HIQA's Medication Safety Monitoring Programme in Public Acute Hospitals

One Year Later

Sean Egan – Head of Healthcare Regulation
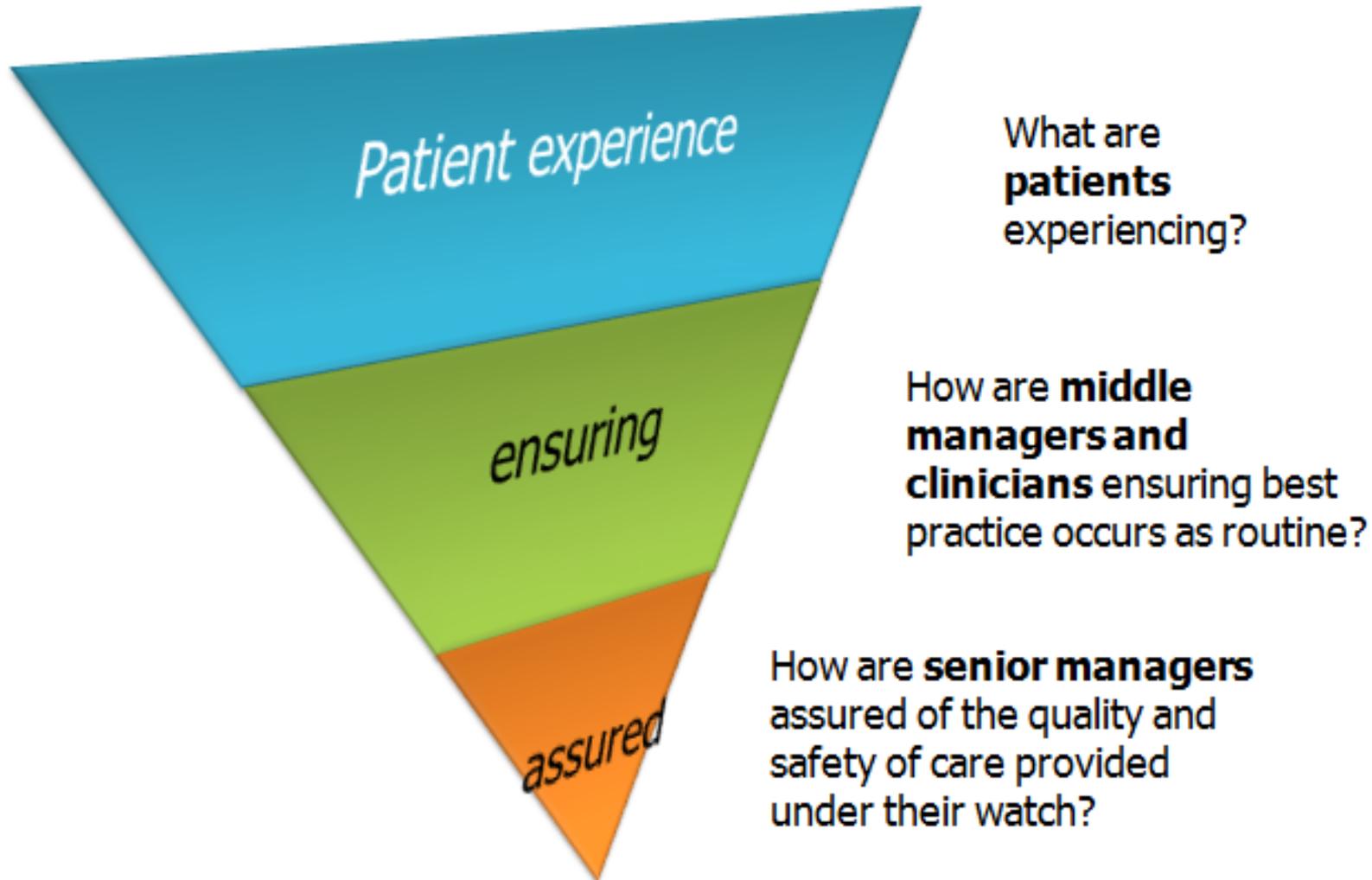Health Information and Quality Authority

