 medication safety programme, to include oversight of clinical trials involving medication.

The management of medication errors and near misses was a function of the Clinical Risk Management Committee. Hospital staff reported medication incidents and near misses on an electronic reporting system. Medication incidents were also discussed at the monthly Network Executive Management Team meeting. The hospital inputted all medication incidents reported within the hospital to the National Incident Management System[‡]. The Risk Coordinator also graded all medication incidents 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 extent.

HIQA noted the low numbers of medication related incidents reported throughout 2016, relative to other hospitals. Near misses in relation to medication related issues were not being routinely reported. As a result key medication related risks could not be recorded, understood or mitigated effectively by the hospital. Low numbers of incidents reported does not necessarily mean a low number of incidents occurring.[9] Studies have found a positive association between incident reporting and safety culture, where an increase in incident reporting was indicative of a positive reporting culture within the hospital.[10]

A review of the documentation provided indicted that the majority of reports were submitted by clinical nursing staff with limited evidence available to suggest that medical staff were reporting medications incidents. Therefore, the culture of reporting medication incidents needs to be broadened out to include medical and pharmacy staff so that safety surveillance is improved, learning is shared, and safety culture is promoted and improved across the hospital.

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.[3,11] Inspectors were informed that the hospital had a process in place to promptly inform patients when medication-related incidents occurred.

[‡] The State Claims Agencies (SCA) 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).

The hospital was in the process of reviewing their Risk Register in line with the HSE policy. [12] Medication safety was included on this risk register.

Governance arrangements for wards A and C

Formalised governance arrangements ensure that there are clear lines of accountability in place at individual, team and service level so that healthcare professionals, managerial staff and everyone working in the service are aware of their responsibilities and accountability.[3]

A review of the Operation Governance Policies for wards A and C outlined shared corporate governance arrangements between St Luke's Hospital and St James's and Tallaght hospitals respectively. This was managed by two shared governance committees supported by senior management representing St Luke's Hospital and St James's and Tallaght hospitals respectively. These policies stated that all medication errors and near misses should be reported to St Luke's Hospital, St James's and Tallaght hospitals respectively.

However, contrary to the Operation Governance Policies for wards A and C, inspectors were informed at interview that governance of these wards relating to medication management came under the full remit of the St James's and Tallaght hospitals respectively. This meant that medication incidents and near misses in wards A and C were not reported to St Luke's Hospital, Rathgar. This reporting arrangement was also documented in the minutes of the Clinical Risk Management Committee in February 2016.

In view of the latent, albeit likely low risk, this apparent lack of oversight was of concern to HIQA and should be addressed by the respective shared governance committees as a priority. [§]

[§] During the due process stage of report writing, further information was received by HIQA from St James's Hospital, Tallaght Hospital and St Luke's Hospital Rathgar in relation to this finding;

- St James explained that that the operational governance policy between St James's Hospital and St Luke's Hospital had been revised in January 2017. This updated policy outlined a single reporting line from Ward A to St James's Hospital.
- Information provided by Tallaght Hospital confirmed that medication safety reports submitted to Tallaght Hospital are overseen by Tallaght Hospital's Drugs and Therapeutics committee.
- Correspondance from St Luke's Hospital stated that both governance documents are due for review to reflect the actual reporting structure outlined above.

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.[13] Elements of medication safety were audited at the hospital, but these audits were not aligned to a formalised medication safety audit programme. Furthermore, audit activity throughout the hospital was neither strategically driven nor centrally coordinated. In addition, the effectiveness of medication safety initiatives implemented over the past two years had yet to be evaluated at the time of this inspection. Current arrangements should be strengthened and formalised to provide assurance to the senior hospital management team about medication safety at the hospital.

Nevertheless, the inspection team was provided with examples of hospital-specific medication safety and medication management audits undertaken in the past 12 months which included:

- 2017 antimicrobial point prevalence survey
- audit of nurse prescribers medicinal product prescribing practices
- medication administration observational audits
- Thyrogen** prescribing audit.

Nursing quality care-metrics†† were monitored across the hospital to review practice around some aspects of medication. Nursing metrics* data in relation to medication safety identified good performance across a number of areas. However, there were consistently less than satisfactory findings in relation to observations around medication prescribing. Feedback in relation to quality care-metrics was provided to nursing staff at ward meetings via nursing management and a communications folder was in place at ward level. Consultants were informed of audit results by the Network Director. Prescribing metrics were also discussed at non consultant hospital doctor (NCHD) induction sessions.

