Queen Alexandra Hospital

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Ratings

Overall rating for this hospital

Are services safe?	
Are services effective?	
Are services well-led?	

Summary of findings

Overall summary of services at Queen Alexandra Hospital

We carried out a short notice announced focused inspection of medicines management in response to increasing concerns highlighted by the incidents reported through national reporting systems and received by direct notification from the trust.

There had been two reported never events relating to wrong route administration of medicines and a series of medicines related discharge incidents had been reported.

Following the most recent inspection, published in January 2020, there was a should action relating to the adequate storage of medicines to avoid medicines errors in the medical care core service. We had found some inner locked controlled drug cupboards were untidy and controlled drugs were mixed with expired stocks and patients own medicines.

Following the inspection published in January 2020 we had not received evidence that showed clear action had been taken to address the concerns raised regarding medicines management in the report.

During this inspection we used our focused inspection methodology to look at medicines management across the hospital. We did not cover all key lines of enquiry and we have not rated this service.

We visited a selection of departments in order to review processes and confirm understanding of medicines management with staff.

We have reported our findings and evidence in relevant core service sections. Where evidence, for example trust governance processes, goes across core services we have reported these in the medical care section only.

During our inspection of 15 July 2020, we visited respiratory wards E7/E8, elderly care wards G1/G2/G3/G4 and C6, surgical ward E2, the acute medical unit and the emergency department (both adult and paediatric departments).

We spoke with 27 members of staff at all levels including nurses, ward managers, practice educators, matrons, pharmacists and pharmacy managers. We also looked at documentation including; patient medicine charts, incident records, quality audits and trust policies and procedures. During the inspection we also spoke with four patients.

After the onsite inspection we interviewed the chief pharmacist using remote video conference technology.

Due to risks associated with Covid-19, we did not visit any areas of the hospital where patients with Covid-19 were being treated.

During this inspection we found improvements regarding medicines management, safe storage of controlled drugs and patients own medicines.

We found:

- Staff described the induction process which encompassed medicines management.
- Pharmacy staff embedded within ward teams and wards.
- Improved storage of medicines, including patients own medicines.
- Improved availability of consumables to aid safe administration of medicines.
- Improvements with the management and storage of discharge medications.
- Patients told us drug rounds took place on time.

Summary of findings

- Incidents were reviewed and learning from recent medication incidents had been shared across the whole trust.
- We saw an open culture with staff of different grades able to challenge each other and confirm medicine related queries.
- Nursing and pharmacy leaders described improved and developing governance arrangements regarding medicines management, thematic reviews and safety.

However, there were some areas for improvement:

- We saw variable adherence to trust policy regarding the security of keys for drug cabinets.
- Staff reported the design and format of medicine charts made it challenging to sign and date the charts as required by trust policy.
- We found there was an inconsistent approach across the trust relating to medicines and the discharge process.
- We saw examples of poor compliance with prescribing and nurse record-keeping best practice on insulin charts.
- We found a reactive approach to medicine related incidents and associated learning across the trust.
- In one department we found a discrepancy with the recording of internal prescription forms.

We also saw examples of good practice:

Practice educators, employed by the trust, had developed and delivered both planned and ad hoc training to staff with regard to medicines management and administration. This included medicines management training for groups of patients that required specialist knowledge and skills to maintain good quality care.

Urgent and emergency services

Summary of this service

Urgent and emergency services are provided by the trust at Queen Alexandra Hospital. The department is open 24 hours a day, seven days a week, with consultant-led emergency care and treatment provided from 8am to 12 midnight, seven days a week to people across the city of Portsmouth and south east Hampshire.

The department has a four-bay resuscitation area, with one bay designated for children. There are two major treatment areas and a separate 'pit stop' assessment area with six trolleys and four chairs.

There is a nine-bed emergency decision unit. This area comprises of two four-bed bays and a single-bed sideroom. The area is used for patients who are unlikely to require admission but who require short term observation or are waiting for test results.

Is the service safe?

Mandatory Training

The emergency department and acute medical unit provided mandatory training in key skills to all staff and made sure everyone completed it.

