



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

Report of the announced inspection of medication safety at St Michael's Hospital, Dun Laoghaire.

**Date of announced inspection:
29 March 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.

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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 Michael's Hospital by Authorised Persons from HIQA; Kay Sugrue, Kathryn Hanly and Noelle Neville. The inspection was carried out on 29 March 2017 between 09:30hrs and 15:00hrs. Interviews were held in the hospital with the following groups of managers and clinical staff:

- Group one: the Chairperson of the Drugs and Therapeutics Committee, the Chief Pharmacist and the Head of Risk Management.
- Group two: the General Manager, a medical consultant and the Director of Nursing.

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

- Male Ward
- Female 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 hospital outpatients who spoke with inspectors.

2. Findings at St Michael's 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.

St Michael's Hospital is a voluntary Model 2 Hospital.⁵ The hospital is a member of St Vincent's Healthcare Group (incorporating St Vincent's University Hospital, St Vincent's Private Hospital and St Michael's Hospital). While the hospital had independent governance arrangements for medication safety in place, there was evidence of shared governance and reporting lines to the St Vincent's Healthcare Group, with clinical links to St Vincent's University Hospital. St Michael's Hospital was also represented at the St Vincent's Healthcare Group Drugs and Therapeutics Committee demonstrating that there was collaboration about medication management at hospital St Vincent's Healthcare Group level.

Inspectors were informed that there were four consultant physicians in St Michael's Hospital each with equal shared clinical responsibility. HIQA noted the lack of a clinical lead on site at the hospital, which is not in keeping with the observed operational norm in the majority of hospitals inspected. The lack of clarity around clinical leadership identified in this instance represents a potential weakness in current governance arrangements and should be addressed as a priority. Furthermore, HIQA noted an apparent relative lack of involvement from surgeons who work at the hospital in clinical governance arrangements, and again this should be addressed by the hospital following this inspection.

Notwithstanding these identified potential weaknesses in clinical governance arrangements, a Drugs and Therapeutics Committee was in place at St Michael's Hospital. The Committee was chaired by a consultant physician recently appointed to the role. The terms of reference stated that the Committee was accountable to the Executive Management Team of St Michael's Hospital. However, ambiguity over who was the accountable person with ultimate responsibility for medication safety within the hospital was evident during interview. Effective leadership and clear lines of accountability are vital components of any healthcare service. The hospital must be

assured that systems are in place to ensure that accountability arrangements for medication safety are clear to all staff and management.

The Drugs and Therapeutics Committee had recently updated their terms of reference that outlined the objectives, membership, frequency of meetings and reporting relationship. There was broad representation on the Committee with representatives from across the hospital group. However, there was no representation on the Drugs and Therapeutics Committee from the surgical service, general practitioners (GPs) or community pharmacists. The hospital should revisit the membership of the Committee with the aim of ensuring greater, more consistent involvement from all staff.

The roles and function of the relevant Committee were divided into five main areas relating to medication management with the purpose of promoting the safe, rational and cost-effective use of medication within the hospital. The Committee had met three times between November 2015 and February 2017, with only one meeting having taken place in 2016. Terms of reference updated in November 2016 indicated that the committee aimed to increase the frequency of meetings from two per year to three in 2017. Inspectors were informed that the decision to increase the frequency of meetings was to facilitate the implementation of initiatives in a responsive and timely way.

Inspectors were informed that the hospital had a medication formulary.* This consisted of a locally approved list of medications stocked in the hospital or readily available from outside sources. It was explained to inspectors that requests for the supply of new medications were initially assessed by the Chief Pharmacist. However, the hospital did not have a more formalised multidisciplinary process for assessing and evaluating all requests. The decision to escalate new applications to the Drugs and Therapeutics Committee was made by the Chief Pharmacist. Inspectors were informed that there was no formal application form relating to the process for requesting to add or remove medications to the formulary in St Michael's Hospital. Decisions with significant budgetary impact were additionally overseen by senior hospital management.

It was noted at the time of the inspection that St Michael's Hospital (a relatively small hospital) had a large number of committees and sub-committees when compared to other hospitals of a similar size. It was explained to inspectors during interview that many of the serving members of the Drugs and Therapeutics Committee were also members of multiple other committees in the hospital. This meant that issues relating to medication safety were regularly and rapidly communicated to other committees and key individuals when relevant, ensuring a real time response to issues identified. However, the multiple layers and complexity

*Local formulary is defined as list of medicines approved for use within a healthcare organisation

associated with this organisational structure could pose a risk of confusion due to the need to report to multiple committees, and potential duplication of work. St Michael's Hospital must therefore assure itself that effective communication pathways are in place through the organisational structure, and that the reporting process in the hospital is not be hindered by the presence of multiple committees.

