We will work with patients, healthcare professionals and organisations to ***reduce patient harm associated with medicines or their omission***

Safermeds Briefing

Update on the National Medication Safety Programme

May 2016

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Quality Improvement Division

National Medication Safety Programme

Ireland is uniquely poised to reduce the potential for patient harm from medicines or their omission. We have exemplars of best practice throughout the country, dedicated professionals focussed on medication safety, a wealth of high-quality research and a will to collaborate and improve.

> *"Medication errors pose the most significant significant risk to patient safety."*
> *Minister for Health Leo Varadkar at the Irish Patients' Association launch of the Pact for Patient Safety, July 2015*

The National Medication Safety Programme, "**Safermeds**", is one of the priority safety programmes within the HSE Quality Improvement Division. Using the HSE framework for improving quality (figure 1), we will work with patients, healthcare professionals and organisations to **reduce patient harm associated with medicines or their omission**. We will build on the excellent work already taking place locally to bring about greater improvement and reduced variation.

Figure 1: Framework for improving quality

Systematic approach to medication safety

In October 2015, the Irish Medication Safety Network (IMSN), Rotunda Hospital and HSE Quality Improvement Division hosted over 100 participants at the 'Institute for Safe Medication Practices (ISMP) Medication Safety Intensive' course in Dublin.

Acknowledging the pressures and constraints within services, the national programme fully endorses the recommendations from the ISMP for a systematic approach to risk-reduction, in particular:

- ✓ ensuring whole hospital commitment to improving medication safety, with support from management, pharmacy, medical and nursing leadership,
- ✓ having a medication safety team, comprising a medication safety facilitator (usually a pharmacist, ideally full-time), with input from a doctor and a nurse,
- ✓ ensuring the primary focus of the facilitator and team is to improve safety and systems, supporting professionals and patients to manage medicines safely.

Priorities for improvement

Improvement efforts, locally and nationally, should focus on the priorities below contributing to the greatest burden of patient harm.

✓ **Managing the risks of high-risk medication** ○ Highest impact: anticoagulants, NSAIDs, opioids, diuretics, antiplatelets, antimicrobials, insulin and hypoglycaemic drugs ○ Also high-risk: methotrexate, theophylline, digoxin, beta-blockers, chemotherapy, sedatives and contrast media
✓ **Improving medication safety at transitions in care** ○ Medication reconciliation at transitions to and from hospital ○ Improving access to patient medication record
✓ **Reducing polypharmacy and improving medication appropriateness**
✓ **Minimising acute kidney injury associated with medicines and modifying medicine choice and dosing in patients with acute or chronic renal impairment**

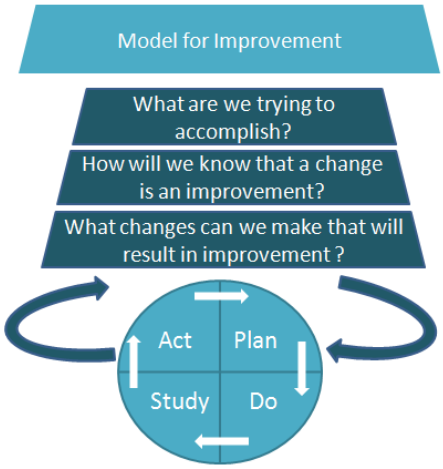
The Thromboprophylaxis Improvement Collaborative

The first Safermeds improvement collaborative will commence in September 2016. We will work with hospitals to support them in **improving thromboprophylaxis in hospital in-patients** to reduce venous thromboembolism (VTE).

This topic has been selected as:

- VTE is associated with a large burden of harm for hospitalised patients,
- Multi-site Irish research has identified that thromboprophylaxis for medical in-patients is not optimal,
- There is a strong evidence-base for reduce VTE risk in hospital in-patients,
- Successes achieved by some Irish hospitals to date could be shared,
- Interest in this area was expressed in our December 2015 survey and
- The project is feasible within a 12 month timeframe and as a collaborative.

The collaborative will utilise the Institute for Healthcare Improvement Breakthrough Collaborative Series methodology, based on the Model for Improvement (right).



More information on the collaborative will be available shortly and we will engage with hospitals in the next few months.

Conclusion

Reducing patient harm associated with medicines or their omission will require our concerted efforts locally and nationally over many years. We look forward to working with you in the upcoming improvement collaborative and in supporting you in your future efforts to improve patient safety.

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