Matrons and nursing managers described systems and processes for training staff in medicines management and safety. Newly qualified nurses we spoke with were aware of the trust medicines related policies and where to find them for future reference.

Nursing managers described the induction process relating to medicines management. The induction took place over a 3-month period and covered: local induction, medicines induction, insulin training and administration skills, drug calculations, oral medicines administration competencies, anaphylaxis, a medicines competency check and skills assessment.

Once the initial induction had been completed nurses are then able to undertake intravenous (IV) administration training and assessment (at approx. 6 months). The IV training was described as a mixture of face to face study days, on the job shadowing and supervision.

Staffing

The emergency department and acute medical unit had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Nursing staff we spoke with told us they did not feel understaffed or under pressure due to current staffing levels. There was reduced activity within the department due to COVID-19. Nurse managers and nursing staff told us the reduced activity had enabled them to manage staff levels more effectively. Our observations of staffing levels in the department during this inspection confirmed this to be the case.

Medicines

The emergency department and acute medical unit used systems and processes to safely prescribe, administer, record and store medicines.

Medicines we checked in the emergency department were labelled clearly, segregated and were in date. Daily stock checks of controlled drugs were in place and these were correctly noted in the controlled drugs register. This was in accordance with trust policy.

Urgent and emergency services

The trust reported two never events relating to the wrong route administration of medication; one of which related to a controlled drug. One of the contributory factors identified was the lack of the correct consumables to enable safe administration. During this inspection, we saw the department had a sufficient supply of consumables to aid safe administration. The items were clearly labelled, stored and segregated.

An emerging theme and concern from reported incidents related to errors with medications being sent home with discharged patients, these are called 'to take out' medications.

In addition, incidents had been reported with the safe storage of patients own drugs which have been prescribed outside of the hospital. These are medications patients bring into hospital with them when they are admitted as an inpatient.

We checked 'to take out' medicines for patients awaiting discharge, these contained the required prescribed medicines for the individuals. These included patients own drugs held in the department and those previously dispensed to patients during admission.

Nursing staff described improvements made following the last inspection to medicines organisation and storage. Staff reported the pharmacy service was effective and pharmacy staff were an integral part of the team. The pharmacy staff attended morning handovers, met with nurse managers to plan discharges and offered training to nursing staff. They also undertook prompt medicines reconciliation in line with trust policy, together with clinical screening of prescribing and arranging medicines for 'to take out'. Where required, pharmacy staff would provide counselling to patients prior to discharge regarding their medications.

Pre-printed 7 day nursing care plans were used across the trust and included a prompt for medication upon transfer or discharge. It was noted these lacked detail as to the criteria to be covered when dealing with discharge medications.

We reviewed the trust discharge and medicines policies. The discharge policy had limited mention of medicines at discharge, and no set criteria for checking them. The medicines policy contained detail about the supply of discharge medication. Through discussion with staff, we found understanding and awareness of the details contained of the policy were not embedded. The lack of a formalised approach had resulted in variability in the discharge process across the trust. We saw some areas of good practice; for example, some wards reported they had developed prompts or checklists for checking discharge medicines, but this activity was not coordinated and these were not widely shared.

In the areas inspected in the emergency department we saw patient's own controlled drugs were logged in a register and kept securely in a separate controlled drugs cupboard. However, there was less secure arrangements for the management of patient 's own drugs. Patient 's own drugs were not always recorded or securely stored, with the exception of controlled drugs, which were logged as above. In some areas we found patient own drugs were left with the patient until reaching their 'onward destination' within the hospital. There was no apparent risk assessment to this approach to ensure other patients in the department could not access these medicines, or to manage potential self-administration. We highlighted this concern to the trust during our inspection. Information from the trust received after the inspection shows they reviewed the situation and had introduced mitigations to address safe storage of patient's own medicines in the emergency department.

We reviewed resuscitation trolleys and found them to be accessible and secure. At the last inspection we found resuscitation trolleys were not secure which led to concerns regarding security of medications stored in them. During this inspection we saw the trust had replaced the resuscitation trolleys. The new style trolleys improved storage, accessibility and security. We also saw records detailing weekly visual inspection and monthly internal inspection and re 'tagging' using tamper evident tags.

