

# Building the Foundations of a Medication Safety Programme in an Acute Hospital

Love B, McFadden T, Martin P, Connolly V, Brennan D, Griffin M, Bracken D, Carroll M, Maguire S, Carr J

Connolly Hospital Blanchardstown, Dublin, Ireland



## DEFINE

Avoidable harm caused by medication is one of the most commonly reported adverse events in healthcare settings.

CHB launched a formal Medication Safety Programme in November 2017 with the establishment of a multi-disciplinary Medication Safety Committee to promote and support the safe use of medications and appointment of a Medication Safety Facilitator.

### DESIGN

The Medication Safety Committee undertook a number of activities to design and establish the programme in the hospital.

- An evidence-base literature review was completed to understand scope, breadth and to collaboratively discuss direction of the programme.
- A baseline in-depth analysis of medication incidents (2016/2017) reported locally on the National Incident Management System(NIMS) was conducted to identify initial targets for improvement. Analysis was undertaken using NCC-MERP, a recognised and validated tool used specifically for medication incidents.
- An annual work-plan (short-term strategy), incorporating necessary elements of a medication safety programme, was devised by the committee with intended goals for the year.

## **DELIVER**

**GOVERNANCE** 

**SAFETY** 

**CULTURE** 

commitment from

medication safety.

**Investigations into** 

medication errors

aligned to a just

and fair systems

**Promotion and** 

reporting and

learning with a

**Awareness Day** 

medication safety

by empowering

enhance

patients

encouragement of

medication safety

approach.

management to

**Prominent** 

hospital

- -Organogram updated to reflect reporting relationship of new committee.
- -Medication Safety made standing item at DTC & Quality & Safety Executive(QSE) meetings.
- -Annual report submitted to Hospital Executive Committee
- -Logo created for the hospital Medication Safety Programme

MEASUREMENT & MONITORING OF MEDICATION **INCIDENTS** 

Quarterly report produced and disseminated to front-line staff tracking and trending medication incidents including narratives.

Performance indicators established for:

- No. of incidents reported (increase in reporting from 2017 to 2018 by 32%)
- Reporter of incidents
- Category of harm
- Stage of medication use process where incidents have occurred

**EDUCATION** & TRAINING

- Regular face-to-face education sessions arranged with front-line staff (didactic and interactive/case-based)
- Quarterly medication safety bulletin devised and disseminated, informed by audit findings and incident reports.

- The successful 'Medication Safety Minute' initiative from St James's Hospital was adopted and implemented, content of which was informed by local incidents.

- Introduction of 'Drug Round Game' to support and improve effectiveness of education sessions

**DEVELOPMENT, UPDATING AND DISSEMINATION** 

- New IV drug administration guides (n=53) developed and updated
- Introduction of one-page 'Medicines Information Sheet' as quick reference guides for key topics (e.g. dose adjustment of Paracetamol, 'how & when to crush medications', Therapeutic Drug Monitoring)
- DOAC prescription and administration guide developed and circulated.

**Medication Safety OF PPPGS** Implementation of the 'Know, Check, Ask' campaign to

**AUDIT** 

-Audit programme established informed by incident analysis, complaints and bestpractice including introduction of an 'audit window' to gather hospital-wide data.

-The 'audit window' is where dispensary is brought to skeletal levels, and all Pharmacy staff are co-ordinated to gather hospital-wide data on various aspects of medication safety. This was considered an efficient method of gathering quality data in absence of clinical pharmacists at ward level

-Via this method, a number of audits have been completed such as 'missed dose audit', 'insulin storage and labelling', insulin prescribing & BGL monitoring, documentation of allergy & weight.

QUALITY **IMPROVEMENT** 

Informed by incident analysis, best-practice and audit findings, a number of moderate-high leverage quality improvement projects were initiated including:

-Removal of concentrated potassium from general clinical areas,

- -Introduction of an insulin & glucose monitoring record
- -Introduction of an automated dispensing cabinet for out-of-hours access to medication.



#### What next?

The structural aspects established for the Medication Safety Programme have been successful in establishing a programme in the hospital and are reproducible by other centres. Work continues in Connolly Hospital to identify themes of incidents, audit of practice and implementation of quality improvement initiatives.







