Report of the announced inspection of medication safety at the Royal Victoria Eye and Ear Hospital.

Date of announced inspection:
28 September 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.

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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.
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1. Introduction

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

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

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

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

An announced medication safety inspection was carried out at the Royal Victoria Eye and Ear Hospital by Authorised Persons from HIQA; Kay Sugrue, Noelle Neville and John Tuffy. The inspection was carried out on 28 September 2017 between 10:30hrs 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, Therapeutics and Antimicrobial Stewardship Committee, the Senior Pharmacist and the Health and Safety Risk Manager.
- Group two: the Chief Executive Officer, the Clinical Director and the Director of Nursing.
Inspectors visited the following clinical areas and spoke with staff and reviewed documentation:

- The Day Ward
- The West Wing

In addition, a survey was conducted among outpatients in the Eye Outpatient 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 Royal Victoria Eye and Ear 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.

The Royal Victoria Eye and Ear Hospital is a specialist hospital within the Ireland East Hospital Group delivering services to adult and paediatric patients with ophthalmic* and otolaryngological† diseases.

The Royal Victoria Eye and Ear Hospital had formalised governance arrangements and organisational structures with clear lines of accountability in place to support the safe use of medications. The hospital had an established Drugs, Therapeutics and Antimicrobial Stewardship Committee. This multidisciplinary Committee was chaired by a Consultant Anaesthetist and was responsible for the governance of the hospital’s medication management system and for ensuring its safety. The Committee acted as an advisory sub-committee to the Hospital Medical Board. In addition, the Committee accommodated oversight of haemovigilance‡ at the hospital.

The Drugs, Therapeutics and Antimicrobial Stewardship Committee terms of reference had been updated in March 2017 and clearly outlined the Committee’s objectives, functions, membership, frequency of meetings and reporting relationships. Membership included clinicians, medical staff, pharmacists, nurses, hospital management, and other healthcare professionals who participated in the medication-use process. However, general practitioners (GPs) were not represented on the Committee and inspectors were informed that attendance by a community pharmacist representative at Committee meetings was not always achieved. Inspectors were informed that the hospital had links with community pharmacists and with GPs through a GP liaison group. It was reported that a community

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* Ophthalmic is relating to, or situated near the eye.
† Otolaryngological is the branch of medicine that deals with diagnosis and treatment of diseases of the ear, nose, and throat.
‡ Haemovigilance is the set of surveillance procedures covering the entire blood transfusion chain, from the donation and processing of blood and its components, through to their provision and transfusion to patients, and including their follow-up.
pharmacist had recently participated and contributed to the revision of the hospital prescription chart. Documentation viewed by HIQA found that efforts had been made by the hospital to expand the membership of the Drugs, Therapeutics and Antimicrobial Stewardship Committee to include external input from a local general practitioner in the second quarter of 2017. Inspectors were informed that this issue was under review and was a priority for the Committee for 2017.

The functions and activities of the Drugs, Therapeutics and Antimicrobial Stewardship Committee during 2016 were evaluated and documented in the Committee’s annual report. This comprehensive report included a synopsis of activities and functions of the Committee. Content of this report included the following:

- summaries of medication management audits completed by pharmacy staff, nursing staff and the antimicrobial Stewardship Committee in 2016
- a pharmacovigilance report
- policy updates and development
- newsletter content, advice and guidance from the Committee
- procurement
- tasks completed and planned initiatives and tasks for 2017.

The report also analysed attendance at the Drugs, Therapeutics and Antimicrobial Stewardship Committee meetings. Documentation viewed by HIQA found that attendance at Committee meetings was varied in 2015, 2016 and up to May 2017. Inspectors were informed that much of the day-to-day operational work of the Committee was undertaken by an informal working group including members of the Pharmacy Department, Chair of the Drugs, Therapeutics and Antimicrobial Stewardship Committee and when required the Clinical Director.

A limited formulary was in place at the hospital, but inspectors were informed that this document had been intermittently updated. This should be reviewed more frequently given the relatively small range of medicines in a specialised hospital of its kind.