Urgent and emergency services

Throughout the emergency department, with the exception of emergency department observation area, when medicine trollies were not in use they were locked and secured to the wall. We saw evidence medical refrigerators were being managed in line with trust policy. Nothing other than medicines were contained within them, they were clean and frost free with the regular monitoring of temperatures.

We did not see excessive quantities of medicines waste and waste was segregated and stored in locked rooms. In the emergency department 'pitstop' waste medicines were placed in a pharmaceutical waste bin, as used across the trust, however the bin was open with no lid and in a public area which could be a potential risk. We were advised by the nurse in charge that this area was manned 24/7 by reception staff. After the inspection the trust confirmed they had removed the waste bin to a secure location and a risk assessment carried out.

We checked the storage of internal prescription documentation, known as FP10s. These are individually identifiable and should be logged and stored securely. In the acute medical unit, we found discrepancies with the log which suggested five FP10 prescription forms were missing. We highlighted this to the department and the trust at the time of the inspection who immediately commenced a review. After the inspection the trust confirmed this was due to an administrative error and the FP10s had been located and accounted for.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team. They were beginning to share learning across the wider service. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff we spoke with were aware of incidents reported and could describe learning that had been identified and shared. The trust created 'Watch Out' posters to alert and educate staff on key issues. We saw 'Watch Out' posters were clearly visible in relevant places such as treatment rooms, as a reminder to staff.

One of the reported never events had occurred in the emergency department. All staff we spoke with were aware of the incident and could describe the learning from both this and the other reported never event.

Matrons told us there were regular weekly meetings where reported incidents were reviewed. These meetings were attended by divisional matrons. We reviewed minutes from the meetings which demonstrated medicine incidents were reviewed and discussed.

Pharmacy leads told us divisional pharmacists were included in the reviews of incidents reported, to aid collaborative working in medicines safety management.

Medicine administration incidents and learning were managed in a supportive and reflective way. Managers told us staff were offered additional training and supervision, renewed competency assessment and where required further shadowing. Nursing staff we spoke with confirmed this took place.

Is the service well-led?

Managing of risks, issues and performance

Leaders and teams used systems to manage performance however they were often reactive to medicines related issues rather than proactive. They were beginning to identify and escalate relevant risks and issues.

Although the trust had systems to manage and review risk and performance, there was insufficient evidence to confirm the trust demonstrated a proactive approach to quality improvement regarding medicines. We saw evidence to demonstrate the trust was reactive to incidents that required attention.

Urgent and emergency services

Staff described, and we saw, some innovative practices being implemented within the emergency department and acute medical unit, for example ‘watch out’ stickers, ‘pegging’ medicine charts with changes and nurse led discharge. However, we found these innovations were not being openly shared and considered more widely across the trust.

Managers within both the emergency department and acute medical unit reported monthly governance meetings, there was evidence as to the output of these meeting within the department in the form of action posters for dissemination to staff.

Medical care (including older people's care)

Summary of this service

Medical services at Portsmouth Hospitals NHS Trust provides care and treatment for acute nephrology, audiology, cardiology, gastroenterology, general medicine, neurological rehabilitation, acute older people's care, respiratory medicine and stroke medicine. There are 580 medical inpatient beds located across 24 wards at Queen Alexandra Hospital.

Is the service safe?

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Matrons and ward managers described systems and processes for training staff in medicines management and safety. Newly qualified nurses we spoke with were aware of the trust medicines related policies and where to find them for future reference.

Ward managers described the induction process relating to medicines management. The induction took place over a 3-month period and covered: local induction, medicines induction, insulin training and administration skills, drug calculations, oral medicines administration competencies, anaphylaxis, a medicines competency check and skills assessment.

Once the initial induction had been completed nurses were then able to undertake intravenous (IV) administration training and assessment (at approximately 6 months). The IV training was described as a mixture of face to face study days, on ward shadowing and supervision.

Data provided by the trust after the inspection showed nurse compliance with medicines management training, within the Medicine and Urgent Care division, was 91% (July 2020).