Medication safety was led by the Chief Pharmacist who played a key role and worked closely with the Risk Manager in implementing and monitoring the medication safety plan at the hospital. The Chief Pharmacist was supported by the Drugs and Therapeutics Committee, the Senior Management Team and staff at the hospital. St Michael's Hospital did not have a formalised medium- to long-term medication safety strategy; however annual medication safety programmes for 2016 and 2017 were in place. These programmes demonstrated that there was an active medication safety plan in place. For example, the 2017 Annual Medication Safety Programme outlined 27 objectives to be achieved. Inspectors were informed that the 2016 Medication Safety Programme was developed following a gap analysis conducted by the hospital in early 2016 relating to medication safety which identified areas for improvement. A medication safety sub-group was formed in 2016 as one of the quality improvement initiatives implemented in at that time, which aimed to improve medication safety within the hospital.

There was evidence that the annual programme for medication safety was reviewed and updated on a regular basis. However, the effectiveness of the programme had not as yet been formally evaluated. The hospital should look to further progress its work in this area by devising a formalised overarching medication safety strategy, potentially linking in with other hospitals in this regard. Such a strategy should not only determine the content of the programme but also advance the achievement of clearly defined objectives. In the absence of national guidance in this area, international guidelines^{6,7} which outlined best practice in relation to medication safety strategic planning and quality improvement should be used.

Senior management told inspectors that there was good reporting of medication-related incidents at the hospital. A clearly defined medication incident reporting structure was in place. A system was in place for staff to voluntarily report medication-related incidents and near misses using a printed incident report form. It was reported that the national incident report form was due to be introduced in the near future. Staff who spoke with inspectors were able to describe the hospital process for reporting medication-related incidents and received feedback at ward level on medication related incidents which have occurred.

Analysis reports of medication incidents were reported to the Drugs and Therapeutics Committee and upwards to the Patient Safety Committee. HIQA was informed that medication incident reports were also discussed at the hospital's

Executive Management Council, St Vincent's Healthcare Group Patient Safety Quality and Risk Committee, St Vincent's Healthcare Board of Directors and Ireland East Hospital Group. Review of the hospital risk register showed the inclusion of risks relating to medication safety and that the risk register was updated regularly and discussed at the Patient Safety Committee before escalation to the Executive Management Team. Monthly reports of medication incidents were communicated to ward managers. Shared learning notices relating to medication safety were fed back to clinical staff through the hospital's intranet, ward meetings, communication meetings and ward handover.

St Michael's Hospital had reported 40 medication related incidents from January 2016 to December 2016. Sub-categorisation and risk rating of the medications incidents was evident, however HIQA noted that incidents were not categorised according to drug class. HIQA recognises that this level of reporting was not in line with internationally accepted norms.² The overall number of medication incidents may also be considered low in the context of the hospital activity levels, services provided and the population of elderly patients cared for in the hospital. 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.⁸ Further efforts to enhance a greater level of incident reporting should therefore be encouraged following this inspection.

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.^{3,9} Inspectors were informed that the hospital had a policy in place to promptly inform patients when medication-related incidents occurred. Documentation viewed and staff who spoke with inspectors could provide examples of when this open disclosure policy was adhered to.

2.2 Audit and evaluation

Line of enquiry:

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

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

- the number of Serious Reportable Events[†] related to medication identified

[†] Serious reportable events: "patient death or serious disability associated with a medication error by the healthcare provider but excluding reasonable differences in clinical judgement involving drug selection and dose." (p 29, HSE 2014)

- antimicrobial usage data
- medication-related incident reporting rates.

Feedback in relation to Serious Reportable Events was provided to prescribers, the Drugs and Therapeutics Committee and senior hospital management. All three indicators were reported to senior hospital management.

In addition, nursing quality care-metrics were monitored across the hospital to review practice around some aspects of medication storage and administration. Action plans and recommendations relating to the findings were applied to these reports. Inspectors viewed the nursing quality care-metrics findings for one ward for a three month period and noted that the results relating to medication storage and custody were generally good. However, more improvement was required with regard to medication prescribing metrics.