Presentation outline

- Recap on the programme aim and methodology

- Breakdown on activity so far

- What we have found to date
  - What was good
  - Where are the required key areas for improvement focus

- Thinking big - key areas for high level focus

- Next steps

Programme aims

- In monitoring against the *National Standards for Safer Better Healthcare*, evaluate the system of care, and how hospitals take a whole system based approach to ensuring the safe and effective use of medicines

  - Involvement from patients, all involved disciplines in the hospital, in addition to professionals working in the community such as GPs and Community Pharmacists

- Ensure that this issue, which is a key risk in any hospital, is recognised as such at a senior management level, and appropriately supported by senior managers to drive improvement

- Ensure a baseline level of provision to improve safety in all hospitals

Systems regulation

Patient experience — What are **patients** experiencing?

ensuring — How are **middle managers and clinicians** ensuring best practice occurs as routine?

assured — How are **senior managers** assured of the quality and safety of care provided under their watch?

Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Initial lines of enquiry

- Leadership, Governance and Management
  - The functioning of the D&T and other relevant committees – clear lines of accountability and responsibility for medication safety

- Medication risk management
  - Audit, evaluation and quality improvement
  - Policies, procedures, protocols and guidelines
  - Access to high quality information at the point of care

- Support structures and initiatives
  - Access to and provision for Clinical Pharmacy Services
  - Access to other infrastructural and ICT supports used to promote medication safety best practice

Initial lines of enquiry

- ## Person Centred Care
  - Provision of accessible, clear, timely and relevant information is provided to service users about their medication in a form they can use and understand.

- ## Staff training and education
  - Safe prescribing and drug administration practices are supported by mandatory and practical training on medication management for relevant staff.
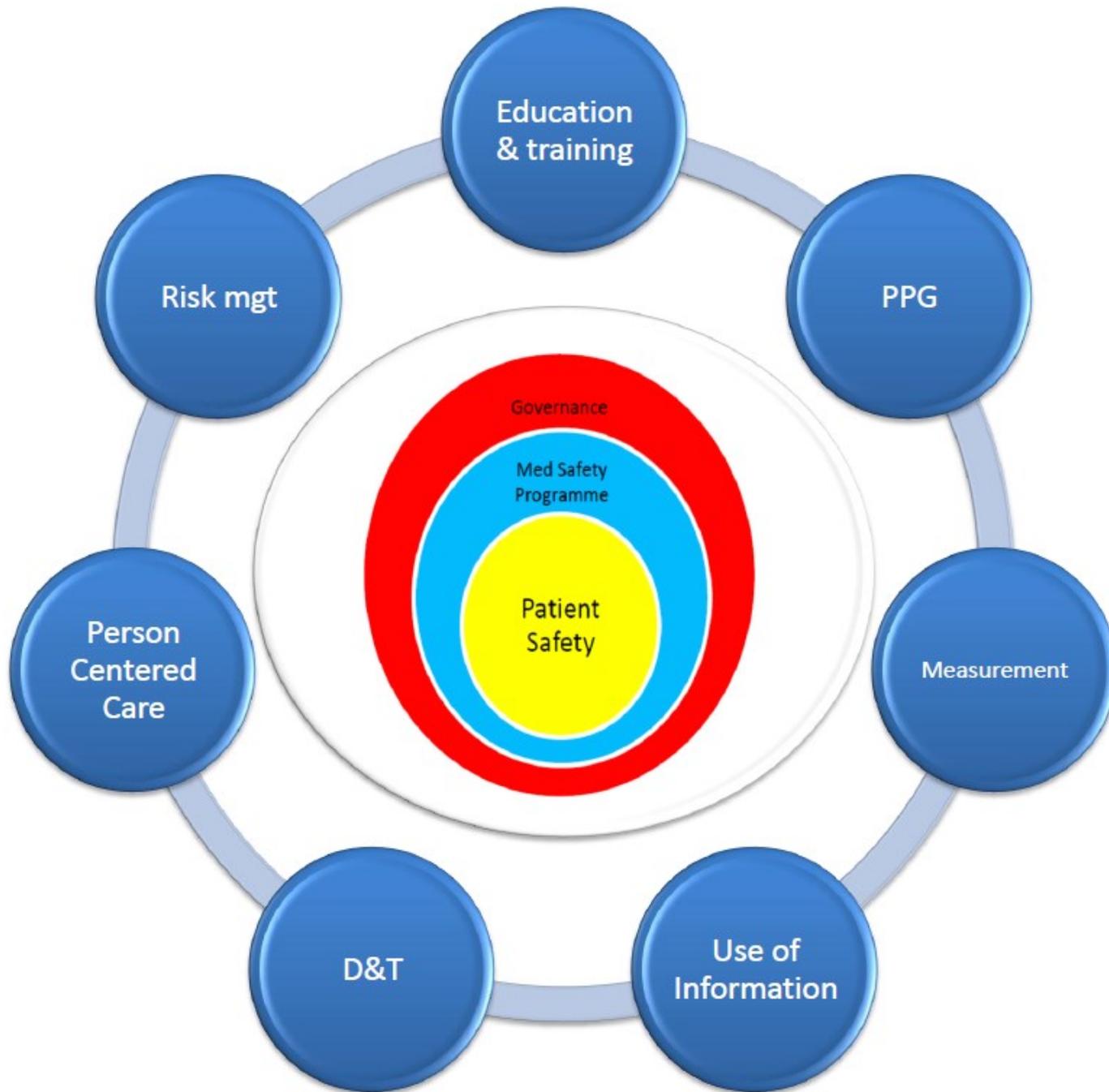
Breakdown on activity so far