The trust confirmed IV training was not recorded as a mandatory requirement on their training record. However, data supplied showed 165 nurses, out of 381 within the Medicine and Urgent Care division, had completed IV competency training.

Staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. It gave bank and agency staff a full induction before they worked on a given ward. However, there was a gap in pharmacy staffing which was created by a combination of vacancies and sickness.

Nursing staff we spoke with told us they did not feel understaffed or under pressure because of staffing levels. There was reduced activity within some departments/wards in the hospital due to COVID-19. Nurse managers and nursing staff told us the reduced activity had enabled them to manage staff levels more effectively. Our observations of staffing levels on wards visited during this inspection confirmed this to be the case.

We saw pharmacists on the wards we visited both supporting nursing teams and speaking with patients. However, pharmacy staff we spoke with reported that there was a gap in staffing which was due to a combination of vacancies and sickness. Some pharmacy staff told us this did have an impact on the level of support provided to wards, although they described how cover was arranged to ensure all wards had some pharmacy support.

The trust used a dispensing system within the ward to reduce the time it took to process prescriptions and to reduce medication errors. This meant pharmacy staff were based on, or near to wards, rather than in a central pharmacy department. Effective systems have been shown to improve turnaround times with dispensing. However, staff told us the lack of accredited checking technicians meant the near patient dispensing systems did not operate as effectively as they could.

Pharmacy managers told us business cases for additional pharmacy posts were being reviewed for submission for approval. The trust had plans to implement an electronic prescribing and medicines administration (EPMA) tool in the coming months. It was envisaged that the implementation of EMPA would alleviate certain risks and pressures, allowing the triage and focus of pharmacy staff.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

The last inspection noted a concern regarding the storage of medicines on wards. During this inspection we found improvements in the storage of medicines. Staff were proactively managing the available cupboard space for the safe storage of medicines and controlled drugs. Medicines we checked were labelled clearly, segregated and were in date.

Daily stock checks of controlled drugs were in place for all wards visited and these were correctly noted in the controlled drugs register. This was in accordance with trust policy.

The trust reported two never events relating to the wrong route administration of medication; one of which related to a controlled drug. One of the contributory factors identified was the lack of the correct consumables to enable safe administration. During this inspection, on all the wards we visited, we saw each ward stored a sufficient supply of consumables to aid safe administration. The items were clearly labelled, stored and segregated across all wards.

An emerging theme and concern from reported incidents related to errors with medications being sent home with discharged patients. Medicines sent home with patients are called 'to take out' medications.

In addition, incidents had been reported with the safe storage of 'patients own drugs'. Patients own drugs are medications patients bring into hospital with them when they are admitted as an inpatient.

We checked 'to take out', including patients own drugs for patients awaiting discharge. All 'to take out' we reviewed were accurate and contained all medications required for the patient being discharged and no erroneous medicines.

Ward staff described improvements made following the last inspection to medicines organisation and storage. Ward staff reported the pharmacy service was effective and pharmacy staff were an integral part of the ward team. The pharmacy staff attended morning handovers, met with ward sisters to plan discharges and offered training to nursing staff. They also undertook prompt medicines reconciliation in line with trust policy, together with clinical screening of prescribing and arranging medicines for 'to take out'. Where required, pharmacy staff would provide counselling to patients prior to discharge regarding their medications.

Pre-printed 7-day nursing care plans were used across the trust and included a prompt for medication upon transfer or discharge. It was noted these lacked detail as to the criteria to be covered when dealing with discharge medications.

We reviewed the trust discharge and medicines policies. The discharge policy had limited mention of medicines at discharge, and no set criteria for checking them. The medicines policy contained detail about the supply of discharge medication. Through discussion with staff, we found understanding and awareness of the details contained of the policy were not embedded. The lack of a formalised approach had resulted in variability in the discharge process across the trust. We saw some areas of good practice; for example, some wards reported they had developed prompts or checklists for checking discharge medicines, but this activity was not coordinated and these were not widely shared.

We saw safe storage of patients own drugs on the wards. We saw controlled drugs were logged in a register and stored securely in a separate controlled drugs cupboard. Other patients own drugs were stored in lockable cabinets at the patient bedside.

