

Medication Safety

Programme Overview



**Aoife Lenihan, HIQA
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Presentation outline

- Role and remit of HIQA
- Aims of the programme
- Findings from HIQA's medication safety monitoring programme 2018/2019
- 2019 Focus on high risk medications and high risk situations
- Reflection on overall findings of programme to date
- Future plans for monitoring



Health Act Section 7

- **Health Act, Section 7—(1)** The object of the Executive is to use the resources available to it in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public.
- Primary aim is to advance high quality and safe care for people accessing services
- To achieve this HIQA aims to assure the public that hospitals are meeting standards through monitoring programmes
- Need to ensure resources are used to best effect

Role and remit of HIQA



- **Section 8** –setting of national standards and monitoring against those standards in publically funded acute hospitals
- **Section 9** – the conduct of Statutory Investigations ... should a serious systemic risk to the health or welfare of persons receiving services be raised

HIQA's monitoring programmes in Healthcare



2012
Prevention
and control of
hospital
acquired
infection



2015-2017
Nutrition and
Hydration



2016
Medication
Safety



2018
Regulating
use of ionising
radiation



2018 -2019
Maternity
services



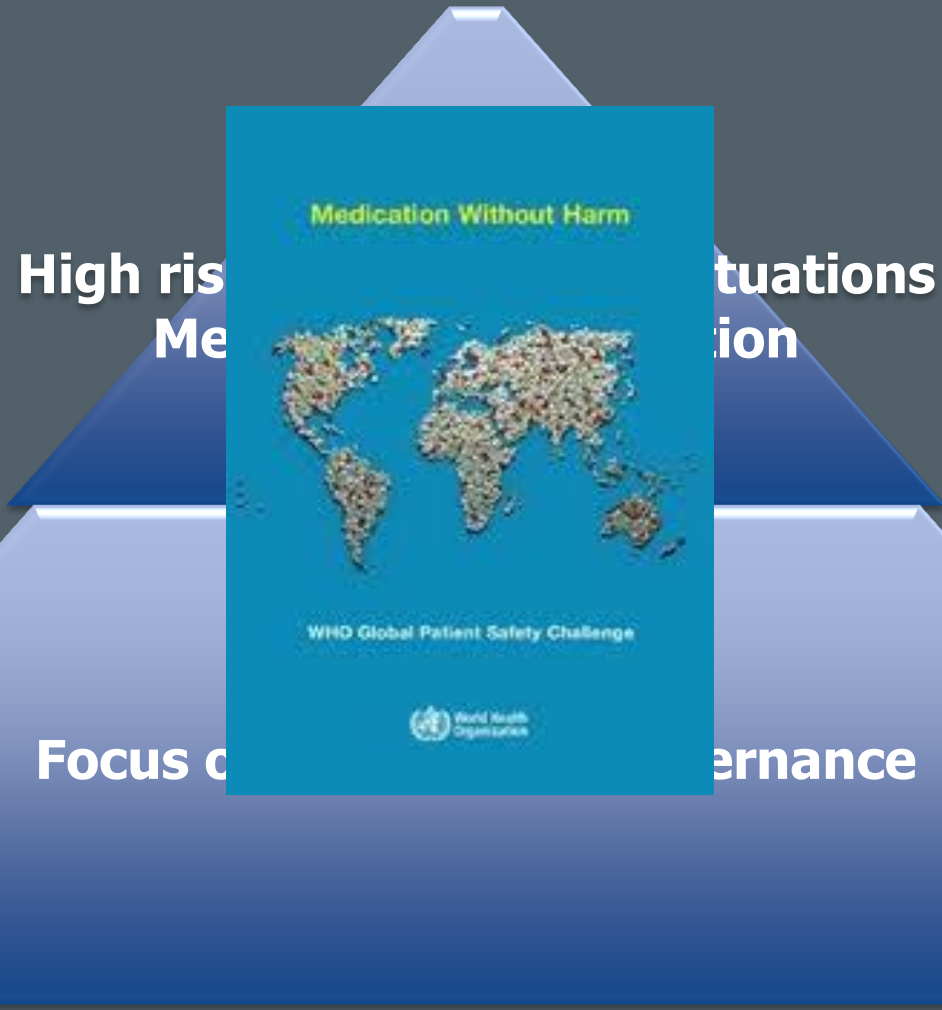
2019
Rehabilitation
Community
healthcare



Medication safety programme Aims 2016-2019

- Aim of the programme was **'to examine and positively influence the adoption and implementation of evidence based practice in hospitals around medication safety'**
- Based on research that identified medication use as the leading cause of unintended harm for patients availing of hospital care- the majority could be potentially preventable
- To date conducted over 60 inspections, 54 published reports