** Thyrogen is used for performing certain tests in patients who have or have had thyroid cancer. It is also used along with a radioactive agent to destroy remaining thyroid tissue in certain patients who have had their thyroid gland removed because of thyroid cancer.

†† Metrics are parameters or measures of quantitative assessment used for measurement and comparison or to track performance

Key performance indicators

Hospital management reported that four key performance indicators were used to evaluate medication safety at the hospital and these included:

- number of medication safety events reported
- number of patients on antibiotics (reported to weekly antimicrobial stewardship round led by a Consultant Microbiologist from St. Vincent's Hospital)
- number of extravasations[‡‡] due to chemotherapy
- number of moderate/ major medication safety events reported.

Feedback in relation to these performance parameters was given to prescribers and senior hospital management. However, results were not communicated to the Drugs and Therapeutics Advisory Committee.

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 recently developed a draft medication safety programme. However, at the time of the inspection, the programme had not been implemented. Inspectors were informed that the medication safety programme would be overseen by a new Medication Safety Committee. It is recommended that the newly formed Medication Safety Committee at the hospital is well supported as it is established and embeds, and that the formal reporting lines to the Drugs and Therapeutics Advisory Committee are established. In addition, it is recommended that the Medication Safety Committee develop an agreed written strategy and operational plan which outlines short, medium and long term goals from which to work from. In the absence of national guidance in this area, international guidelines which outlined best practice in relation to medication safety strategic planning and quality improvement should be used.[14,15] This document would likewise aid the hospitals Drugs and Therapeutics Advisory Committee in its oversight of the medication safety programme.

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 had recently implemented the National Cancer

[‡‡] The leakage of blood, lymph, or other fluid, such as an anticancer drug, from a blood vessel or turbe into the tissue around it.

Control Programme (NCCP) chemotherapy dose banding tables[§§]. The implementation of the national dose banding tables will ensure a standard approach to dose banding across all hospitals thus minimising risks when staff move between different hospitals.[16] It was also envisaged that dose banding will result in less chemotherapy wastage and improved safety through reducing possible dispensing errors.

The hospital maintained a list of high alert medications that present a heightened risk of causing significant patient harm if not used correctly. Inspectors were informed that this list of high risk medications was identified from international evidence. Coloured labels were used on the medication prescription and administration record to highlight the use of high alert medications such as insulin, warfarin and chemotherapy and to prompt careful checking.

The hospital's standard medication prescribing record had been redesigned to include separate sections for anticoagulants, sliding scale insulin, reducing dose steroids and intravenous fluids. The record included provision for recording therapeutic drug monitoring levels for antimicrobials.

Interruptions during medication administration rounds are thought to be a prominent causative factor of medication errors.[17] To minimise or eliminate nurse distraction during medication administration process, red aprons were worn by nursing staff while preparing or 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.

Clinical pharmacy services

The role of clinical pharmacists was documented in a standard operating procedure for clinical pharmacy activities. Clinical pharmacists reviewed medication prescription and administration charts with the purpose of identifying medication-related problems and recommending changes to optimise the medical treatment. [18] However, pharmacy interventions were not routinely monitored or evaluated, therefore this data was not effectively used to promote learning and improvement.

The hospital had resourced both B and D wards with designated clinical pharmacists[***]. 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.[19,20,21,22,23,24]

[§§] An agreed system whereby doses of chemotherapy calculated on an individual basis, that are within defined ranges or bands are rounded up or down to predetermined standard doses.[16]
[***] Clinical pharmacy describes the activity of pharmacy teams in ward and clinic settings.

All parenteral[†††] chemotherapy prescriptions were screened and signed by a clinical pharmacist. Clinical pharmacists also provided key information about medication to medical and nursing staff and to patients.

A formal medication reconciliation[‡‡‡] service was also provided by the clinical pharmacists to all patients on both admission and discharge from hospital in line with recommended practice. 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. [13,25,26,27] Inspectors were informed that patient's best possible medication history was obtained and verified by a clinical pharmacist on admission using a minimum of two information sources. This list was then compared to the patient's hospital medication prescription and administration record and the medical team was contacted to resolve discrepancies that were found.