We observed drug rounds and staff demonstrated good practice relating to: verification of patient identification by name and date of birth; allergy status confirmation, medicine and dose confirmation with patients prior to administration, obtaining consent prior to administration of injectables and administration.

Patients we spoke with told us drug rounds were usually on time. They also said time was taken for each patient and nurses would talk them through what was being administered and answered any questions.

Management of time sensitive medicines was variable from ward to ward and there did not appear to be a standardised mechanism in place to ensure that patients routinely received their time sensitive medicines at the prescribed time. Nurses we spoke with, each had their own way of remembering which time sensitive doses are due. However, after reviewing medicine charts, we found no documented concern in the administration timings of medicines.

Staff reported that the format of the medicine charts made it difficult to record the timings of regular medicines. For example, there was limited space on the chart to record when a dose of regular paracetamol had been administered late due to the medicines round being delayed. Feedback from nursing staff also identified the forms did not provide space to counter sign where trust policy requires, for example controlled drugs.

We noted areas of good practice. Specialist nurses were available 'on call' across the trust to support patient education of high-risk medicines. Training would also be provided where the patient received additional support from a relative or friend. The high-risk medicines included anticoagulants and insulin. Where it was felt that such medicines cannot be safely managed upon discharge, nursing staff were able to make referrals to community nursing teams to support patients in their own homes.

We reviewed resuscitation trolleys and found them to be accessible and secure. At the last inspection we found resuscitation trolleys were not secure which led to concerns regarding security of medications stored in them. During this inspection we saw the trust had replaced the resuscitation trolleys. The new style trolleys improved storage, accessibility and security. We saw the new trolleys on all the wards visited. We also saw records detailing weekly visual inspection and monthly internal inspection and re 'tagging' using tamper evident tags.

When medicines trollies were not in use, they were locked and secured to the wall.

We saw evidence most medical refrigerators on medical wards were being managed in line with best practice. There was nothing other than medicines contained within them, they were clean and frost free with the regular monitoring of temperatures. However, we found there was no clear system which enabled staff to check what should be contained within each refrigerator. For example, we saw on ward G3 there was a list of medications contained within the refrigerator but no stock list.

Overall the management of waste medicines on wards we visited was in line with trust policy. We did not see excessive quantities of waste and waste was segregated and stored in locked rooms.

We saw all staff following trust policy when handling controlled drugs, preparing them for administration and when giving to patients. However, we saw some nurses preparing controlled drugs and they told us they were unaware of recordkeeping requirements with regard to noting errors made. We saw errors being crossed out which does not follow national guidance. When asked, staff stated they were aware of the trust's controlled drugs policy and where to find it.

We observed key security for controlled drugs cabinets did not follow the trusts policy in all departments we visited. The policy states keys should be kept separated from others key and/or kept with the nurse in charge. However, we saw variable adherence with the management of the keys on all wards visited.

Incidents

Medical care (including older people's care)

Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team. They were beginning to share learning across the wider service . Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff we spoke with were aware of incidents reported and could describe learning that had been identified and shared. The trust created 'Watch Out' posters to alert and educate staff on key issues. We saw 'Watch Out' were clearly visible in relevant places such as treatment rooms on wards, as a reminder to staff.

Matrons told us there were regular weekly meetings where reported incidents were reviewed. These meetings were attended by divisional matrons. We reviewed minutes from the meetings which demonstrated medicine incidents were reviewed and discussed.

Pharmacy leads told us divisional pharmacists were included in the reviews of incidents reported, to aid collaborative working in medicines safety management.

Medicine administration incidents and learning were managed in a supportive and reflective way. Managers told us staff were offered additional training and supervision, renewed competency assessment and where required further shadowing. Nursing staff we spoke with confirmed this took place.

Is the service effective?

Pain Relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

During our inspection of medicines management we reviewed the timeliness of medication rounds carried out by nursing staff.

We observed each ward had multiple drug trollies which enabled medications to be given concurrently on the wards. Staff giving medications were allocated the role as part of the shift rota and were not disturbed during the rounds.