- 34 public acute hospitals inspected to date – 70% of the total number eligible under HIQA's current remit
- 27 reports published so far, remainder to follow over the coming weeks – also working on an overview report

Hospital Group	Number of hospitals Inspected so far
Children's Hospital Group	1
Dublin Midlands Hospital Group	7
Ireland East Hospital Group	9
RCSI Hospital Group	3
Saolta Hospital Group	6
South/Southwest Hospital Group	6
University of Limerick Hospital Group	2

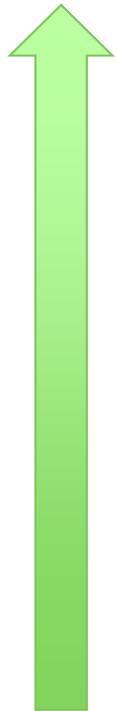# Findings – Leadership, Governance and Management

- Higher performing hospitals have developed effective multidisciplinary governance structures

- Chief Pharmacist Leadership + Senior Management support = More effective safety programmes

- Reporting lines into overarching Clinical Governance or Patient Safety Committees found in many larger hospitals
  - Some hospitals have supplemented these committees with Medication Safety Subcommittees – more of a working group to drive initiatives

- There is a role for hospital group cooperation and collaboration

- Some hospitals have come a long way in a short time – and are learning from the work of others

High performance – strong leadership, whole hospital involvement

Hospital Group

Executive Management Team

Clinical Governance Committee (Larger hospitals)

Active Multidisciplinary IPC/D&T Committee

Actively seeking assurance on patient safety

Escalating risk for management if needed
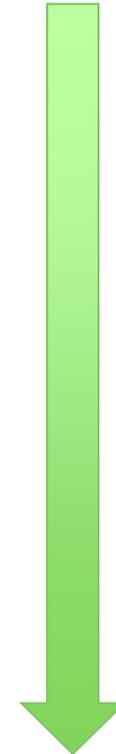
Leadership, Governance and Management – key learning from the better performers

