

HIQA - Medication Safety Monitoring Programme in Irish Public Acute Hospitals

Future Plans

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Presentation Overview

Background and Rationale for Programme



Project Scope and Plan



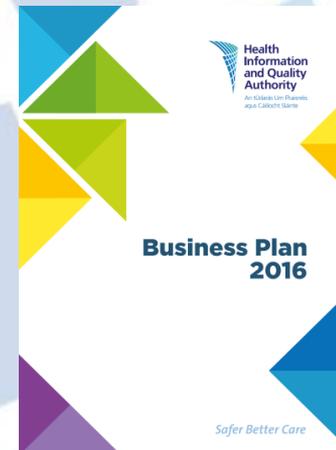
Intended Initial Methodology



Timelines and Next Steps

HIQA Corporate and Business Plan 2016

- Sets out how HIQA will deliver regulation and monitoring programmes aimed at safeguarding people who use health and social care services
- The Business Plan 2016 commits to conducting a programme of monitoring medication safety against the *National Standards for Safer Better Healthcare*



HIQA's current mandate under the Health Act 2007

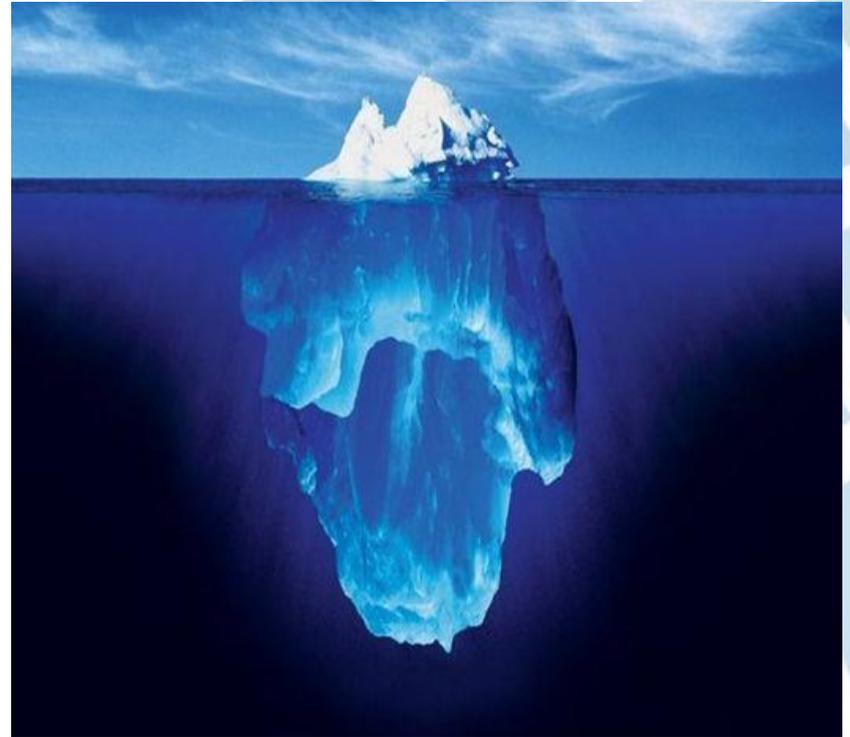
- HIQA's current mandate within healthcare extends to monitoring compliance with standards in publicly funded acute hospitals
- Future Enactment of the Health Information and Patient Safety Bill will extend mandate to private providers
- Plans for future legislation which will set out the parameters for the Licensing all healthcare providers

Why Medication Safety?

- 26% of Irish people aged 50 or over use five or more medicines daily.
- 20% of readmissions to hospital within a year of discharge are medicines related, 8% of all emergency hospital admissions are medicines related.
- 8% of adverse patient safety incidents reported to the Clinical Indemnity Scheme are medicines related.
- 6% of hospital discharge prescriptions have a potentially severe medication error.