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 promoting 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.

St Luke's Hospital carried out monthly surveys of patient experience within the hospital. The 2017 surveys showed that 100% of patients reported that they had received adequate information from nurses about their medication.

The hospital had systems in place to support the provision of information and education to patients in relation to medication. Inspectors were informed that clinical pharmacists ensured a seamless transition of care by offering counselling to patients prior to discharge. The Chemotherapy Liaison Nurse played a prominent role in providing patients with medication education. Patient information leaflets were available at the point of care and via the hospitals website.

[†††] By some route other than through the alimentary canal, such as by subcutaneous, intramuscular, intrasternal or intravenous injection.

[‡‡‡] Medicines reconciliation is a formal, systematic process for obtaining a current and accurate list of medicines a patient was taking when admitted to hospital, known as a best possible medication history, and reconciling this history against the patient's medicines prescribed at admission, transfer and discharge on the medication chart.

As part of this inspection, HIQA requested that a small sample of hospital outpatients attending the Outpatient Department complete an anonymised questionnaire in relation to prescribed medications. The questionnaire was completed by six patients who had been inpatients in St. Luke's Hospital within the past year and who were prescribed regular medications. Of the six patients surveyed, two patients had not been prescribed any new medicines and four patients had been prescribed new medicines. Of these four patients:

- one patient said that while in hospital, a staff member had explained the purpose of new medication in a way that they could completely understand.
- one patient said that prior to discharge from hospital, a staff member told them about all the possible medication side effects to look out for following discharge home.
- three 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 on the hospital's controlled document management system. All medication-related policies, procedures, guidelines and protocols were approved by the Drugs and Therapeutics Advisory Committee prior to implementation. Education briefing sessions were provided to support the implementation of medicines management related policies, procedures and guidelines and a register of same was maintained.

Inspectors were informed that online access to multiple decision support tools were available to staff in clinical areas. These included online medicines information, hard and soft copy up to date versions of the British National Formulary and access to medication safety information available through the Health products Regulatory Authority website. The clinical pharmacy team also provided medicines information as required. Clinical staff had access to prescribing guidelines for antimicrobial medications and to clinical microbiology advice on a twenty four hour basis.

It was identified that the hospital did not have a suite of locally adapted intravenous drug administration, reconstitution and administration guidelines used to assist staff in the safe administration of intravenous medicines. Staff relied on instructions from the package insert for instruction on reconstitution and administration instructions. The hospital reported that A-Z reconstitution and administration guidelines for intravenous medication from St James's Hospital were being adapted for local use. This needs to be progressed as a priority throughout the Network.

While St Luke's Hospital reported that they did not have a prescriber's guide,[§§§] the hospital used NCCP approved chemotherapy protocols for concomitant chemotherapy/ radiotherapy regimes.[****] The standardised chemotherapy regimens supported safe, evidence-based and cost-effective cancer treatment for patients. Pre-printed chemotherapy prescriptions were available from the Pharmacy Department. Where a standard chemotherapy protocol was not used consultants were required to provide a reference paper supporting the regimen they were requesting. This communication was also forwarded to the Drugs and Therapeutics Advisory Committee for approval.

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 electronic patients' laboratory results 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.

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

[§§§] Prescribers' Guide – a guide that contains the hospitals agreed policies involving medications as well as the hospital medication formulary.
[****] Administration of chemotherapy and radiation simultaneously.

formalised education programme for clinical staff linked to an overall medication safety strategy. However, staff training and education in relation to medication safety issues was a core element listed in the draft medication safety programme viewed by inspectors.

HIQA was informed that all nurses working in the hospital had completed the HSELanD online Medicines Management program.[29] Anaphylaxis training for nursing staff had recently commenced at the hospital. At the time of the inspection, six out of 14 nurses on the ward visited by HIQA had completed anaphylaxis training. Training dates were allocated to the remainder of staff on the ward to complete this training by the end of the year.

In addition, inspectors viewed medicines administration competency assessment records for each nursing staff member which included but was not limited to the following:

- the administration of chemotherapy
- intramuscular injections
- intravenous medicines
- subcutaneous medicines
- intravenous cannulation.