At the time of our inspection we saw rounds completed in a timely manner which meant patients received their medication and pain relief when they should. We reviewed medicine charts which confirmed pain relief was given within the required timeframe.

Competent Staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Ward managers and practice educators described how they managed staff competency. They told us where additional training needs were identified they would arrange training.

Practice educators described some innovative strategies for updating staff on safety alerts and changes in trust processes. One educator told us they used a 'trolley dash' around the wards where they gave quick updates to staff on wards. Staff reported these worked well as they enabled training to be accessed easily and they told us they remembered the message more effectively.

Is the service well-led?

Culture

Medical care (including older people's care)

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us, and we saw, they were empowered to raise and address concerns. We observed a newly qualified nurse preparing an intravenous antibiotic for infusion. The nurse wasn't satisfied that the dose on the medicine chart was correct for the patients weight. We saw the nurse was able to openly discuss the concern with the prescribing doctor and clarify the intravenous dose required before administering the medicine.

Governance

Leaders were developing governance processes , throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Matrons described regular meetings had commenced, attended by divisional matrons, where medicine related incidents were an agenda item for review and discussion. We reviewed minutes of these meetings which confirmed the discussions took place.

Pharmacy leaders described how work had begun to review medicine related incidents on a thematic basis. The themes being looked at included insulin and anticoagulant prescribing. We were told the output from these reviews would be fed into quality improvement projects.

Pharmacy leaders and staff described positive developments with regard to medicines management across the trust. The pharmacy team undertook monthly medicines reconciliation audits. It was the intention for these audits to become more focused and responsive to emerging themes. For example, a previous focus was oxygen prescribing which resulted in a decrease in issues reported and harm.

The patient discharge process was variable across the trust. There was no formalised or documented set of responsibilities for nursing staff when discharging patients. Nurse managers told us nursing staff, responsible for discharging patients, were aware of the expectations of them and this included medications. However, this expectation was not formalised within the discharge policy or the medicines and controlled drugs policy.

Staff described areas of individual good practice on a number of wards by the way of prompt sheets and checklists. Although some of these are specifically related to certain specialties, we noted this good practice had not been shared across the divisions.

Managing of risks, issues and performance

Leaders and teams used systems to manage performance however they were often reactive to medicines related issues rather than proactive. They were beginning to identify and escalate relevant risks and issues.

Although the trust had systems to manage and review risk and performance, there was insufficient evidence to confirm the trust demonstrated a proactive approach to quality improvement regarding medicines. We saw evidence to demonstrate the trust was reactive to incidents that required attention.

We saw that leaders across divisions and between wards did not always work together to address quality improvement. However, we were told cross divisional working was improving. Matrons described regular meetings which took place to review key themes, including: leadership, safety and reported incidents. Each meeting was chaired by a representative from different a division and had a set agenda.

Medical care (including older people's care)

Both ward staff and pharmacy staff were positive regarding the move to base pharmacy staff on wards. This was primarily in response to the Covid-19 situation. However, both nursing and pharmacy teams told us the change had made positive impact on the management of medicines. Nursing staff told us it was easier and quicker to access the pharmacy team for help and guidance. Pharmacy staff told us being on the wards made it easier to be responsive to requests from the nursing and medical teams.

Ward managers reported monthly governance meetings, there was evidence as to the output of these meeting on wards in the form of action posters for dissemination to the wards' staff.

Areas for improvement

The trust should:

- Assure themselves staff adhere to trust policy regarding the handling and management of keys for controlled drugs cabinets.
- Assure themselves staff document record keeping errors in the controlled drug register in line with trust policy.
- Assure themselves prescribers adhere to trust policy regarding completion and revision of prescriptions.
- Consider reviewing discharge processes used across the trust in relation to medicines to develop and document a consistent approach.
- Consider how the design of prescription charts affects staff ability to complete them in line with trust policy.

Surgery

Summary of this service

Portsmouth Hospitals NHS Trust provides district general hospital surgical services at the Queen Alexandra Hospital. The surgical specialties offered at the hospital are colorectal, urology, breast and plastics, lower and upper gastrointestinal, vascular surgery, bariatric and general surgery.

