Epsom and St Helier University Hospitals NHS Trust

St Helier Hospital and Queen Mary's Hospital for Children

Inspection report

Wrythe Lane
Carshalton
SM5 1AA
Tel: 02082962000
www.epsom-sthelier.nhs.uk

Date of inspection visit: 12 November 2020
Date of publication: 13/01/2021

Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**

Our findings

Overall summary of services at St Helier Hospital and Queen Mary's Hospital for Children

Inspected but not rated

Epsom and St Helier University Hospitals NHS Trust provide services to a population of approximately 490,000 people living across south west London and north east Surrey. The trust also provides more specialist services, in particular orthopaedic, renal and level two neonatal intensive care to a wider catchment area.

The trust has approximately 890 beds located across two acute locations; Epsom General Hospital which is located in Epsom and St Helier Hospital and Queen Mary's Hospital for Children which is located in Sutton.

The trust was last inspected in September 2019. It was rated Good overall, with Requires Improvement in Safe.

We conducted an unannounced, focused inspection of Medical care (including older people's care) across the trust as we had received information giving us concerns about the safety and quality of services.

These concerns involved the occurrence of three never events across the trust within a six month period. Two of these occurred at Epsom General Hospital, and the third at St Helier Hospital. The never events involved patients being administered medical air instead of oxygen. Never events are patient safety incidents that are wholly preventable and have the potential to cause serious patient harm or death.

We did not rate this service at this inspection. Although the previous rating of good remains, we found:

- Air flowmeters were not always removed from terminal units and stored in an allocated place when not in active use. Some air flowmeters were not always fitted with a labelled, moveable flap. We were concerned that this was not in line with instructions given in a national patient safety alert issued in 2016 and meant that patients could be accidently connected to medical air instead of oxygen.

We issued a letter of concern to the trust, outlining our concerns that there was an ongoing risk that patients could be administered medical air instead of oxygen. We asked the trust to provide an action plan on the mitigations in place, to ensure patients who were receiving oxygen were not accidently given medical air. We asked the trust to provide a policy on the administration of oxygen to patients. We also asked the trust to provide us with regular equipment audits to ensure that air flowmeters were being used correctly.

How we carried out the inspection

During the inspection we visited four wards across both hospitals. We interviewed six ward nurses as well as the chief nurse for the trust.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Medical care (including older people's care)

Inspected but not rated

We did not rate this service at this inspection. The previous overall rating of the trust remains as good. We found:

- Air flowmeters were not always removed from terminal units and stored in an allocated place when not in active use. We also found that some air flowmeters were not always fitted with a labelled, moveable flap. We were concerned that this was not in line with instructions given in a national patient safety alert issued in 2016 and meant that patients could be accidently connected to medical air instead of oxygen.

Is the service safe?

Inspected but not rated

We did not rate this service at this inspection. The previous rating of requires improvement remains. We found:

- The Acute Medical Unit used piped medical air for the administration of nebulisers. However, we did not find evidence of air flowmeters left in wall outlets, whilst patients were not being actively administered nebulisers.
- Following the onsite inspection, the chief executive informed us that the trust agreed for the period of the COVID-19 pandemic within medical and emergency areas, for those patients requiring nebulised treatment, air flowmeters would remain in the airport for the duration of the patient's prescription. The trust considered that this decision, balanced against the risk of nursing COVID-19 patients within their challenged estate, was the right mitigation.
- The chief nurse told us that air flowmeters were left in the wall during a patient's admission if they were prescribed nebulisers frequently, for example four times a day. We were told that this was because it would be time consuming for staff to remove and insert the air flowmeter between doses of nebulisers. We were told by senior leaders that following a risk assessment of the trust policy, changes to this practice would introduce additional risk. This was not in line with the patient safety alert directive. Senior leaders informed us that staff removed the air flowmeters between doses of nebulisers, if patients were on less frequent doses, for example twice a day.
- However, during the inspection we spoke with six trained nurses across both hospitals. Four nurses told us that the air flowmeters stayed attached to the wall at all times during a patient's stay and were never removed between doses of nebulisers. Two nurses told us that the air flowmeters were removed between doses of nebulisers. This meant that there was inconsistency across the trust as to how the air flowmeters were to be used.
- We found that some air flowmeters were not always fitted with a labelled, moveable flap. We found three air flowmeters in the store room on the Acute Medical Unit that did not have moveable flaps attached. The chief nurse told us these were old and were discarded immediately after our visit. We were concerned that air flowmeters without labelled, moveable flaps was not in line with instructions given in a national patient safety alert issued in 2016 and meant that patients could be accidently connected to medical air instead of oxygen.
- Following the inspection, the chief executive sent us the trust's policy on Safe Management and use of Medical Gases. This policy outlined the trust's process for managing the risk of the wrong medical gas being administered to patients. We asked for and received copies of audits of the safety of air flowmeters for November 2020. We have asked for these audits to be submitted to us on a monthly basis.

Medical care (including older people's care)

Areas for improvement

- Where air flowmeters are left in wall outlets during a patient’s admission, the trust should have documented individual risk assessments for why this is necessary.
- The trust should remove all air flowmeters that do not have labelled, moveable flaps.
- The trust should continue to undertake regular audits on the use of air flowmeters across the trust.

Our inspection team

The team that inspected the service comprised an Inspection Manager, a CQC lead inspector, and another CQC inspector. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.