Competencies assessed were relevant to each nurse's scope of practice. Competencies were assessed by the ward manager with oversight of the Director of Nursing. While demonstrating competence does not guarantee that medication errors will not occur, the process itself is educational and can help better prepare practitioners for safe medication practices.[28]

Inspectors were informed that all pharmacy staff were required to undergo induction training, supported by a medicines management manual, standard operating procedures, and clinical guidelines.

Induction training was also provided to non-consultant hospital doctors on commencement of their rotation to St. Luke's Radiation Oncology Network. Inspectors were informed that additional education briefings were provided to non-consultant hospital doctors by the Pharmacy Department. Content of induction training was regularly reviewed and prescribing best practice was included in induction training. In addition, medication safety alerts were circulated to doctors by email via the Clinical Directorate Office. Ensuring 100% compliance with completion of induction training was an ongoing challenge due to the continuous rotation of the junior doctor cycle and staggered start dates.

Medication safety awareness in the hospital was promoted and communicated to staff through education briefing sessions for medication management related

policies. Ward rounds also facilitated the sharing of information and provided opportunities to communicate issues relating to medication safety. Inspectors noted that multiple communication channels were in place on the ward visited which supported the dissemination of medication safety information such as:

- staff notice board
- ward communication book
- monthly Clinical Nurse Manager meetings
- staff nurse meetings
- ward meetings
- ward-based face-to-face communication.

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.[1] Medication safety should therefore be a priority area for all acute hospitals as they seek to provide a high quality and safe service for patients.

The Drugs and Therapeutics Advisory Committee in St Luke's Hospital provided the leadership and structure to select appropriate medications for the recently developed formulary and promoted rational drug use. However, on review of the Committee's terms of reference, inspectors found that the scope and function this Committee was primarily focused on formulary management. International literature recommends that Drugs and Therapeutics Committees should be responsible for the governance of medication management to ensure the judicious, appropriate, safe, effective and cost- effective use of medications.[5,13] Hospital management acknowledged that governance arrangements for medication safety within the hospital needed to be further developed and fully formalised. In addition the hospital should both fully clarify the governance arrangements for medication safety in wards A and C, and ensure that shared learning around safety issues occurs across each clinical area in the hospital, regardless of reporting relationships.

While some medication safety interventions were in place, the medication safety programme was informal. Nevertheless, at the time of this inspection it was evident that a more structured approach to medication safety at the hospital was beginning to emerge. More formal structures will aid in more effective teamwork and better collective risk management.

Strategies employed to improve medication safety included ward based clinical pharmacists, admission and discharge medication reconciliation, standardised chemotherapy protocols, dose banding and competency based educational programmes. In addition, there was good access to specialist expertise with respect to medication usage.

The hospital should build on their work to date to develop and implement a medicines safety strategy and operational plan that sets out a clear vision for medication safety across the organisation. 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 used.[30]

Inspectors also determined that there remains scope for improvement in working to promote a more effective culture of medication error and near miss reporting as part

of a wider more formalised approach to the development of a more comprehensive medication safety programme in the hospital.

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 a more structured approach to the planning of audit in the area of medication safety aligned to the hospital's formal medication safety strategy.

St Luke's Hospital, Rathgar was actively collaborating with other hospitals within the Dublin Midland's Hospital Group and through the National Cancer Control Programme, was committed to standardising practice in order to improve medication safety. It is recommended that this report is shared with senior managers, clinicians and other relevant staff at St Luke's Hospital to highlight both what has been achieved by the hospital in implementing medication safety activities to date.