*"Internationally it is estimated that **one medication error occurs per hospital in-patient per day***

*This translates to over **3 million medication errors in Irish public hospitals per year**".*



International approaches to monitoring medication safety

- Organisations regulating/monitoring in other jurisdictions include:
 - Joint Commission International
 - United Kingdom – multiple agencies/organisations
 - Australian Commission on Safety and Quality in Health Care (ACSQHC)
 - Clinical Excellence Commission Australia
- International regulation/monitoring look at different aspects of medication management and safety

National Developments

- Commission on Patient Safety and Quality Assurance recommendations in relation to medication safety, 2007
- National Medication Safety Forum, DoH
- Irish Medication Safety Network, 2007
- Health Products Regulatory Authority (HPRA), 2014 (formerly IMB)
- National Medication Safety Programme, Quality Improvement Division, HSE
- National Patient Safety Office, DoH
- HIQA Principles of good practice in medication reconciliation: May 2014



Report of the Commission on Patient Safety and Quality Assurance



Underpinning principles for this monitoring programme

- Systems versus persons approach – focus on the systems not the individual
- Promotion of a patient safety culture and 'just' culture
- Awareness of the significant underreporting of adverse incidents related to medication

Project Aim

- To monitor and report on the approach taken in public acute hospitals to promote medication safety, using the *National Standards for Safer Better Healthcare* as an overarching framework for assessment.
- To drive the implementation of international best practice in relation to medication safety across all public acute hospitals – reduce the variance
- Plan to build on some of the findings of the antimicrobial stewardship review

How will this be achieved?

Preparation

- Literature review
- Input from an External Expert Advisory Group

Monitoring

- Announced inspections

Reporting

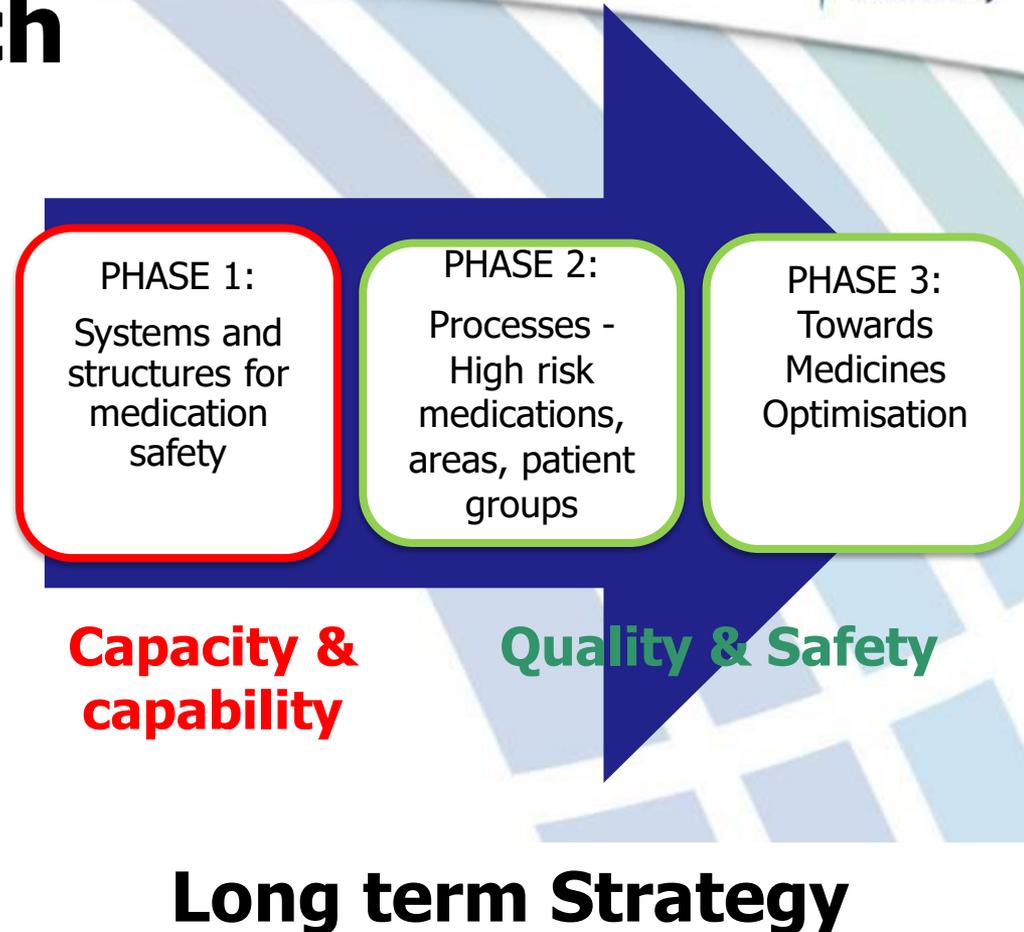
- Present the findings of inspections in a report to individual hospitals
- Publish inspection reports