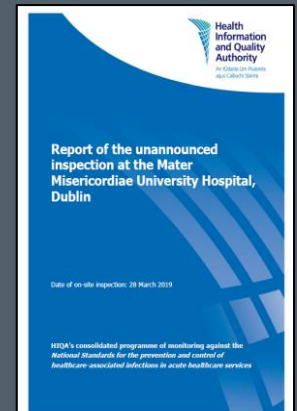
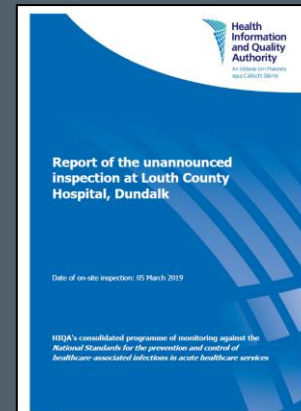
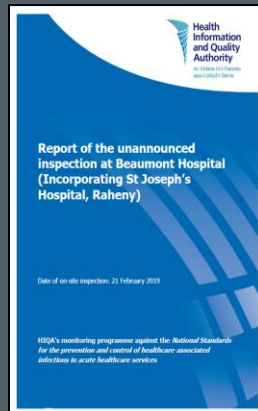
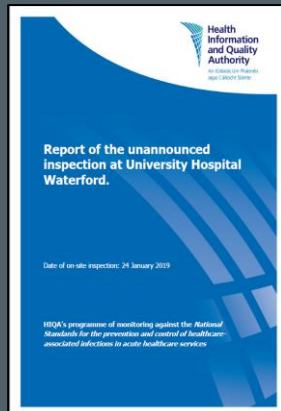
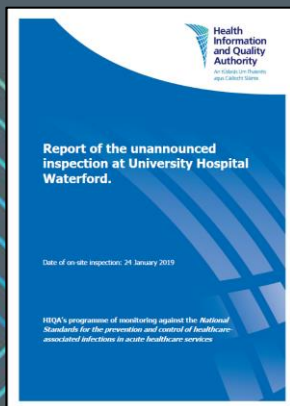
Medication Safety Monitoring Programme Approach



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Reporting

- Reports issued to hospitals
- Risks escalated in line with HIQA's risk management process
- Reports published: www.hiqa.ie



Findings

Governance and risk management

- All hospitals had functioning Drugs and Therapeutic Committees- *this has improved since 2016/2017*
- All hospitals had risk management systems including risk registers and systems for incident reporting
- Most had increased reporting of medication safety incidents with some exceptions
- **Improved culture of reporting is a recommendation for all**

Findings

Higher risk situations

- Visits to operating theatres/areas conducting sedation
- Medication safety during perioperative period
- Procedural sedation in non theatre environment



Findings

Person centred care

- Used *National Patient Experience* data -
Most hospitals are improving -
<https://yourexperience.ie/>
- Medication reconciliation undertaken
where clinical pharmacy services existed
- Higher rates of medication reconciliation
conducted at admission than discharge

Findings

Model of service

- Variance in the availability of clinical pharmacy services
- Improvements and better systems where there is clinical pharmacy, for example- increased medication reconciliation, formularies, increased medication incident reporting where there are specialist clinical pharmacy services
- This is still an important issue to be addressed system wide

Findings

Monitoring evaluation/Access to information/Education

- One third of hospitals had formularies, others progressing the development of same
- Most access to information on medications at the point of care, some out of date information
- Most provided some training on medication safety but room for improvement
- Monitoring limited to nursing metrics and audits

Overall reflections on monitoring programme

- Significant variance remains and not all patients are being equally protected -includes variance between hospitals of like size/model
- Common elements for good performance were sustained/long term focus, strong leadership and management support and clinical pharmacy



Overall reflections on monitoring programme

- Governance is better
- All have risk management systems but reporting of incidents needs to improve
- Most have systems in place for high risk medications and high risk situations but gaps exist- **these must be addressed**

Overall reflections on monitoring programme

- Medication reconciliation better but needs improving
- Many improvements can be expected if gaps with clinical pharmacy services are addressed
- Systems for monitoring at development stages
- Improvement seen but in some hospitals the pace of change is slow.

Future legislative changes

- Changes to HIQA's powers in relation to healthcare
- New legislation pending includes the Patient Safety Bill which will expand HIQA's remit into private healthcare
- This legislation will require providers to notify HIQA about serious incidents



Future medication safety monitoring?

- Anticipate that programme in its current guise will conclude in 2020
- Plans to develop and continue this important area of monitoring
- Changes to HIQA's monitoring approach will involve communication and stakeholder engagement



Thank You

Contact us

Email: qualityandsafety@hiqa.ie

Website: www.hiqa.ie