- Every effective programme needs a clearly articulated plan – Both long-term strategic, and short term operational
  - Such a plan should be the hospitals plan – and not confined to a single speciality or department

- Hospitals that have improved the most from a governance perspective have done so by designing and implementing a multidisciplinary governance structure, with active participation and clear accountability

- The Chief Pharmacist is a critically important position – some hospital groups have acted to support this role through the formation of Chief Pharmacist groups

The governance of the introduction into use of new medicines at hospital level

- A key safety measure for patients and staff in all hospitals

- Well established systems of evaluation and multidisciplinary oversight in place in higher performing hospitals – all new meds approved by D&T
  - Alternate fast track systems in place for one-off medicines also in place

- Other hospitals either had more informal systems or no system in place – a significant concern

- Some hospital groups had begun to consider the role for a group-wide approach

Findings - Risk Management – Learning from the high performers

- More mature programmes have better established systems of assurance through audit and incident/near miss reporting
- Audit
  - Some hospitals have strategically planned and centralised audit – ensures economy of effort and a smarter focus, better continuity and a greater likelihood of progression to improvement
- Incident reporting
  - Many hospitals have established incident reporting systems in place – senior support for same has driven reporting culture
  - However often these are mainly supported by clinical pharmacists and/or nurses – underreporting from medical staff
  - Some hospitals with higher reporting rates had established local reporting systems supported by technology to reduce the time to report – a key barrier

Common areas of Quality Improvement focus across hospitals

- VTE collaborative participation in 22/34
- Medication prescription & administration record updated or refined 20/34
- Labelling associated with high risk drugs (eg DOAC & Insulin) including the introduction of pre-filled syringes in theatre (in some hospitals) 20/34
- Red apron 20/34
- Review of discharge prescription documentation 4/34
- Introduction of electronic discharge prescriptions with discharge summary collaborating with the community pharmacist and GP 8/34
- Electronic access to intravenous monographs
- Use of applications to support antimicrobial stewardship

PPPG's and access to information at the point of care

- Areas of good practice
  - Some sharing and collaboration between hospitals
  - The use of mobile technology for access to medicines information at the point of prescribing and administration
- Key areas of focus for improvement
  - Ensuring access to standardised, locally approved information to aid staff in the safe IV administration of medicines
  - Ensuring the availability of up-to-date PPPG's to guide safe medication practices.
  - Governance and oversight of decision support tools approved for use within organisations
  - More sharing and collaboration within hospital groups and nationally
  - Electronic documents control management system for PPPG's

Support Structures and Initiatives – Clinical Pharmacy Services

Figure 9. Total number of WTE clinical pharmacist positions allocated by hospital type in each hospital group, July 2015
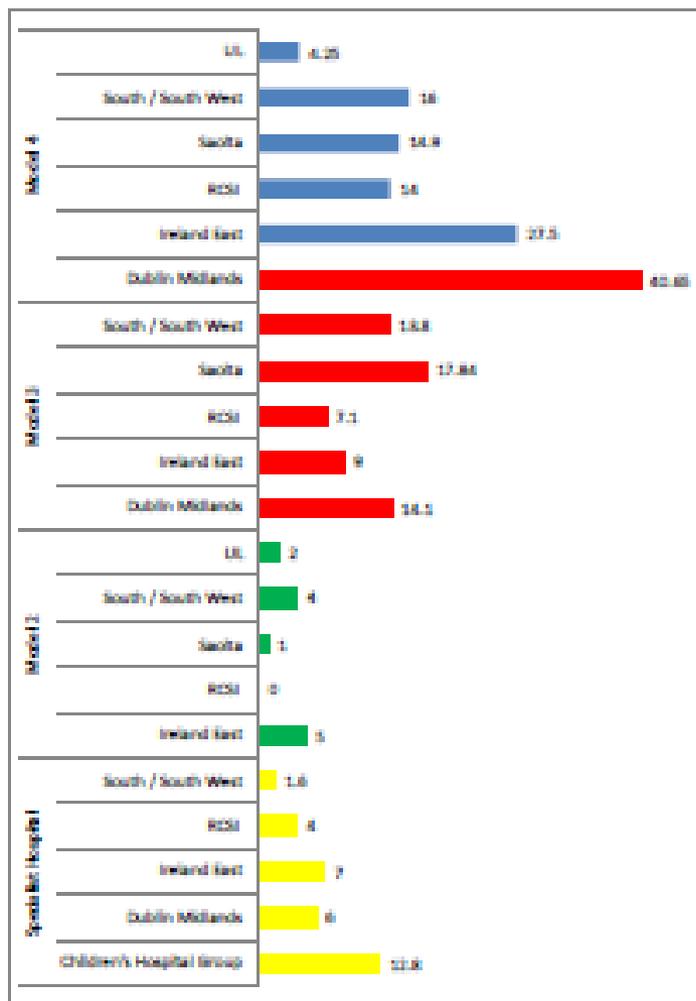
Findings from HIQA's *Review of Antimicrobial Stewardship in Public Acute Hospitals* – Published July 2016 (Data as of July 2015)