It was explained that there was limited auditing capacity in the hospital up to the time of the inspection which meant that many of the initiatives implemented had not yet been audited. Inspectors were informed that an additional pharmacy resource was recently approved by the Executive Management Council. It is anticipated that this additional resource should help to augment the auditing capacity relating to medication safety within the hospital.

HIQA was informed that an auditing programme to evaluate the medication safety programme and initiatives implemented was under development. It was anticipated by the hospital that this would provide the hospital with the opportunity to align audits to strategic medication safety objectives. Medication safety related clinical audits conducted in 2016 included:

- post fall medical review (including review of medications)
- audit on opioid prescribing (pilot stage of audit completed)
- audit of missed doses (pilot stage of audit completed)
- annual antimicrobial point prevalence survey of hospital prescriptions in Ireland
- monthly medication nursing metrics.

The 2017 Medication Safety Programme outlined six potential audits planned for this year.

Current arrangements should be strengthened and formalised to provide greater 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.

Inspectors saw examples of quality improvement initiatives that had been implemented and evaluated. A strong emphasis was placed on minimising the risks associated with high alert medications and sound alike look alike drugs (SALADS) in 2016 through raising awareness around storage, dosing labelling and administration. High alert medications remained a focus for improvement in 2017.

In addition, the hospital had implemented or was trialling multiple initiatives aimed at optimising medication safety including:

- revision of the patient medication prescription and administration record to include a designated highlighted section for prescribing anticoagulants
- a focus on patient falls assessment to review the impact of medications prescribed with regard to falls
- referral of patients taking high alert medications to a pharmacist (trial completed)
- referral of patients for drug counselling to the Pharmacy Department
- double checking by the Pharmacy Department of patients' prescribed direct acting oral anticoagulants[‡] on their discharge prescription
- drug administration assessment for new staff
- introduction of red "do not disturb" tabards worn by nursing staff while administering medications for drug rounds to minimise interruptions
- introduction of hypoglycaemic boxes[§] available in clinical areas
- piloting the use of an electronic application to facilitate better communication between ward managers and staff.

It was noted by HIQA that the patient's weight was not routinely documented in the patient medication prescription and administration record and was not included in the minimum data requirement for adult prescriptions. A prompt as to where the patient weight was documented was not evident. It was explained to inspectors that weight fluctuations in the hospital's patient population were common. Therefore, a decision was taken by the hospital to record the patient weight in the nutritional assessment tool as this provided the most accurate up-to-date record of patient's

[‡] Medications used to treat or prevent blood clots.

[§] Hypoglycaemia refers to low blood sugar. Hypoglycaemic boxes are frequently used in hospitals and contain glucose products necessary to treat the symptoms of low blood sugar in patients.

weight. The process for recording patient weight was not reflected in the hospital policy on medication management. Many medication doses are based on the patient's weight. Failure to obtain, record, or communicate a patient's weight clearly has the potential to contribute to serious medication errors.¹⁰ The hospital needs to assure itself that prescribers are familiar with this process to ensure that dosing of medications based on patient's weight are accurately prescribed and communicated.

Documentation viewed showed that medication safety alerts were circulated to heads of departments by the Pharmacy Department. The hospital had resourced the clinical areas with designated clinical pharmacists^{**}. This service was provided in St Michael's Hospital by two whole time equivalent posts, one of which included the Chief Pharmacist. Antimicrobial stewardship was included and was prioritised as part of these roles. 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.^{11,12,13,14,15,16}

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.^{17,18,19,20,21} Inspectors were informed that medication reconciliation was a multidisciplinary responsibility within the hospital but was generally completed by the admitting doctor. 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. Inspectors were informed that clinical pharmacists prioritised high risk elderly patients on multiple medications for medication reconciliation. In assessing this provision, HIQA is conscious that the nature of the elderly patient population served by the hospital who may be more likely to require multiple medications and may be more vulnerable to adverse drug effects.²²

The Chief Pharmacist had responsibility for oversight of medication reconciliation within the hospital. However, HIQA found that there was some ambiguity over who was responsible for performing medication reconciliation on a day to day basis. Notwithstanding the importance of a multidisciplinary approach to ensuring the effectiveness of this process, individual roles needs to be clearly defined to support staff in performing formalised medication reconciliation. Policies and information provided by the hospital should also reflect roles and responsibilities relating to this process which should be included in training courses provided to staff. It was reported that an audit of medication reconciliation is planned for 2017.