Documentation reviewed by inspectors showed that the hospital had a defined application process for the formal evaluation and approval of new medicines in the hospital. New medicines were evaluated on the basis of efficacy, safety, quality and cost. Decisions with significant budgetary impact were additionally overseen by the Drugs, Therapeutics and Antimicrobial Stewardship Committee.

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5 Pharmacovigilance is the study of drug-related adverse effects carried out by pharmaceutical industries to suggest warnings or recommendations for product withdrawal.

** Formulary: a hospital’s approved list of medicines that staff can use as a reference document to ensure safe and cost-effective prescribing.
Important lessons can be learned from analysis of medication-related incidents and near misses. Reporting of incidents is of little value unless the data collected are analysed and recommendations are disseminated. There was an established system for reporting and addressing medication errors and near misses using electronic medication event reporting forms available hospital wide on desktop computers. Medication incidents had been reported using this electronic system since October 2014.

The Pharmacy Department managed all reported medication incidents. Medication incidents and near misses were tracked and trended to assess progress and to identify emergent medication safety concerns. It was reported that all medication events were graded using the National Co-ordinating Council Medication Error Reporting and Prevention (NCC MERP) classification system to categorise incidents in terms of patient harm (see Appendix 2). This classification system considers factors such as whether the error reached the patient and, if the patient was harmed, to what degree. The hospital reported that it was compliant with reporting all medication incidents to National Incident Management System (NIMS)††. Inspectors were informed that all incidents reported in 2017 up to the time of the inspection were categorised as low risk and did not result in patient harm.

Monthly reports on quality and safety activity and monitoring were generated by an external provider and provided an overview of incidents and complaints reporting and management. In addition, these reports also included an overview of audit activity, quality improvement plans and document control. However, medication incidents were not prioritised or risk rated in these reports. Documentation relating to medication incident reporting viewed by inspectors identified a potential to further expand trending and analysis of medication incidents reported to include drug class involved in the incident.

The hospital had identified a considerable decline in reporting rates in 2016 when 41 medication safety events were reported. This rate was significantly lower than the number of reports received in 2015. In an effort to address the serious decline in reporting rates, seven initiatives were implemented by the hospital. A paper-based reporting form was trialled in February 2017 in conjunction with a ‘Medication Safety Month’. A ward based medication safety champion was introduced on one ward with an aim of having one based in each clinical area in the future. These and other initiatives taken were reported to have improved reporting rates in 2017. However, it was acknowledged by senior managers during interview that further improvements were needed to increase hospital wide reporting levels.

†† 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).
Inspectors were informed that at the time of the inspection, there were no risks related to medication safety recorded on the corporate risk register. It was also reported that the Pharmacy Department’s local risk register was recently re-established in December 2016 and was updated regularly. Inspectors observed that risks were escalated through the hospital’s risk management process to departmental and hospital level in line with local policy.

Hospital managers informed inspectors that the Drugs, Therapeutics and Antimicrobial Stewardship Committee did not have oversight of clinical trials involving medicines that were being conducted in the hospital. This was not in line with the Committee’s terms of reference. It was reported that trials involving medicines were relatively limited and were overseen by the hospital’s Ethics Committee. The Drugs, Therapeutics and Antimicrobial Stewardship Committee planned to address this anomaly and stated that more information relating to trials including medication would be sought in the future.

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.3,7 Inspectors were informed that the hospital had a policy in place to promptly inform patients when medication-related incidents occurred.
2.2 Audit and evaluation

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

Audit represents a key component of all effective clinical governance programmes.\(^8\) Elements of medication safety practices were audited at the hospital. Medication safety audits were planned by the Drugs, Therapeutics and Antimicrobial Stewardship Committee as part of tasks and quality initiatives to be achieved annually. However, these audits were not aligned to a formalised medication safety audit programme or strategy. Oversight of audits conducted in the hospital was managed through the central electronic repository system and an overview report was generated inclusive of all quality and safety activity and monitoring completed in the hospital within a given month.