Figure 10. A box plot outlining the relative degree of clinical pharmacist employment per 100 bed-days used in statutory (HSE) hospitals and voluntary hospitals funded by the HSE
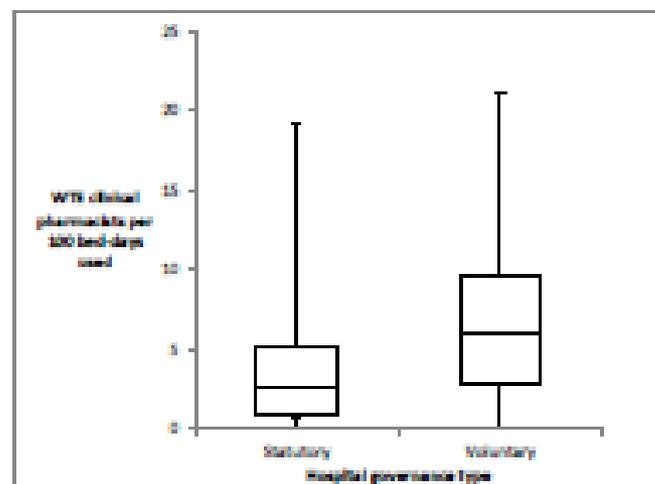
Types of clinical pharmacy service

