Walsall Healthcare NHS Trust

Manor Hospital

Inspection report

Moat Road
Walsall
WS2 9PS
Tel: 01922721172
www.walsallhospitals.nhs.uk

Date of inspection visit: 20 June 2023
Date of publication: 15/09/2023

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Inspected but not rated**

Our findings

Overall summary of services at Manor Hospital

Requires Improvement 

Walsall Healthcare NHS Trust provides local general hospital and community services to around 260,000 people in Walsall and the surrounding areas. The trust is the only provider of NHS acute care in Walsall, providing inpatients and outpatients at the Manor Hospital, as well as a wide range of services in the community. Manor Hospital has 554 acute beds (501 overnight beds and 53-day case beds) and provides a wide range of services including a 24-hour accident and emergency department and maternity services.

Walsall Healthcare NHS Trust is working in collaboration with another NHS trust with the leadership of a joint chair and chief executive.

On 20 June 2023, we carried out an unannounced focused inspection of the medicine core service (including older peoples care) provided by the trust. We needed to follow up a Section 29a Warning Notice, issued to the trust in October 2022, as we found significant improvement was required in the safe management of medicines. This included prescribing, administration, recording and storage, within medical services. We visited the following wards: the Acute Medical Unit, wards 1, 2,17 and 29.

We did not inspect any other services at Walsall Healthcare NHS Trust because our monitoring process had not highlighted any further concerns and the trust had not had sufficient time to address all the requirements made at our last inspection. We will re-inspect other services as appropriate.

We inspected but did not rate the safe domain, we did not inspect effective, caring, responsive and well led.

Our rating of Manor Hospital stayed the same. We rated them as requires improvement.

- Whilst the service had made some improvement in the safe management of medicines, further improvement was required.
- Staff did not always follow systems and processes to prescribe and administer medicines safely.
- Staff did not always complete medicines records accurately and keep them up to date.
- Staff did not always follow national practice to check patients had the correct medicines when they were admitted, or when they moved between services.

However

- Staff mostly stored and managed medicines safely.
- Staff learned from safety alerts and incidents to improve practice.

Medical care (including older people's care)

Inspected but not rated

We did not rate this inspection. The previous rating remains

- Whilst the service had made some improvement in the safe management of medicines further improvement was required.

Is the service safe?

Inspected but not rated

Medicines

Staff did not always follow systems and processes to prescribe and administer medicines safely. Prescriber's instructions on prescription charts were not always clear which increased the risk of a medicine error. An instruction to administer a medicine as 'IV' (intravenous) was crossed through and changed to 'PO' (oral). The date of the change was not recorded, and it was not possible to know from the records if the medicine had been given IV or orally.

Prescribers were not always clearly identifying themselves and were not printing their name next to their signature or printing their General Medical Council number. This is important to ensure records show the name of the prescriber.

Prescribed medicines were not always available to administer to patients. Inhalers (those used to prevent a patient having breathing difficulties) were not available for 4 patients. We were told that patients were encouraged to use their own inhalers, however, the process to obtain these medicines if they were not available was not always followed. For example, 1 patient had not had their inhaler (used to control wheezing and shortness of breath) for 6 days. Not having medicines as prescribed increases the risk of harm to patients.

Following our inspection the trust told us they would ensure inhalers of all types were available to patients both when pharmacy was open and outside core pharmacy hours in a dedicated stock cupboard. Posters on out of hours ordering of inhaler stocks had been put up in all wards. Staff had training to increase their awareness of obtaining medicines, including all types of inhalers in and outside of pharmacy opening hours. The trust told us they would be auditing patients medicine records and would act on non-compliance. This would be reduced in frequency to weekly after 7 consecutive days of 100% compliance. Processes and systems were not always followed to ensure patients medicines were administered at the prescribed time. On the Acute Medicine Unit (AMU) a 1 stop medicine electronic storage and dispensing system was available, however nurses were observed queuing up to use the storage system. Concerns were raised by staff that it was delaying the administration of patients' medicines. We observed medicines being administered at 10.30am for the 6 am to 8am medicine administration round due to the queues at the storage system. There was some confusion about how the system should be used to ensure the safe administration of medicines at the right time.