^{**} Clinical pharmacy describes the activity of pharmacy teams in ward and clinic settings.

2.4 Person-centred care

Line of enquiry:

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

The hospital had a system in place to support the provision of patient information and education in relation to medication. Inspectors were informed that clinical pharmacists offered counselling to all patients prescribed oral anticoagulant medication before discharge. Clinical pharmacists were available to counsel patients in relation to medication issues on request from ward staff. Pharmacist referral forms designed in 2016 and due to be introduced hospital wide in 2017, with the aim of formalising and documenting existing processes. In addition, clinical nurse specialists also provided education and support to patients, for example, around the management of diabetes mellitus or respiratory disease.

Inspectors were informed that patient information leaflets in relation to medication use from the Health Products Regulatory Agency were provided to patients upon initiation of new medication at the point of care.

As part of this HIQA inspection, a small sample of patients attending the hospital's Outpatient Department completed an anonymised questionnaire in relation to prescribed medications. The questionnaire was completed by 16 patients who had been inpatients in St. Michael's Hospital within the past year and who were prescribed regular medications. Of the 16 patients surveyed, six patients had not been prescribed any new medicines and 10 patients had been prescribed new medicines. Of these 10 patients:

- 30% patients said that to some extent a staff member had explained the purpose of new medication in a way that they could understand.
- 60% patients said that to some extent a staff member told them about possible medication side effects to look out for following discharge home.
- 60% patients said to some extent they received instruction on how to take their medications at home.

It is acknowledged that this was a small sample of patients who completed the anonymised questionnaire in relation to prescribed medications at the hospital's Outpatient Department, and therefore was not representative of all recently discharged patients taking prescribed medication. This 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.

Prescribers in St Michael's Hospital had online access to the St Vincent's Healthcare Group Medicines Guide which was available on the hospital's intranet system. Other online resources included access to:

- intravenous antibiotic medication monographs ^{††} specifically designed for use in St Vincent's University Hospital were on display in St Michael's Hospital. The Clinical Pharmacist explained that the monographs had been double checked to ensure that all products listed corresponded with the St Michael's Hospital intravenous product inventory.
- guidelines of injectable medicines
- electronic British National Formulary (eBNF)
- renal drug handbook
- translations (into English) of information package inserts for some unlicensed medicines

The Drugs and Therapeutics Committee had approved a number of multidisciplinary medication management policies, procedures, protocols and guidelines to support safe medication management systems within the hospital. Inspectors observed that up-to-date versions of medication policies, procedures, protocols and guidelines were readily available to staff in clinical areas through a controlled electronic document management system.

Collaboration within the St Vincent's Hospital Group had provided a valuable opportunity to adapt medication management policies, procedures, protocols and guidelines for use within St Michael's Hospital.

Generalised prescribing and administration supports were available to clinical staff. Hard copies of the most current version of the 'British National Formulary' were available in the clinical areas visited. Clinical staff also had access to online evidence-

^{††} An approved set of standardised and approved instructions for the correct preparation and administration of intravenous medication, that have been designed to reduce the risk of error, and that are specifically tailored to the intravenous medicines stocked within the hospital.

based clinical information resources for reference. Inspectors also observed intravenous medication monographs^{‡‡} on display in clinical areas.

Clinical staff also had access to patient's laboratory results on computers in clinical areas across the hospital. Healthcare requires 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.

Nursing staff also reported that they had regular access to, and support from, the ward based clinical pharmacist. Medication safety awareness was promoted through safety notices developed by the Pharmacy Department in response to medication incidents and near misses reported locally in addition to guidance, alerts, recalls and recommendations issued by external bodies.

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 is an important error prevention strategy when combined with other strategies that strengthen the medication use system.^{23,24} The hospital had developed a competency assessment for medicines administration. Each staff nurse involved in administering medicines was competency assessed by the Clinical Facilitator on induction to the clinical area. Assessments were completed on ten separate medication administration rounds.

Medication safety awareness in the hospital was promoted through staff communication including circulation of medication safety alerts and through medication safety education and policies. Ward based education sessions were regularly conducted.

The Clinical Facilitator organised regular education and intravenous study days for nursing staff. Inspectors were told that nursing staff completed the HSE LanD Medication Management online training programme annually²⁵ and anaphylaxis training was completed by nurses who administered first dose antimicrobial medications. However, there was some discrepancy reported by staff to inspectors relating to hospital policy on the requirement for staff to complete anaphylaxis training prior to administering first dose intravenous antibiotics and practices at ward level. The hospital should seek assurance relating to compliance with this issue.

^{‡‡} An approved set of standardised and approved instructions for the correct preparation and administration of intravenous medication, that have been designed to reduce the risk of error, and that are specifically tailored to the intravenous medicines stocked within the hospital.

Education for medical staff at the hospital included 'Grand Rounds'^{§§} and weekly meetings at which particular aspects of medication safety were presented and discussed. However, these weekly meetings were targeted towards the medical services; therefore clinicians from the surgical service were not represented. HIQA identified potential scope for greater surgical involvement relating training and communication of information on medication management and the medication safety programme at the time of this inspection.

The implementation of changes to hospital policies, procedures and guidelines were supported by staff education and communicated via email and the hospital's shared computer network.

§§ Grand Rounds describes a formalised meeting system to facilitate the presentation and discussion of clinical cases to hospital consultants and their teams. These meetings focus on patient outcomes, promote collaboration between different medical specialities and act as a training tool and means to educate junior doctors.

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 ensure a high quality and safe service for patients.

St Michael's Hospital had an established Drugs and Therapeutics Committee in place at the time of this inspection. Systems, processes and practices were in place to support medication safety, some of which were under development. It was evident that medication safety had been progressed over a period of time with notable prioritisation and development of a medication safety programme in 2016. Notwithstanding some lack of clarity at interview around reporting relationships, HIQA found that medication safety was prioritised at organisational level with clear leadership from the Chief Pharmacist and the support of the Drugs and Therapeutics Committee, the medication safety sub-committee and staff at the hospital.

However, inspectors identified a lack of clarity around accountability and responsibility from a clinical leadership perspective. Four medical consultants shared responsibility for clinical governance within the hospital; however there was no assigned leader on site with responsibility for oversight and planning. In addition, surgical consultant involvement at clinical leadership level was not evident at the time of this inspection. The hospital needs to work to broaden out participation in the medication safety programme to ensure involvement and engagement with all clinical staffing groups particularly clinicians from the surgical service.

The hospital is represented on St Vincent's Healthcare Group Drugs and Therapeutics Committee which in turn reports to the Ireland East Hospital Group. HIQA recommends that St Michael's Hospital continues to collaborate within these structures to share good practice pertaining to medication safety and to share learning, experience and resources.

The introduction of new medications needs to be carefully overseen, and appropriate information, supports and safety systems need to be provided for both staff and patients. The hospital must ensure that there is a robust and transparent process for formulary decision making with clearly defined and consistently applied standard criteria for decision-making.²⁶

The hospital had an established system for reporting and addressing medication errors and near misses, and promoted an open reporting culture for learning from medication-related incidents and near misses. HIQA found that learning from incidents was documented and disseminated to all clinical areas. However,

inspectors identified that medication-related incidents were likely under reported at the hospital. While a break down and trending of reported incidents was evident, the class of drugs involved in medication incidents was not included as a sub-categorisation. These potential identified weaknesses could lead to a lack of understanding as to the exact nature and contributory factors leading to medication-related incidents and, as a result, an inability to effectively engage in prevention, multidisciplinary learning or systems improvement. The hospital should look to further encourage higher rates of medication-related incident and near miss reporting by medical, nursing and pharmacy staff.

Audit represents a key component of all effective clinical governance programmes. HIQA identified that assurances relating to effectiveness of the medication safety programme were developing with an increased focus on medication related clinical audits planned for 2017. The hospital should continue to work to promote quality assurance systems including auditing of the medication safety programme which are aligned to a formalised medication safety strategy. They need to ensure that the findings and recommendations of audits are effectively actioned by seeking assurance that improvements in care have been made.

Scope for improving the process of medication reconciliation was identified in St Michael's Hospital. The hospital should ensure that medication reconciliation is carried out in a structured manner by trained and competent health professionals with the necessary knowledge, skills and expertise.^{17,18,19,20}

HIQA recommends that hospital management build on their work to date to develop a medicines safety strategy that sets out a clearly articulated multidisciplinary vision for medication safety across the organisation in advancing the medication safety agenda.^{6,7}

It is recommended that this report is shared with senior managers, clinicians and other relevant staff at St. Michael's 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.

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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 underpinned by 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 medicines 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 or 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 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

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