Clinical Pharmacy Service Provision 2016-17 in Public Acute Hospitals

	Ward based clinical pharmacy service	Team based clinical pharmacy service	Dispensing service only	No clinical pharmacist on site
■ Model 4 Hospitals	6	1	0	0
■ Model 3 Hospitals	9	2	1	0
■ Model 2 Hospitals	3	0	4	0
■ Specialist Hospitals	7	0	0	1
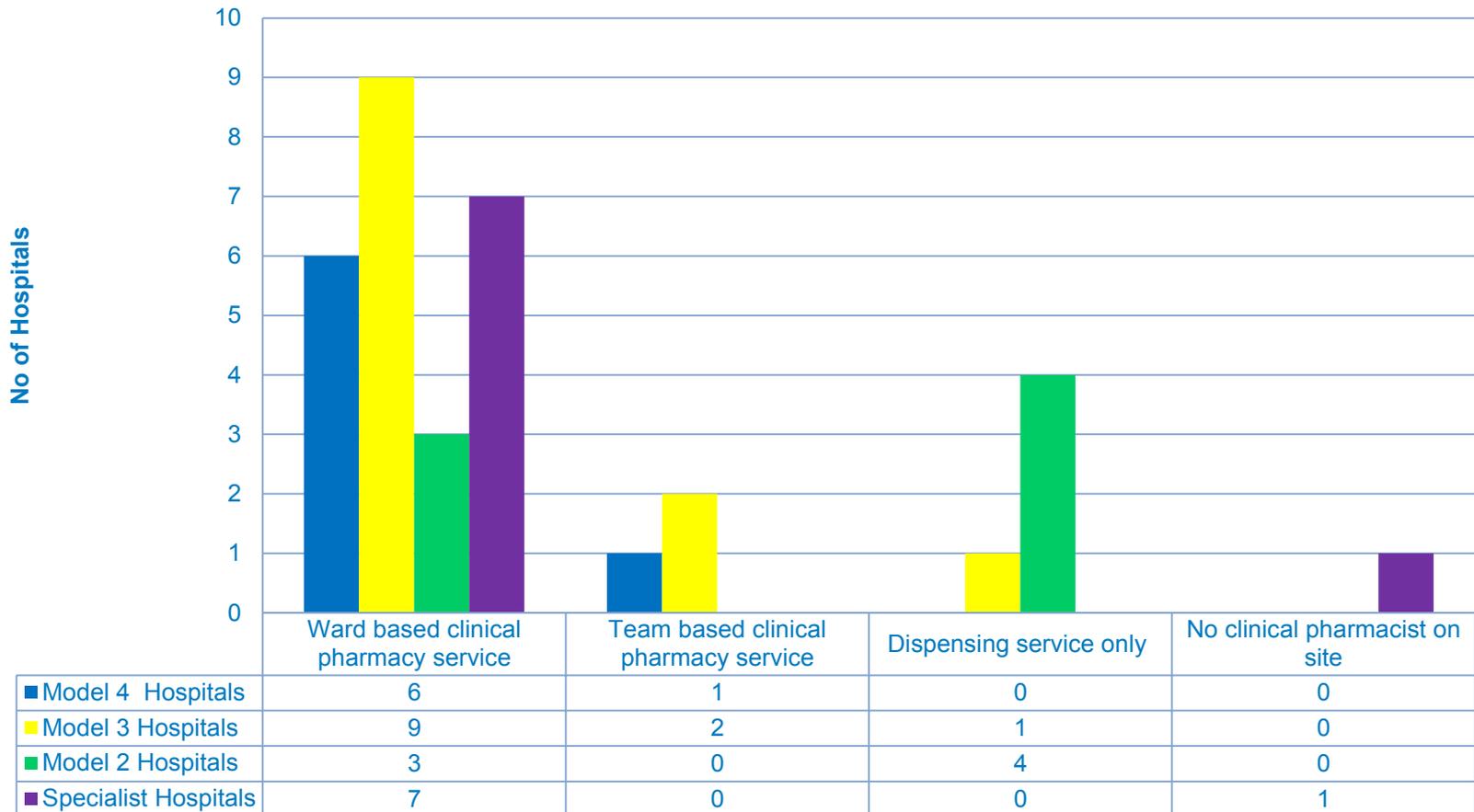
Medication Safety Officers
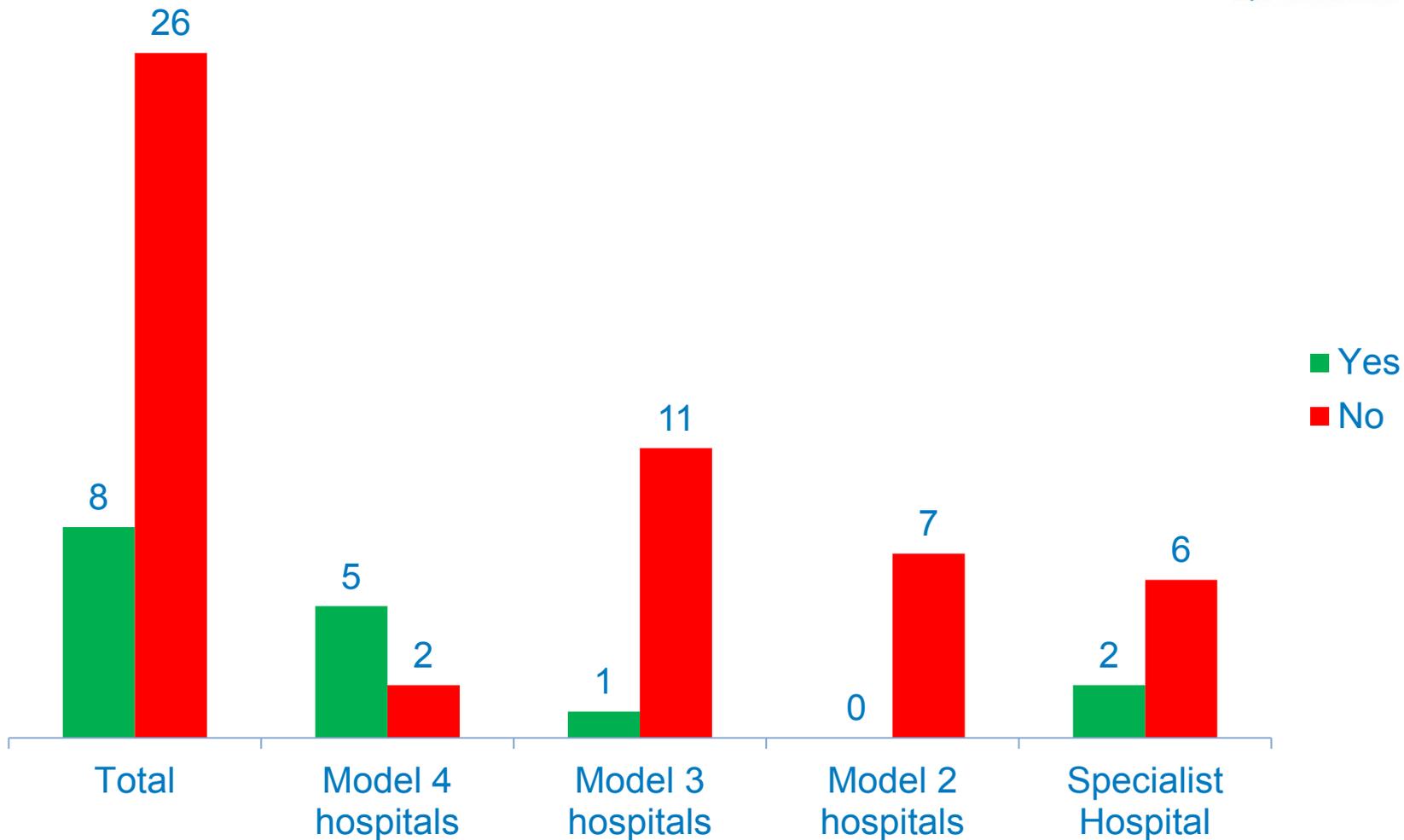
Medicines Reconciliation

