Liverpool Women's Hospital

Crown Street
Liverpool
Merseyside
L8 7SS
Tel: 01517024038
www.liverpoolwomens.nhs.uk

Date of inspection visit: 28 July 2020
Date of publication: 08/09/2020

Ratings

Overall rating for this hospital

Are services safe?

Summary of findings

Overall summary of services at Liverpool Women's Hospital

Liverpool Women's NHS Foundation Trust is a specialist trust that specialises in the health of women, babies and their families. As one of only two such specialist trusts in the UK and the largest women's hospital in Europe the trust holds a unique position.

Liverpool Women's Hospital is the main hospital and is a modern landmark building near Liverpool city centre. It is here that the team deliver around 8,000 babies and perform some 10,000 Gynaecological procedures each year.

The maternity team cares for women and their babies from conception to birth supported by the neonatal team who provide around the clock care for premature and new born babies needing specialist care. The trust's fertility team helps families to improve the chance of conceiving babies. In gynaecology, the trust undertakes care of women with the many varied conditions associated with the female reproductive system and is a centre for gynaecology oncology. The genetics team supports families with the diagnosis and counselling of genetic conditions.

On average 20 babies and three premature babies are born and cared for daily, the trust is primarily known for maternity and neonatal services. However, the trust also carries out 30 gynaecology operations and the reproductive medicine unit completes six cycles of IVF treatment every day.

We did an unannounced focused inspection of Liverpool Women's Hospital; the trust was given 48-hours' notice of our inspection. This was because at our last inspection we found concerns relating to the safe and proper management of medicines in gynaecology, maternity and neonatal services. We visited maternity and neonatal services and gynaecology services including theatres. We spoke to staff in all three core services and senior managers.

We did not rate the hospital at this inspection as we only inspected one key line of enquiry to ensure the hospital now managed medicines safely. We found the following improvements:

- The hospital now used systems and processes that ensured the safe prescribing, administering, recording and storage of medicines. This was in all core services inspected, maternity, gynaecology and neonatal services.

Maternity

Summary of this service

We did not rate maternity services at this inspection. We only looked at those areas where we had found breaches of regulations and wanted to check that the service had improved. We did an unannounced focused inspection of safe, looking at how the service ensured the safe and secure management of medicines.

We found:

- The service had improved systems and processes to safely prescribe, administer, record and store medicines.

However:

- At this inspection we found, while there had been improvements overall, there was still some inconsistent practice in relation to the monitoring of medicines stored in fridges.

Is the service safe?

We did not rate safe. We found:

- The service had improved systems and processes to safely prescribe, administer, record and store medicines.
- The service now had robust processes to ensure oversight of the safe and proper management of medicines by senior staff and managers.

However:

- At this inspection found while there had been improvements overall, there was still some inconsistent practice in relation to the monitoring of medicines stored in fridges.

Detailed findings from this inspection

Is the service safe?

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. At our last inspection, we found unsecured medicines on an emergency trolley. We did not find this during this inspection. The service had an action plan to continue to address this. Senior managers reviewed and updated the action plan regularly and this was monitored through the divisional board and reported to the trust quality committee. Action plans were monitored through an online system by senior managers. We reviewed performance board minutes and saw action logs were reviewed by managers.

The service provided medicines management training for all clinical staff via online learning. The service reported compliance of 97.75% against a target of 95%.

The three prescription charts we saw evidenced that medicines were safely administered. However, the time recorded on the three prescription charts we viewed for dalteparin was the time of prescribing and not the correct time for administration.

Maternity

Following our inspection in December 2019 the service commissioned an independent audit of the action they had taken to address the breaches of regulation. This reported the action plan was in place and was reported to and reviewed by relevant committees.

The service had an electronic system 'MyKitCheck' to ensure compliance with emergency and resuscitation trolley checks. MyKitChecks included the expiry dates of medicines on the trolley and a prompt for staff to remove them. The service provided information for compliance with checks for May to July 2020. This showed compliance across the service with daily checks as 99.5% for the period. The service analysed the gaps in compliance and took action to address this.

Following our last inspection, the service added a difficult airway box to the emergency trolley in theatres. Managers we spoke with told us the resuscitation committee and medicines safety committee worked closely together to ensure any issues with medicines on emergency and resuscitation trolleys were quickly escalated.

The service conducted 'safe and secure' audits of medicines management. We reviewed the audits for April to June 2020. These showed some areas of poor compliance such as processes for rotating medicines and designated areas for medicines to be discarded. We reviewed minutes of the medicines management committee and saw this was reported to them in May 2020. The service presented detailed reports and action plans to address audit outcomes at this meeting.