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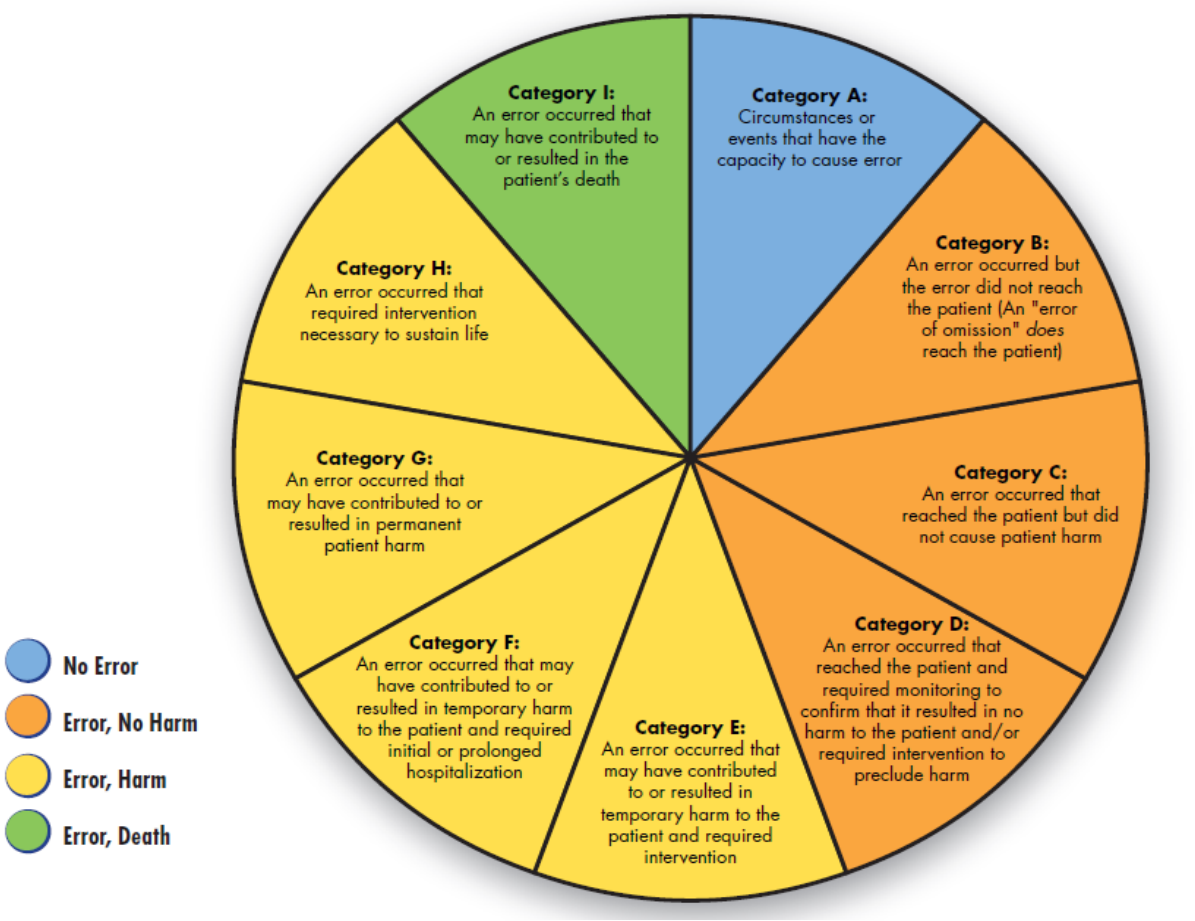
5.Appendices

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

Area to be explored	Line of enquiry[1]	National Standards for Safer Better Healthcare
Clear lines of accountability and responsibility for medication safety	Patient safety is enhanced through an effective medication safety programme aligned to formalised governance structures and clear accountability arrangements.	3.1, 5.1, 5.2, 5.4, 5.5, 5.6, 5.8, 5.9, 5.10, 7.1
Patient involvement in service delivery	Patients and or carers are informed about the benefits and associated risks of prescribed medications in a way that is accessible and understandable.	1.4, 1.5, 1.7, 3.1, 4.1
Policies procedures and guidelines	Hospitals develop effective processes to promote medication safety that are implemented and supported by clear and up-to-date policies, procedures and protocols.	2.1, 3.1, 3.2, 3.3, 3.5, 3.6, 3.7, 5.8, 5.11, 8.1
Risk management	There are established arrangements in place to identify, report and manage risk related to medication safety throughout the hospital.	3.1, 3.2, 3.3, 3.5, 3.6, 3.7, 5.8, 5.10, 5.11, 8.1
Audit and evaluation	The effectiveness of medication management systems are systematically monitored and evaluated to ensure they are effective.	2.8, 3.1, 5.8, 8.1
Education and training	Safe prescribing and drug administration practices are supported by mandatory and practical training on medication management for relevant staff.	6.2, 6.3
Access to information	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.	2.5, 8.1

Appendix 2. National Coordinating Council for Medication Error Reporting and Prevention. Index for Categorising Medication Errors.



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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