The Drugs, Therapeutics and Antimicrobial Stewardship Committee had identified eight areas for clinical audit relating to medication safety for 2017 in its 2016 annual report of activities. Documentation reviewed showed that a number of medication safety-related audits had been undertaken by clinical staff at the hospital which included the following:

- audit of interventions on discharge prescriptions for inpatients April 2017
- therapeutic drug monitoring of vancomycin and gentamicin (ongoing)
- post anaesthetic care unit administration of intravenous opioids (ongoing)
- national antimicrobial point prevalence survey 2016
- acute hospital point prevalence survey of hospital acquired infections and antimicrobial use 2017
- in house antimicrobial point prevalence surveys 2017.

In addition, medication safety was monitored and evaluated at the Royal Victoria Eye and Ear Hospital through a number of key performance indicators. A total of five areas relating to medication safety management were audited in 2016. In general, compliance with key performance indicators for January, April and September 2016 was high with a drop in compliance noted in two of the five indicators in December 2016. Competing challenges, activity levels and patient throughput in less than 24 hours were identified as contributing reasons for reduced compliance at the time of this audit. There was evidence of review, revision and expansion of these key performance indicators by the Drugs, Therapeutics and Antimicrobial Stewardship Committee for 2017 in documentation viewed by HIQA. In general, of the seven
indicators selected for 2017, compliance was high for five with a drop in compliance noted for the other two from March 2017 to September 2017.

Reporting of performance in relation to these parameters was fed back to prescribers, the Drugs and Therapeutics Committee and senior hospital management. However, inspectors found that awareness of and compliance with defined key performance indicators required improvement in the clinical areas visited.

Nursing quality care-metrics‡‡ were monitored across the hospital on a monthly basis and included practice around four aspects relating to medication safety. Results of nursing metrics were posted on notice boards in each of the clinical areas visited by inspectors. Nursing quality care-metrics results for November and December 2016 were reviewed by inspectors. While the results relating to medication storage, custody and administration were satisfactory, improvement was required with regard to medication prescribing.

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

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.

A formal medication safety strategy, programme or plan for the Royal Victoria Eye and Ear Hospital was not evident at the time of the inspection. Despite this, it was clear that the medication safety agenda was being actively progressed at the hospital. Documentation viewed by inspectors indicated that the hospital planned to develop a medication management plan for 2017 and thereafter which would be reviewed on an annual basis. A draft medication safety strategy was submitted by the hospital following the inspection as part of documentation requested by HIQA at the time of the inspection.

‡‡ Metrics are parameters or measures of quantitative assessment used for measurement and comparison or to track performance
While good progress with the medication safety agenda was evident at the time of the inspection, inspectors found that there was scope to improve uniform awareness relating to medication safety across the hospital and staff disciplines. HIQA recommends that the hospital should look to further progress its significant work relating to medication safety management by progressing and implementing a formalised written medication strategy with clearly defined objectives.

Operational implementation of the medication safety programme was overseen by the Drugs, Therapeutics and Antimicrobial Stewardship Committee and led by the Senior Pharmacist and Pharmacy Department. The Pharmacy Department was responsible for tracking, trending and management of all medication incidents in the hospital in addition to provision and supply of medications, aseptic compounding of medicine products, update of policy, procedures and guidelines (related to medicines) and provision of education to hospital staff members.

While acknowledging the key responsibility and accountability roles that a Pharmacy Department plays in the implementation of organisational-wide medication safety systems, over reliance on the Pharmacy Department to progress the hospital’s medication safety agenda could potentially impact on the resilience, sustainability and future progression of this programme. Medication management is a complex multi-step, multidisciplinary process often reliant on collaboration, communication and participation of not only hospital staff but also patients and carers to achieve best possible medication safety outcomes. HIQA found that there was scope to further expand and develop medication safety in this small specialist hospital through broadening the responsibility amongst staff disciplines to participate in and manage medication safety activities.