The trust is an orthopaedic centre, providing elective and emergency trauma surgery, with the head and neck clinical service centre at the trust also providing ophthalmic (eye) surgery, dental, maxillo-facial and oral surgery.

Is the service safe?

Staffing

We visited ward E2 which had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Nursing staff we spoke with told us they did not feel understaffed or under pressure because of staffing levels. There was reduced activity within some departments/wards in the hospital due to COVID-19. Nurse managers and nursing staff on the ward told us the reduced activity had enabled them to manage staff levels more effectively and our observations of staffing levels during the inspection confirmed this.

Medicines

We visited ward E2 which used systems and processes to safely prescribe, administer, record and store medicines.

The last inspection noted a concern regarding the storage of medicines on wards. During this inspection we found improvements in the storage of medicines. Across most wards we visited there was adequate cupboard space for the safe storage of controlled drugs. Medicines we checked were labelled clearly, segregated and were in date.

The controlled drugs cupboard on ward E2 was a small, single cupboard and staff reported this made it challenging to store medicines effectively. However, the ward staff had raised the concern and put this on the ward risk register. To mitigate any issues, the ward staff worked with the pharmacy team to keep the stock levels to a minimum. All the other wards we visited had double cupboards for the storage of controlled drugs.

We observed key security for controlled drugs cabinets did not follow the trusts policy in all departments we visited. The policy states keys should be kept separated from others key and/or kept with the nurse in charge. However, we saw variable adherence with the management of the keys on all wards visited.

Daily stock checks of controlled drugs were in place for all wards visited and these were correctly noted in the controlled drugs register. This was in accordance with trust policy.

The trust reported two never events relating to the wrong route administration of medication; one of which related to a controlled drug. One of the contributory factors identified was the lack of the correct consumables to enable safe administration. During this inspection, we saw ward E2 had a sufficient supply of consumables to aid safe administration. The items were clearly labelled, stored and segregated.

An emerging theme and concern from reported incidents related to errors with medications being sent home with discharged patients. Medicines sent home with patients are called ‘to take out’ medications.

In addition, incidents had been reported with the safe storage of ‘patients own drugs’. Patients own drugs are medications patients bring into hospital with them when they are admitted as an inpatient.

Surgery

We checked 'to take out', including patients own drugs for patients awaiting discharge. All 'to take out' we reviewed were accurate and contained all medications required for the patient being discharged and no erroneous medicines.

As noted on the medicines wards, ward staff described improvements made following the last inspection to medicines organisation and storage. Ward staff reported the pharmacy service was effective and pharmacy staff were an integral part of the ward team. The pharmacy staff attended morning handovers, met with ward sisters to plan discharges and offered training to nursing staff. They also undertook prompt medicines reconciliation in line with trust policy, together with clinical screening of prescribing and arranging medicines for 'to take out'. Where required, pharmacy staff would provide counselling to patients prior to discharge regarding their medications.

Pre-printed 7-day nursing care plans were used across the trust and included a prompt for medication upon transfer or discharge. It was noted these lacked detail as to the criteria to be covered when dealing with discharge medications.

We reviewed the trust discharge and medicines policies. The discharge policy had limited mention of medicines at discharge, with no set criteria for checking. The medicines policy contained more detail regarding the supply of discharge medication. However, through discussion with staff, we found understanding and awareness of the details contained within the policy was not embedded. The lack of a formalised approach has resulted in variability of the discharge process across the trust. We saw some areas of good practice and a number of wards reported developing prompts or checklists for this purpose, however these were not widely shared.

We saw safe storage of patients own drugs on the ward. We saw controlled drugs were logged in a register and stored securely in a separate controlled drugs cupboard. Other patients own drugs were stored in lockable cabinets at the patient bedside.

Medicine charts we reviewed reflected that medicines had been administered safely and effectively, however policy and best practice were not always followed. Management of time sensitive medicines was variable from ward to ward and there did not appear to be a standardised mechanism in place to ensure that patients routinely received their time medicines at the prescribed time. Nurses we spoke with, each had their own way of remembering which time sensitive doses are due, of the medicine charts reviewed. However, after reviewing medicine charts, we found no documented concern in the administration timings of medicines.