- Practice related to medicines reconciliation in Irish hospitals during transitions of care remains extremely variable

    - Only 3 of the 34 hospitals inspected had a formal medicines reconciliation policy and process in place, which included the recognition of best practice around information gathering, was accompanied by staff training, and included audit of practice to provide assurance around compliance.

- Other practices to support medicines reconciliation were observed to a greater of lesser extent in the majority of hospitals

- 8 hospitals had a Clinical Pharmacist in their ED to support medication reconciliation on admission

- Three hospitals had implemented systems to support medicines reconciliation accuracy on admission and discharge using electronic technology

eHealth

HIQA found:

- Introduction of electronic med rec on admission and discharge 3/34

- Electronic ordering at ward level 2/34

- Pharmacy Dept developed new technology to manage medications incidents 2/34

- Electronic prescribing in critical care areas 3/34

- Electronic prescribing in OPD in one hospital

- Automatic dispensing systems 3/34

Other support structures and initiatives

- List of High Alert drugs 31/34
- Salad List 11/34
- Implemented high leverage reduction strategies for governance of high risk medications 12/34
- Standardisation of medication storage 4/34
- Automated dispensing system 3/34
- Introduction of smart pump technology 5/34
- POD (patient's own drugs) system 3/34
- 'My Medicines' Leaflet/ card 4/34
- Focus on Drug Allergies 10/34
- Safety Pause/Huddles or Leadership Walk Around 5/34