A designated clinical pharmacist was allocated to inpatient services at the hospital. 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. Inspectors were informed that the clinical pharmacy service endeavoured to see each inpatient on every working day. At the time of the inspection, the clinical pharmacist documented pharmaceutical care in patient medical notes and on the patient prescription sheet. A draft inpatient prescription sheet was in the final stages of development and included a new dedicated area to document pharmaceutical care and pharmacy interventions.

The hospital had established a formal structured pharmacy-led medication reconciliation service. Medication reconciliation at the 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

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55 Clinical pharmacy describes the activity of pharmacy teams in ward and clinic settings.
admission. It was reported to inspectors that approximately 80% of inpatients received a medication reconciliation service. Staff who spoke with inspectors indicated that responsibility for medication reconciliation rested with the clinical pharmacist. While particular areas of medication reconciliation may be allocated to one discipline, a multidisciplinary approach is required to ensure success, consistency and sustainability of the process at all transitions of care. HIQA found that responsibility and awareness of medication reconciliation across staff disciplines could be improved.

The process of the medication reconciliation service was outlined in the hospital’s Medication Management Manual which indicated that medication reconciliation should be performed as soon as feasible after the decision to admit the patient to the hospital, and preferably within 24 hours following admission. Adherence to this process was regularly monitored as a hospital key performance indicator.

A policy and procedure for the management of high-alert and sound-alike look-alike (SALADs) medications was developed by the Pharmacy Department. The Drugs, Therapeutics and Antimicrobial Stewardship Committee reviewed and approved this policy. The list of high alert medications was approved annually and included a list of sound-alike and look-alike drugs. Strategies to ensure that high alert medications were stored, prescribed, dispensed and administered safely included:

- limiting access to these medications
- designated storage areas in pharmacy and clinical areas
- using “high alert” labels to prompt careful checking
- employing independent double checks
- prescribing and administering restrictions
- insulin vials and pens dispensed from the Pharmacy Department in an appropriately labelled and tamper proof sealed bag.

Compliance with the storage of high alert medications as per the hospital’s policy and staff awareness related to this policy was monitored on a quarterly basis as a key performance indicator in which overall compliance was shown to be high.

Inspectors saw an example of a quality improvement initiative that had been implemented in 2012 and further developed in 2017. In this example, feedback and queries relating to legibility or ambiguity on discharge prescriptions received from community pharmacists and general practitioners had resulted in the implementation of pre-printed prescription pads. The range of these pre-printed prescription pads had been expanded in 2017. Inspectors were informed that feedback on this initiative had been positively received by prescribers, clinical staff, community pharmacists and general practitioners.
The Chair of the Drugs, Therapeutics and Antimicrobial Stewardship Committee also sat on the Pharmacy and Therapeutics Committee in St James’s Hospital. It was reported to HIQA that this platform facilitated the exchange of information and sharing of knowledge and expertise relating to medication safety between the two hospitals. This collaboration could potentially be expanded upon in the future. HIQA also identified potential to expand the sharing of knowledge and expertise gained by this specialist hospital relating to medication safety among the specific cohort of patients that it treats, with other hospitals within its group, and indeed with other acute Irish hospitals.

2.4 Person-centred care

**Line of enquiry:**

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

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

The Royal Victoria Eye and Ear Hospital had systems in place to support the provision of information and education to patients in relation to medication. Patient information leaflets were available to patients. Information and education in relation to the use of eye drops was provided to patients in the form of a video in the Outpatient Department. Senior managers told inspectors that there was a multidisciplinary approach to patient information and education. In addition, counselling by members of the Pharmacy Department was available to patients in certain instances.

As part of this inspection, HIQA asked the hospital to administer an anonymised questionnaire in relation to prescribed medications to a small sample of hospital patients attending the Outpatient Department. The questionnaire was completed by 20 patients who had been inpatients at the Royal Victoria Eye and Ear Hospital within the last year and who were prescribed regular medications. Of the 20 patients surveyed, 19 patients had been prescribed regular medications. Of these 19 patients:

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

It is acknowledged that this was a small sample of patients who completed the anonymised questionnaire in relation to prescribed medications at the hospital’s Eye 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.