We reviewed an insulin chart of a surgical patent. This was for a long acting insulin for administration once daily, which should be administered at the same time each day. It was evident from the time recorded blood glucose monitoring undertaken each day, that this was being administered at the same time, however the intended time was not recorded in the prescribing or administration details. In addition, there had been an alteration from a fixed dose to a variable dose range, good practice would dictate that this would be rewritten and signed by the prescriber. Trust policy states when a dose needs to be changed, the trust requires doctors to completely rewrite the prescription to avoid misinterpretation, this had not occurred.

We noted areas of good practice. Specialist nurses were available 'on call' across the trust to support patient education of high-risk medicines such as anticoagulants and insulin to ensure safe administration by patients, or where the patient receives additional support from a relative or friend. Where it was felt that such medicines cannot be safely managed upon discharge nursing staff were able make referrals to community nursing teams to support patients in their own homes.

We reviewed resuscitation trolleys and found them to be accessible and secure. At the last inspection we found resuscitation trolleys were not secure which led to concerns regarding security of medications stored in them. During this inspection we saw the trust had replaced the resuscitation trolleys. The new style trolley improved storage, accessibility and security. We also saw records detailing weekly visual inspection and monthly internal inspection and re 'tagging' using tamper evident tags.

When medicines trollies were not in use, they were locked and secured to the wall.

Surgery

Overall the management of waste medicines on the ward was in line with trust policy. We did not see excessive quantities of waste and what we saw was segregated and stored in a locked room in accordance with trust policy.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team. They were beginning to share learning across the wider service. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff we spoke with were aware of incidents reported and could describe learning that had been identified and shared. The trust created 'Watch Out' posters to alert and educate staff on key issues. We saw 'Watch Out' were clearly visible in relevant places such as treatment rooms on wards, as a reminder to staff.

Matrons told us there were regular weekly meetings, where reported incidents were reviewed. These meetings were attended by divisional matrons. We reviewed minutes from the meetings which demonstrated medicine incidents were reviewed and discussed.

Pharmacy leads told us divisional pharmacists were included in the reviews of incidents reported, to aid collaborative working in medicines safety management. The pharmacy department had developed training aids to address specific incidents such as patients being discharged with incorrect 'to take out' medications. We saw examples of the training aids which demonstrated clear communication across the hospital.

Medicine administration incidents and learning were managed in a supportive and reflective way. Managers told us staff were offered additional training and supervision, renewed competency assessment and where required further shadowing. Nursing staff we spoke with confirmed this took place.

Within the surgical division, we were told of learning events held every 6 months. The learning need for each session was identified by the nursing staff and comprised of face-to-face session and discussion, followed by an audit.

Is the service effective?

Pain Relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

During our inspection of medicines management we reviewed the timeliness of medication rounds carried out by nursing staff.

We observed each ward had multiple drug trollies which enabled medications to be given concurrently on the wards. Staff giving medications were allocated the role as part of the shift rota and were not disturbed during the rounds.

At the time of our inspection we saw rounds completed in a timely manner which meant patients received their medication and pain relief when they should.

Competent Staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Ward managers and practice educators described how they managed staff competency with regard to medicines management. They told us where additional training needs were identified they would arrange training. For example, this included specific training for administering intravenous medicines.

For example, at the time of the inspection the surgical ward E2 were accepting patients who had different surgical procedures than they were used to. Practice educators arranged training for nurses in how to care for these patients in advance of their admission. Where this wasn't possible, for example for an emergency admission rather than elective, specialist nurses or the outreach team (ITU nurse led service) would be called for immediate assistance.

Practice educators described some innovative strategies for updating staff on safety alerts and changes in trust processes. One educator told us they used a 'trolley dash' around the wards where they gave quick updates to staff on wards. Staff reported these worked well as they enabled training to be accessed easily and they told us they remembered the message more effectively.

Our inspection team

The team that inspected the service comprised a CQC lead inspector supported by a medicines inspector, an Inspection Manager, and a specialist advisor with expertise in governance, nursing and medicines management.

The inspection was overseen by Catherine Campbell, Head of Hospital Inspection (South East Region).