There had been improvements in recording patient weights on prescription charts which is important to ensure the correct dose was prescribed.

Staff did not always complete medicines records accurately and keep them up to date.

Medical care (including older people's care)

Medicine administration records were not always completed, and it was not always possible to determine if a patient had received their prescribed medicine or not. This increased the risk of a medicine error and harm to patients.

We could not be assured of the accuracy of the administration of some medicine records. For example, paracetamol was often prescribed as 'IV/PO' (intravenous/oral). However, records did not always show the route used to administer the paracetamol.

The trust had developed a new prescription chart to improve medicine administration records and to improve recording of missed doses. It was due to be launched at the end of June 2023.

Staff mostly stored and manage medicines safely. Medicines storage overall had improved with increased monitoring from pharmacy to ensure medicines were stored safely and securely. Checks had also been undertaken by pharmacy to ensure medicines were within their expiry dates. All medicines seen were within their expiry dates. However, the treatment room in 1 area we visited was not locked. On entering the treatment room, the medicine fridge containing insulin was unlocked and intravenous fluids were stored on open shelving. This increased the risk of unauthorised access to medicines which were not secure or safely stored. After the inspection the trust reported, they were going to perform daily drug storage security audits and act on non-compliance. This would be reduced in frequency to weekly after 7 consecutive days of 100% compliance. The auditors were required to be independent of the department audited.

Staff did not always follow national practice to check patients had the correct medicines when they were admitted, or when they moved between services. Following our last inspection, we were told the trust had increased the medicine reconciliation process undertaken by ward-based pharmacists which was welcomed by nursing staff. Medicine reconciliation is the process of accurately listing a person's current medicines on admission or when their treatment changes. However, it was not clear how effective this was particularly when there was a change made to a patient's treatment. For example, 1 patient who had insulin dependent diabetes was not eating, and their prescribed insulin was stopped. We noted that their blood sugar levels were increasing however, there was a lack of follow up on the changes made to their treatment to assess what further action was needed. We raised this with staff at the time of our inspection. After the inspection the trust reported, all diabetic patients were going to have a medical review for harm and provision of the correct treatment. This was in addition to a daily review and audit of all patients' medicine treatment records.

Staff learned from safety alerts and incidents to improve practice. A pharmacy interventions dashboard was used to record pharmacy interventions and identified any emerging trends to share learning with staff. For example, pharmacists were attending the weekly multidisciplinary AMU teaching sessions to share good practice, such as the importance of recording patients' weight on the medicine charts.

Following our inspection, we shared our findings with the trust. We asked the trust what actions would be undertaken to provide assurance patients received their prescribed medicines to ensure their health and wellbeing. The trust provided comprehensive information which included assurance all patients we identified (above) had been reviewed and had no detriment to their health. Audits were undertaken of the availability and administration of inhalers and diabetes treatment management and when needed action undertaken to address any concerns. There were improved arrangements to ensure availability of medicines when pharmacy was closed. Daily audits of all ward-based patients medicine records and medicine storage were being undertaken.

Medical care (including older people's care)

Areas for improvement

Action: the trust MUST take is necessary to comply with its legal obligations. Action: a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Medicine core service

- The trust must ensure medicines are prescribed, administered and stored safely (Regulation 12(2)(g)).

Action the trust SHOULD take to improve:

Medicine core service

- The trust should ensure that medicine prescribers clearly identify themselves and either print their name next to their signature or print their General Medical Council number. (Regulation 12(2)(g))
- The trust should consider a review of the use of the 1 stop medicine electronic storage and dispensing system on AMU. (Regulation 12(2)(g)).

Our inspection team

The inspection team included 3 pharmacy inspectors and 1 inspector. During our inspection we spoke with 16 staff including nurses, doctors, pharmacy staff and managers. The inspection team was overseen by Charlotte Rudge, Interim Deputy Director.

We reviewed 19 patient's notes and medication records. We also reviewed a range of policies, procedures and other documents relating to the running of the service.

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.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment