Report of the announced inspection of medication safety
Mercy University Hospital.

Date of announced inspection:
05 September 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.

**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.

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**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.
# Report of the announced inspection of medication safety at Mercy University Hospital

## Table of Contents

1. Introduction ........................................................................................................................................... 1
2. Findings at Mercy University Hospital .................................................................................................. 3
   2.1 Governance and risk management ................................................................................................... 3
   2.2 Audit and evaluation ......................................................................................................................... 7
   2.3 Medication safety support structures and initiatives ........................................................................ 9
   2.4 Person-centred care .......................................................................................................................... 12
   2.5 Policies procedures and guidelines and access to information .................................................. 13
   2.6 Training and education ...................................................................................................................... 14
3. Conclusion ............................................................................................................................................ 15
4. References ............................................................................................................................................. 17
5. Appendices ........................................................................................................................................... 21

Report of the announced inspection of medication safety at Mercy University Hospital
1. Introduction

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

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

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

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

An announced medication safety inspection was carried out at Mercy University Hospital by Authorised Persons from HIQA; Kathryn Hanly, Dolores Dempsey Ryan and Nora O’Mahony. The inspection was carried out on 05 September 2017 between 10.30hrs and 16.00 hrs. Interviews were held in the hospital with the following groups of managers and clinical staff:

- Group one: the Chairperson of Drugs and Therapeutics Committee, the Chief Pharmacist, and the Quality and Risk Manager.
- Group two: the Deputy Chief Executive Officer (deputising for Chief Executive Officer), the Clinical Director and the Nurse Practice Development Co-Ordinator (deputising for the Director of Nursing).
Inspectors visited the following clinical areas, spoke with staff and reviewed documentation:

- St. Finbarr's - Male Medical
- St. Anne's - Paediatric

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

HIQA would like to acknowledge the cooperation of staff who facilitated and contributed to this announced inspection and the hospital outpatients who completed an anonymised questionnaire.
2. Findings at Mercy 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.

Mercy University Hospital is a Model three voluntary, general acute hospital catering for both public and private patients. The hospital is located in Cork city and is part of the South/South West Hospital Group governance structure. The hospital provides a range of inpatient, day and outpatient services, including a 24/7 emergency department, an urgent care centre, and various medical and surgical specialities.

The hospital had an established Drugs and Therapeutics Committee. This Committee was chaired by a Consultant Physician and comprised multidisciplinary membership to reflect the fact that medicines management was the responsibility of a number of clinical professional groupings. HIQA confirmed that the Committee was well attended by the majority of members with a structured agenda and schedule. However the Committee did not have a representative from surgery, community pharmacy or general practice. Inspectors were informed that the Clinical Governance Committee included a representative from general practice who provided a perspective on issues arising in the context of the Drugs and Therapeutics Committee.

The Drugs and Therapeutics Committee was one of 13 committees that reported into the hospital's Clinical Governance Committee. The Clinical Governance Committee reported into the Executive Management Board. The hospital reported that key members of the Drugs Therapeutics Committee were also members of the Clinical Governance Committee and the Executive Management Board and this shared membership supported governance and oversight of medication safety.

The Drugs and Therapeutics Committee had updated its terms of reference outlining the functions, membership, frequency of meetings and reporting relationship in

* The South/Southwest Hospital Group comprises nine hospitals operating across the counties Cork, Kerry, Waterford, Tipperary and Kilkenny. This group is led by a Group Chief Executive Officer with delegated authority to manage statutory hospitals within the group under the Health Act 2004.
November 2016. However, poor compliance with the functions and objectives outlined in these terms of reference was identified by HIQA during this inspection. In the absence of national guidance in this area, international guidelines which provide criteria to evaluate current performance should be used to evaluate the effectiveness of the Drugs and Therapeutics Committee.

A formal process for evaluating requests for the supply and evaluation of new medications in the hospital had been developed and inspectors were provided with examples of where a request for the introduction of a new medication was discussed at Drugs and Therapeutics Committee meetings. However, contrary to the committee’s terms of reference, an up-to-date local approved medication formulary did not exist in the hospital at the time of this inspection. Rationalising the number of drug options and products available through a managed hospital formulary can produce safer patient care and financial benefits. A formulary system should be established to manage risk and ensure efficiency in the use of medicines used in hospitals. Inspectors were informed that in the absence of a local formulary, the British National Formulary was available as a reference point in each clinical area and an inventory of medications stocked in the hospital was maintained by the Pharmacy Department.

All medicines must undergo clinical trials before they are granted a licence in Ireland, or in Europe. Inspectors were informed that all clinical trial applications were reviewed and approved by the Clinical Research Ethics Committee of the Cork Teaching Hospitals. However, contrary to the Drugs and Therapeutics Committees terms of reference, it was reported at interview that the Committee 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.

Medication safety was a standing item on the Drugs and Therapeutics Committee agenda. However, a formal medication safety strategy for Mercy University Hospital was not evident at the time of the inspection. Nevertheless, the hospital demonstrated awareness of many of the inherent weaknesses in the existing medication safety systems and had acted to address some of the deficiencies identified. For example, issues which were considered to potentially compromise the safe administration of medication were risk assessed and included on the pharmacy department’s risk register and escalated where necessary to the hospital risk register. Inspectors viewed the Pharmacy Department’s risk registers, and noted that risks relating to medication safety were recorded with existing controls identified.

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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.
The absence of a medication safety programme was included on the Pharmacy Department’s risk register. The hospital should progress the work conducted to date to develop a medicines safety strategy that sets out a clear vision for medication safety across the organisation. In the absence of national guidance in this area, international guidelines\textsuperscript{9,10} which outlined best practice in relation to medication safety strategic planning and quality improvement should be used.

**Risk Management**

The hospital had an established system for reporting and addressing medication incidents and near misses. This system was supported by an incident reporting policy. Hospital staff voluntarily reported medication incidents and near misses on a risk management occurrence form. Medication-related incidents were a standing agenda item at meetings of the Drugs and Therapeutics Committee where such occurrences were reviewed.

Important lessons can be learned from analysis of medication-related incidents and near misses. The hospital had two systems in place for tracking and trending medication incident data. The first system was via the hospital’s Quality and Risk Management Department. The second system was via the Nurse Practice Development Unit and Pharmacy Departments shared databases of medication incidents. The hospital reported that they had planned to standardise the system for tracking and trending medication incident data.

A 2016 medication safety incident annual report was prepared by the Quality and Risk Management Department. Sub-categorisation and risk rating of the medications incidents was evident. The type of incident/near miss and area where the incident occurred was also recorded. However, HIQA noted that incidents were not categorised according to drug class. This represents a lost opportunity for learning and identifying key areas for improvement. Inspectors were informed that medication incidents were graded using the Health Service Executive (HSE) risk matrix and the according to National Incident Management System (NIMS) severity ratings.\textsuperscript{11} In addition, senior management stated that the hospital inputted all medication incidents reported within the hospital to the NIMS.

The 2016 Quality and Risk Management Department medication safety incident report showed medication incident and near miss reporting had increased by 68% since 2006 (Figure 1). However, HIQA was informed that despite recent success in improving incident reporting rates, medication-related near misses were still likely to be under reported at the hospital. Studies have found a positive association between

\textsuperscript{1} 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).
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. HIQA also note that notwithstanding this positive trend in reporting, the majority of reports were submitted by clinical pharmacists and nursing staff with limited evidence available to suggest that medical staff were reporting medications incidents. The culture of reporting medication incidents needs to be extended to include other healthcare staff so that safety surveillance is improved, learning is shared, and safety culture is promoted and enhanced across the hospital.

Figure 1: Number of medication incidents reported annually in Mercy University Hospital 2006-2016

Reporting of incidents is of little value unless the data collected is analysed and recommendations are disseminated. Quarterly medication error reports had been generated from the Nurse Practice Development Unit and Pharmacy Department shared databases of medication errors. The first report was presented to the Drugs and Therapeutics Committee in May 2017. Learning from the 2016 Nurse Practice Development Unit and Pharmacy Department medication error databases was presented at Grand Rounds. Inspectors were informed that medication incidents were also discussed at morbidity and mortality meetings. In addition medication safety notices were circulated to medical and nursing departments by the Pharmacy Department.

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§ Grand rounds are formal meetings where physicians and other clinical support and administrative staff discuss the clinical case of one or more patients. Grand rounds originated as part of medical training.
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.\textsuperscript{13,14} Inspectors were informed that the hospital had a process in place to promptly inform patients when medication-related incidents occurred. This was confirmed by ward staff. A review of the Executive Management Board minutes indicated that an audit carried out in November 2016 by the Quality Assurance and Verification Division of the Health Service Executive (HSE) provided assurances that the process was operating effectively in the Mercy University Hospital.

Medication-related incident reporting facilitates the identification of risk and opportunities for improvement. However, on its own it does not provide a complete picture of all potential sources of risk and patient harm.\textsuperscript{15} The hospital reported that they used a variety of additional information sources to identify strengths and weaknesses in the hospital medication management system including:

- retrospective chart review
- direct observation
- audit
- risk assessments
- patient surveys
- staff surveys.

2.2 Audit and evaluation

**Line of enquiry:**

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

Audit involves a cyclical approach to planning, standard selection, measuring performance leading to improvement in practice and sustaining that change.\textsuperscript{16} Inspectors were informed that a total of 70 staff had attended clinical audit training sessions which were facilitated by the Quality and Risk Management Department. An annual quality conference was held where staff were encouraged to present an overview of audits and quality improvement initiatives they had undertaken.

While elements of medication safety were audited at the hospital, these audits were not aligned to a formalised medication safety strategy. Nevertheless, the inspection team was provided with examples of recent medication management audit activities which included:

- audit of insulin storage
- audit of medicated infusion labelling
- audit of medication round interruptions
• audits of medication reconciliation
• audits of appropriate thromboprophylaxis in adult medical and surgical inpatients
• antimicrobial point prevalent study
• audit of restricted antimicrobials.

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

Inspectors saw examples of where medication safety audit results and relevant data were used as the basis for decision-making, action and change. Following a baseline audit of anticoagulant and antiplatelets medications prescribing practices the medication prescription and administration record had been revised. Changes included designated sections for venous thromboembolism risk assessment and a separate section for anticoagulant and antiplatelets medication prescriptions. In addition inspectors were informed that at the point of dispensing, pharmacists requested and reviewed every medication prescription and administration record where a direct oral anticoagulant was newly prescribed. A post implementation audit of this initiative found improvements in anticoagulant and antiplatelet medication prescribing in the revised medication prescription and administration record.

However, a review of a number of other audit reports submitted found that quality improvement plans and recommendations were not routinely developed following audit to address identified issues requiring improvement. Current arrangements should be strengthened and formalised to provide assurance to the senior hospital management team about medication safety at the hospital.

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

While HIQA identified elements of a medication safety programme in place this programme was not formalised and a medication safety strategy had not been developed. However it was evident that a medication safety agenda was being progressed at the hospital.

Inspectors were provided with examples of where medication safety quality improvement initiatives were strategically driven by learning gained from analysis of medication incidents or near misses. For example, following the analysis of medication errors reported in the first three months of 2017, the hospital identified that anti-Parkinson’s†† medications were implicated in a number of medication incidents reported. In response the pharmacy department had identified a local list of medicines where timeliness of administration was crucial.‡‡ This list of time sensitive medications also included anti-infectives, anticoagulants, insulin, resuscitation medications and other medications identified locally.

High-alert medications are medicines that bear a heightened risk of causing significant patient harm when they are not used correctly. The hospital had adopted the Institute of Safe Medication Practices high-alert medications list.17 Medication safety awareness of high alert medications and time sensitive medications was promoted through memos, in service education and awareness campaigns. The hospital should continue to develop plans to systematically review, implement and evaluate risk reduction strategies to manage these high alert and time sensitive medications.

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

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†† Parkinson’s disease is a long-term degenerative disorder of the central nervous system that mainly affects the motor system. The symptoms generally come on slowly over time. Early in the disease, the most obvious are shaking, rigidity, slowness of movement, and difficulty with walking.

‡‡ Time sensitive medicines are those where the omission or delay is likely to cause the most harm.
Interruptions during medication administration rounds are thought to be a prominent causative factor of medication errors.\textsuperscript{18} To reduce interruptions, red “do not disturb” tabards were worn by nursing staff while administering medications on a number of wards. 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. HIQA were informed that this initiative had been formally evaluated following implementation.

**Clinical pharmacy services**

There are currently no agreed national standards outlining requirements for the provision of clinical pharmacy services in hospitals. International studies support the role of clinical pharmacists in hospital wards in preventing adverse drug events.\textsuperscript{19,20,21,22,23,24} The hospital reported that they had resourced the majority of clinical areas with a designated clinical pharmacist.\textsuperscript{55} The hospital had assigned a dedicated pharmacist to the Emergency Department to review the medication prescription and administration charts and reduce medication incidents. While this is a positive step, inspectors found that the provision of clinical pharmacy services was not universally available in all wards and clinical departments. For example, at the time of the inspection it was reported that the paediatric ward only had access to a clinical pharmacy service one day a week. It is recommended that the hospital reviews its current provision for clinical pharmacy services, in the interest of optimising medication safety in the hospital.

Where available, clinical pharmacists reviewed inpatient medication prescription charts to prevent, identify, and intercept medication prescribing-related incidents. Clinical Pharmacists also played a key role in communicating with the multidisciplinary team with regard to all aspects of drug therapy and inpatient counselling and education. The pharmacy department also regularly liaised with community pharmacists and general practitioners.

**Medication reconciliation**

Medication reconciliation at time of admission is a systematic process conducted by an appropriately trained individual, to obtain an accurate and complete list of all medications that a patient was taking prior to admission.\textsuperscript{25,26,27,28} The hospital had established a formal structured pharmacy-led medication reconciliation service in the Emergency Department and for a cohort of elderly patients in St Mary’s and St Finbarr’s wards at both admission and discharge. The medication reconciliation process was supported by a medication reconciliation training manual.

\textsuperscript{55} Clinical pharmacy describes the activity of pharmacy teams in ward and clinic settings.
Inspectors were informed that clinical pharmacists in the Emergency Department prioritised high risk patients on multiple medications for medication reconciliation. It was estimated that 25% patients admitted through the Emergency Department received medication reconciliation. This process had been audited over a three week period in July 2017. Results demonstrated that in 51% of completed medication reconciliations, patient’s pre-admission medications were only verified using one information source, which was predominantly the patient. It is recommended that the medication information received from the patient should be verified with more than one source as appropriate.\textsuperscript{27}

In assessing the provision of medication reconciliation in inpatient areas, the hospital prioritised patients in the care of the elderly services who may be more likely to require multiple medications and may be more vulnerable to adverse drug effects. Patients in St Mary’s ward received pharmacy led medication reconciliation on admission and discharge. Inspectors were informed that patient’s medications were verified by a clinical pharmacist using two information sources. In January 2017 this service was expanded to include care of the elderly patients in St Finbarr’s ward. In St Mary’s Ward and for Care of the Elderly patients on St. Finbarr’s Ward the patients “best possible medication history” \textsuperscript{***} was documented on the Mercy University Hospital Admission Medication Reconciliation Form and filed in the patient’s medical notes by the Clinical Pharmacist. Inspectors were informed that all patients under the care of Consultants in Geriatric Medicine received medication reconciliation on St Finbarr’s Ward. Inspectors were informed that an average of two patients a week received medication reconciliation in St Finbarr’s ward.

Inspectors were informed that in all other patient areas in the hospital, medication reconciliation was initiated by doctors, nurses and pharmacists. However, the effectiveness of this process had not been audited in these areas. The Pharmacy Department had facilitated a number of medication reconciliation training sessions to medical, nursing and pharmacy staff.

\textsuperscript{***} A standardised method of collecting and documenting an accurate current list of prescribed and non prescribed medication for an individual patient using as many sources of information as possible.
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. 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.

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

As part of this inspection, HIQA asked a small sample of hospital outpatients attending the Outpatients Department to complete an anonymised questionnaire in relation to prescribed medications. The questionnaire was completed by 19 people who had been inpatients in Mercy University Hospital within the past year and who were prescribed regular medications. Of the 19 people surveyed:

- 11 patients said that while in hospital, a staff member had explained the purpose of new medication in a way that they could completely understand.
- nine patients 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.
- 15 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 outpatients and therefore was not representative of all recently discharged patients taking prescribed medication. This information did however, provide some information about outpatients understanding 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.

All medication-related policies, procedures and guidelines were reviewed by the Drugs and Therapeutics Committee prior to formal approval by the Policy Approval Committee. Inspectors observed that up to date versions of medication policies, procedures, protocols and guidelines were readily available to staff in clinical areas in hard copy and on the hospital intranet.

Mercy University Hospital did not have up to date prescribers guide. The hospital had a prescribers guide in the past but these had been withdrawn from use because it needed to be fully revised and updated. However, multiple sources of medication information and decision support tools were readily available to staff involved in medication use including:

- The British National Formulary in print and in electronic formats
- Recently updated A-Z intravenous drug monographs for the general wards
- Online evidence-based clinical decision support resources for reference.

The clinical pharmacy team also provided medicines information as required.

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. Clinical staff had access to patient’s diagnostic results on computers in clinical areas across the hospital. Inspectors were informed that there was laboratory-to-laboratory connectivity across the acute hospitals in Cork city. This laboratory information management system provided access to complete and up-to-date accurate laboratory data 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. Inspectors were informed that a quality improvement learning and sharing workshop entitled “Quality Improvement Lunch and Learn” was held every Friday in the hospital. This was a forum facilitated by the Quality and Risk Management Department for the multidisciplinary team to discuss how quality improvement initiatives had contributed to improvements in the quality of patient care delivered.

Inspectors were informed that medication safety was included in induction programmes for all new medical, nursing and pharmacy staff. As part of their induction programme, new nurses were required to complete an “Administration of Medication Workbook”. Nursing staff were also required to complete the Health Service Executive medication management online training programme. Inspectors were informed that nursing staff also completed anaphylaxis training to facilitate the administration of first dose antimicrobial medications.

There was an ongoing education programme in the hospital for medication safety. Inspectors were also told that nursing staff could attend regular medication safety programmes facilitated by the Nursing Practice Development Unit. Pharmacy also delivered training on all medication management courses for nurses. Medication safety in the hospital was also promoted through 10 minute medication safety awareness sessions by the Nursing Practice Development Unit. It was evident that oversight of medication management training was well managed by the Nursing Practice Development Unit.

Medication safety awareness in the hospital was also promoted through staff communication including circulation of medication safety alerts and through medication safety education and policies. A medication management communication folder was available for nursing staff at ward level.

It was also reported that ongoing training on medication safety was provided to medical staff at hospital grand rounds.†††

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

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

The Mercy University 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. However, HIQA found that the hospital did not have a formal medication safety programme in place, which was underpinned by an overarching medication safety strategy or prioritised on the basis of identified risk. Hospital management and staff should build on their work to date to develop a medicines safety strategy 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 governance and improvement are available, and should be considered by the hospital.

The inspection team was provided with examples of hospital-specific medication safety audit activity. However current medication safety auditing arrangements should be strengthened and formalised to regularly provide assurance to the hospital corporate management team about medication safety at the hospital.

The hospital promoted an open reporting culture and a process for learning from medication-related incidents and near misses. However, inspectors also determined that there remains further scope to improve rates of incident and near miss reporting by medical, nursing and other relevant staff. This should be part of a wider more formalised approach to the development of a more comprehensive medication safety programme in the hospital. Reported medication incidents and near misses were tracked and trended to assess progress and to identify emergent medication safety concerns. Inspectors were also informed that medication-related incidents and near misses were analysed and actions were taken to address them with further recommendations made to prevent reoccurrences of such incidents.

There is also potential for better cooperation with other hospitals in the South/ South West Hospital Group to make better use of collective resources, as many of the issues that the hospital is are working to address may be common to all hospitals in the group.

It is recommended that this report is shared with senior managers, clinicians and other relevant staff at Mercy University Hospital to highlight both what has been
Report of the announced inspection of medication safety at Mercy University Hospital

achieved by the hospital in implementing medication safety activities to date, and to foster further collective progression from this time point.
4. References


### 5. Appendices

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

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

Health Information and Quality Authority
Dublin Regional Office
George’s Court
George’s Lane
Smithfield
Dublin 7

Phone: +353 (0) 1 814 7400
Email: qualityandsafety@hiqa.ie
URL: www.hiqa.ie

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