Person centred care

- Patient education
  - Many hospital had multidisciplinary approach to patient education.
  - Some specialist hospitals provided structured approach to patient counselling prior to discharge e.g. paediatrics
  - Clinical pharmacists had formalised approached to counselling patient commenced on anticoagulants and were available to provided counselling as required for other patients.
  - Clinical nurses specialists provided patient education e.g. in diabetes and respiratory
- Patient involvement
  - Hospital had undertaken patient surveys using patient feedback to guide quality improvements
  - 'Know your meds' initiative was in place to increase patients awareness of their own medicines

Person centred care

Patient survey ($n = 444$ patients)

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Q1. While in hospital did a member of staff explain the purpose of the new medicines in a way you could understand	**Q1**
	yes — 58%
	Yes, to some extent — 16%
	No — 10%
	No explanation required — 5%
	None prescribed — 11%

Q2. Prior to discharge from hospital, did a member of staff tell you about possible side effects of medicine?	**Q2**
	Yes — 43%
	Yes, to some extent — 17%
	No — 25%
	No explanation required — 15%

Q3. Were you told how to take your newly prescribed medicines in a way you could understand	**Q3**
	Yes — 64%
	Yes, to some extent — 9%
	No — 11%
	No explanation required — 16%

Staff training and education

- What worked well
  - Some hospitals had structured medication safety training programmes
  - Medication management sessions for nurses and doctors on induction
  - Short focused education sessions provided by clinical pharmacist and clinical facilitators
  - Some novel methods of sharing new information e.g. One minute tutorial slides
  - Medication safety week
  - Medication safety newsletters
- Where is further improvement required
  - Organisations should have on going structured targeted medication safety programme for staff with medication management
  - Availability of information technology to supports dissemination of information to front line staff

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Thinking big – key areas for national improvement focus

- As a country, we need to continue to progress the eHealth agenda to improve patient safety
  - Medicines reconciliation in particular could be much improved

- There is a need for targeted investment in some hospitals to bring Clinical Pharmacist staffing levels up to the level deemed necessary and therefore employed by higher performing hospitals
  - National strategic planning and oversight may be needed to enable this

- Collaboration between hospitals is happening, however a greater focus on this would reduce duplicate effort, and yield faster progression in driving collective improvement
  - Support for Chief Pharmacists within the construct of the hospital group a welcome development

Next Steps

Programme of Monitoring and Improving Medication Safety in Acute Hospitals

Assumption: Medication safety covers all aspects including unwanted effects & interactions, safe processes and systems and effective communication between professionals

Medicines optimisation

P3:Ongoing: Outcomes

Assumption: By targeting drugs that have the greatest potential to cause harm we have the greatest opportunities for improvement

Safe processes & systems are implemented and evaluated to protect the patient from identified risks

P2:Processes

Assumption: aim to avoid monitoring the system without the necessary foundations of a medication safety programme in place first.

Baseline review of the structure and operation of medication safety programmes to support positive patient outcomes

P1: Structures

LINES OF ENQUIRY
1. Clear lines of accountability and responsibility for medication safety.
2. Patient involvement in service delivery.
3. Risk Management Systems
4. Policies procedures and guidelines
5. Education and training
6. Clinical effectiveness
7. Access to information

Quality Improvement

Capacity & Capability

Year two of this programme

- We will complete inspections in remaining hospitals not inspected so far under the current methodology

- We will also re-inspect those hospitals that fared less well in 2016/17, under the same methodology to determine the level of progress achieved

- We will enhance our monitoring approach in 2018 with the assistance of our external advisory group – intention to commence these inspections towards the latter end of the year

- We will communicate any changes to this programme in advance to all impacted stakeholders

Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Thank You