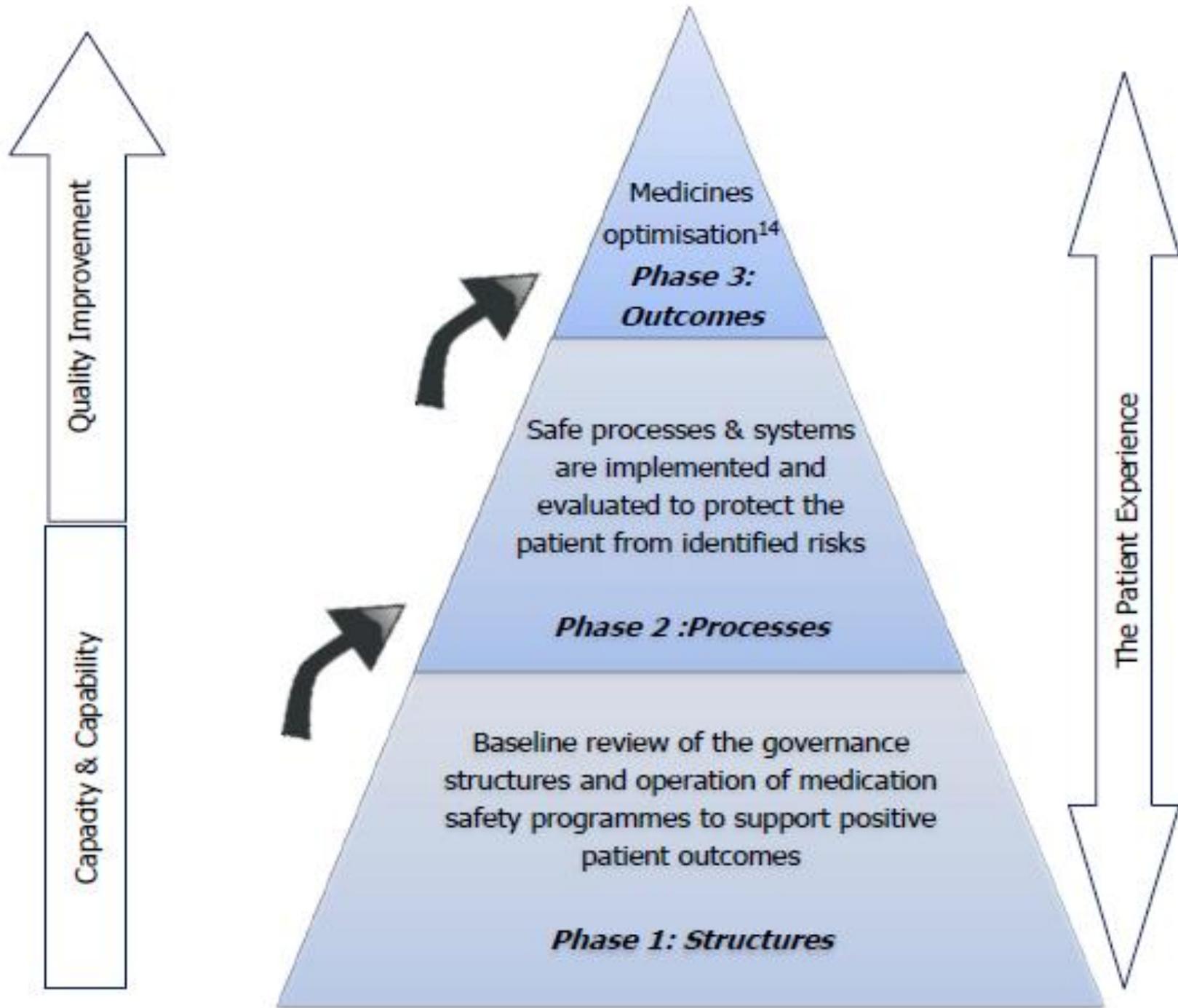
What we already know from our review of antimicrobial stewardship