The Pharmacy Department in conjunction with the Drugs, Therapeutics and Antimicrobial Stewardship Committee had developed and implemented a suite of medication management policies, procedures, protocols and guidelines to support safe medication management systems within the hospital. All medication-related policies, procedures and guidelines were approved by the Drugs, Therapeutics and Antimicrobial Stewardship Committee prior to implementation. Medication policies, procedures, protocols and guidelines were readily available to staff through the hospital’s controlled document management system. In addition, the hospital had developed a smart phone application to facilitate easy access to antimicrobial guidelines and medication related policies procedures and guidelines at the point of care.

Clinical staff reported that they had electronic access to patient’s laboratory and radiological imaging results at clinical level. Generalised prescribing 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 by inspectors. While up-to-date hospital antimicrobial guidelines and generalised hospital prescribing and administration supports were available to clinical staff, standardised locally adapted hospital guidelines for adult and paediatric patients on the reconstitution and administration of intravenous medications were not available in the hospital.
Pharmacy Department ‘Drugs and Bugs’ newsletters were developed and circulated hospital wide in response to medication incidents and near misses and included updates relating to medication information and medication safety. Staff who spoke with inspectors referred to these newsletters as the main means used to disseminate information relating to medication safety across the hospital and noted that there was scope for improvement in relation to receiving direct feedback about medication incidents reported at local level.

Inspectors also noted that there was an established system in place to respond to guidance, alerts, recalls and recommendations issued by regulatory bodies in relation to medication safety.

### 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.¹⁹

The Royal Victoria Eye and Ear Hospital did not have a formalised education programme for clinical staff linked to an overall medication safety strategy. However, inspectors were informed that some nursing staff had completed the online HSELaND Medication Management programme which was not mandatory in the hospital at the time of the inspection.²⁰ Medication education sessions were held for all clinical staff in 2017. In addition, some nursing staff had completed anaphylaxis training to facilitate the administration of first dose antimicrobial medications. The Royal Victoria Eye and Ear Hospital had developed competency frameworks for nursing staff in relation to medicines administration including for the administration of intravenous and intravitreal medications.

Senior managers informed inspectors that non-consultant hospital doctors ††† received induction training which included information in relation to medication safety. This training was provided by the hospital’s Pharmacy Department.

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*** Intravitreal is a route of administration of a drug or other substance, in which the substance is delivered into the eye.

††† Non-consultant hospital doctor (NCHD) is a term used in Ireland to describe qualified medical practitioners who work under the (direct or nominal) supervision of a consultant in a particular speciality.
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 Royal Victoria Eye and Ear Hospital had an established Drugs, Therapeutics and Antimicrobial Stewardship Committee in place at the time of the 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 oversight from the Committee. HIQA found that medication safety was prioritised at organisational level with clear leadership from the Senior Pharmacist and the support of the Drugs, Therapeutics and Antimicrobial Stewardship Committee.

Following this inspection, the hospital should look to build on the good work conducted to date to ensure further involvement of all disciplines in activities relating to medication safety were identified. HIQA recommends that the hospital progress the implementation of a formalised medication strategy outlining its short, medium and long term objectives. Medication related audits and training should also be aligned with this medication safety strategy.

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. Despite this, the hospital had identified that medication related incidents were likely under reported at the hospital and there had been a decline in reporting rates in recent times. HIQA found that there was scope for improvement in relation to reporting rates, trending of incidents and near misses, feedback provided to staff in clinical areas and staff awareness in relation to learning from incidents.

Hospital management and other staff should continue to build on their work to date to progress the implementation of a formalised medication safety strategy that sets out a clear vision for medication safety across the organisation. It is recommended that this report is shared with senior managers, clinicians and other relevant staff at the Royal Victoria Eye and Ear 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 point in time.
4. References


Available online from: http://www.sciencedirect.com/science/article/pii/S0883944110001188


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