- Some hospitals have good structures and good governance in relation to medication management and safety
- Others have more limited formal structures to underpin medication safety
- Significant variance across the country

Overall Approach

- Significant undertaking monitoring all aspects of medication management and safety
- Long term, ongoing monitoring programme
- Plan to proceed without delay using a three phase approach based on areas of highest risk





Inspecting against the *National Standards for Safer, Better Healthcare*



**Dimensions of
Quality and
Safety**

**Dimensions of
Capacity and
Capability**

What we will monitor in phase one

1. Are there 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 throughout the organisation, leading to the board of management.

See Council of Australian Therapeutic Advisory Groups. Achieving effective medicines governance – guiding principles for the roles and responsibilities of Drugs and Therapeutics Committees in Australian Public Hospitals www.catag.org.au/wp-content/uploads/2012/08/OKA9964-CATAG-Achieving-Effective-Medicines-Governance-final1.pdf

2. Are patients informed about their medicines?

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

3. 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.

4. Risk Management. There are arrangements in place to identify, report and manage risk related to medication safety throughout the hospital.

5. Audit and Evaluation. The effectiveness of medication management systems are systematically monitored, evaluated and continuously improved.

6. Education and training. Safe prescribing and drug administration practices are supported by mandatory and practical training on medication management for relevant staff

7. Access to information. Essential information about medicines is readily available to relevant staff in a useful form and is considered when prescribing, dispensing and administering medications.

What do we hope to incentivise through this work?

- All public acute hospitals will have **effective structures** in place to safeguard patients from medication safety incidents in line with international best practice
- Hospitals have developed **safe systems** to ensure that risks associated with medicines are effectively identified and managed in line with international best practice, and regularly monitor their effectiveness occurs

Further Phases

- Further phases will build upon approach and findings of Phase 1
- Timing of progression will be determined by identified readiness during initial inspections
- Further focus will also be informed by international best practice, and input from our external expert advisory group

Towards Medicines Optimisation

- An example - The National Institute for Health and Care Excellence, UK - Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes
 - Patient involvement in decision making
 - Patients informed how to identify and report problems associated with medicines use
 - Healthcare providers monitor patient safety incidents
 - Acute hospitals – medicines reconciliation within 24 hours of admission
 - Patient discharge – medicines reconciliation into GP records within 1 week
 - Structured medicines review in the community for an identified cohort of patients who would benefit

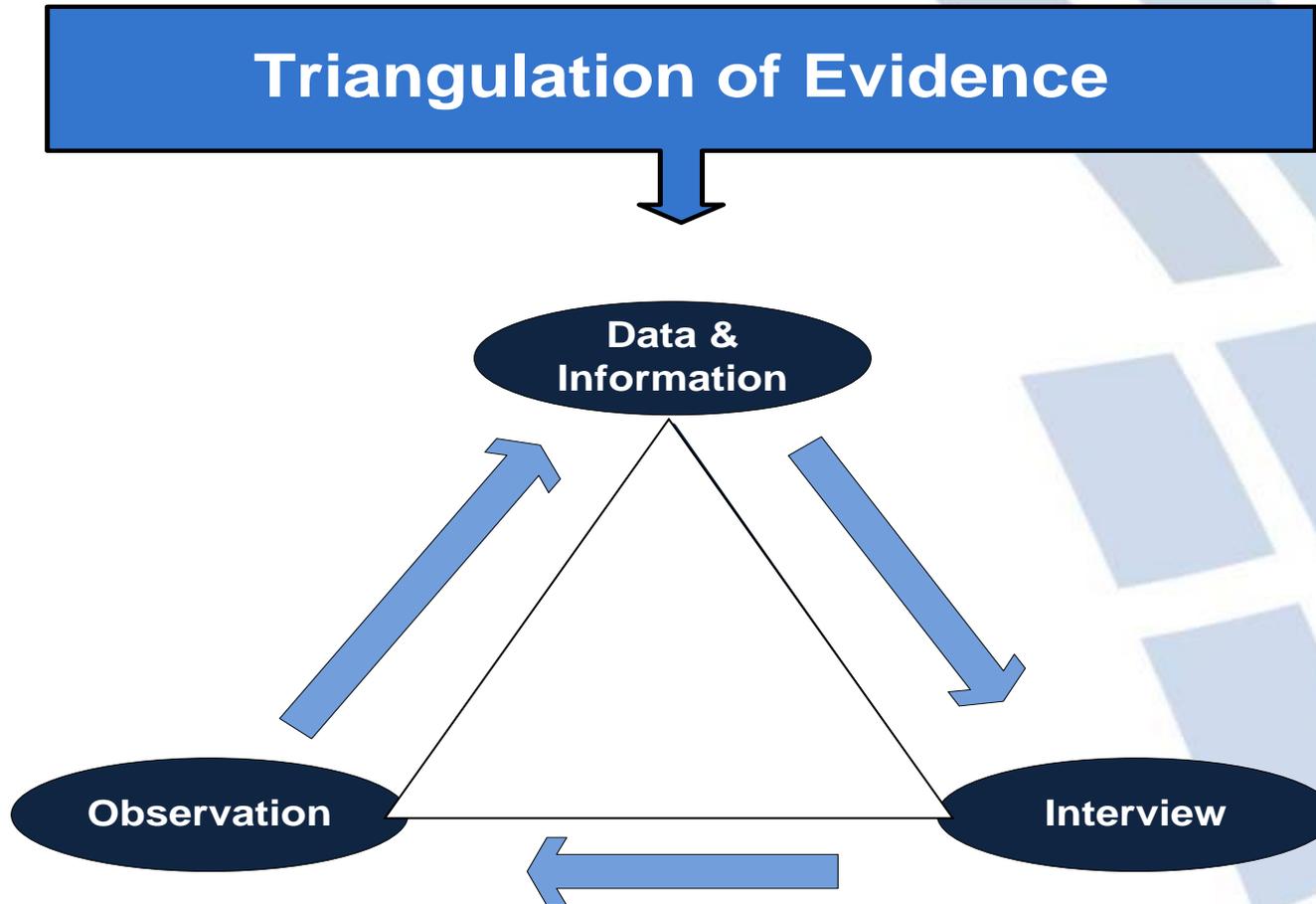
What will monitoring in phase one look like?

- Announced inspections (10 days written notice will be provided to the hospital)
- Pre inspection information and documentation will be requested – for return within 5 working days
- Individual published reports
- Should any high risks be identified, these may be escalated in writing to the appropriate level within the Hospital/HSE

Intended activities during inspection



Inspection Methodology



Patient Experience

- Target discharged patients
- Focus on questions regarding advice on new/existing medications
- Questions aligned to national patient experience survey (Picker methodology), and other key published documents
- Anonymous surveys given and collected from recently hospitalised patients – no patient identifiable data collected
- HIQA distribute in outpatient clinics at sign in
- Will request and inform patients of hospital point of contact for concerns
- **Note this methodology may be extended at phase two and three**

Report Writing and Publication

- Reports will be written based upon our findings
- Draft reports be returned to the hospital General Manager/CEO for due process comment and feedback prior to publication
- It is not our practice to name individuals
- Reports will be published on our website – hospital will be informed 5 working days in advance of publication

Timelines and Next Steps

- Phase one – to begin in November 2016, and continue until at least January 2017
- We will evaluate preliminary findings in Q1 2017 with the assistance of our external advisory group
- The timing of progression to Phase two, and the areas of focus, will be determined based upon the cumulative findings from this first phase
- Communication related to any changes will be provided to all acute hospitals in advance