Staff reviewed women's medicines regularly and provided specific advice to patients and carers about their medicines. The trust's pharmacy team provided a 'top up' supply service and clinical pharmacy visits to the maternity ward and high dependency women on the delivery suite.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Managers made appropriate changes to standard operating procedures and policies regarding medicines following our last inspection. They had communicated changes to staff through an email communication bulletin. All procedures and policies were available on the intranet for staff to access. Executive staff conducted walk rounds and spoke to staff to ensure they understood the issues relating to medicines raised at the previous inspection and ensure they knew how to follow best practice.

Medicines were kept securely. Emergency drugs were accessible and checked regularly.

However, staff did not consistently follow the trust's process for monitoring the temperature of the medicine fridge. Following our last inspection, the service had introduced a standardised fridge temperature monitoring system across all areas. However, on the maternity ward we found the maximum fridge temperature had been exceeded on seven occasions in July 2020. We could not find evidence of action taken to address this and recheck fridge temperatures. The safe and secure audit for April to June 2020 identified poor compliance with evidence of appropriate action taken to address when temperatures fall outside acceptable range. Following our inspection, the service provided information that showed they had updated their standard operating procedure to include a weekly review of maximum temperatures, with appropriate escalation, where the temperature was out of a defined range for a period of seven consecutive days.

Staff followed current national practice to check women had the correct medicines. Following our last inspection, the service amended the emergency medicines policy for theatres to include anaesthetic medicines. The risk of out of date emergency medicines kit was added to the trust risk register to ensure ongoing review.

The service had systems to ensure staff knew about safety alerts and incidents, so women received their medicines safely. The service issued a weekly bulletin to staff called 'Medicines Management Monday'. This focused on medicines managements issues or key topics such as discharge processes and to take home medicines.

Maternity

The service had a safety and governance ‘huddle’ meeting weekly for staff working in maternity theatres. During this meeting managers discussed any medicines incidents and learning and outcomes of audits. Information was shared with staff via communication board and book in the staff office. Additionally, the service had a daily safety ‘huddle’ for all maternity staff which included any medicines incidents and learning.

Matrons from the service attended the medicine safety group which was established in May 2020 and included pharmacy staff. They reviewed any medicines related risks and incidents at this group and reported to the safety senate. There were clear lines of reporting from this group through to the quality committee and trust board and we saw medicines management updates were reviewed in minutes of both the safety senate and quality committee. Risks relating to medicines management were reviewed by the trust risk committee. We reviewed minutes of the medicines management committee and saw risks and incidents were reviewed and action identified.

Areas for improvement

We found areas for improvement in this service. We found one thing the service should improve because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

We told the service it SHOULD:

- The service should continue to make improvements to the safe and proper management of medicines. Specifically, to ensure temperature checks on fridges containing medicines are robust and any discrepancies acted upon.

Gynaecology

Summary of this service

We did not rate gynaecology services at this inspection. We only looked at those areas where we had found breaches of regulations and wanted to check that the service had improved. We did an unannounced focused inspection of safe, looking at how the service ensured the safe and secure management of medicines.

We found:

- The service had improved systems and processes to safely prescribe, administer, record and store medicines.

Is the service safe?

We did not rate safe. We found:

- The service had improved systems and processes to safely prescribe, administer, record and store medicines.
- The service now had robust processes to ensure oversight of the safe and proper management of medicines by senior staff and managers.

Detailed findings from this inspection

Is the service safe?

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. At our last inspection we found emergency medicines kits in gynaecology theatres contained out of date medicines. We also found pre-drawn medicines in gynaecology theatre that did not have patient identification, preparation date and time and expiry date. We did not find this during this inspection. The service had an action plan to continue to address this and senior managers reviewed and updated the action plan weekly. The action plan was monitored through the divisional board and reported to the quality committee.

Medicines were safely prescribed on the one electronic prescription available for us to view.

Following our last inspection, the service amended the emergency medicines policy for theatres to include anaesthetic medicines. The risk of out of date emergency medicines kit was added to the trust risk register to ensure ongoing review.

Matrons conducted twice weekly medicines audits. The service provided information that showed current compliance was 90%. Theatre coordinators carried out daily checks of the emergency medicines kits. The service had fitted a secure medicine cupboard in theatres to ensure safe storage of medicines.

Gynaecology

The service conducted ‘safe and secure’ audits of medicines management. We reviewed the audits for April to June 2020. These showed some areas of poor compliance such as processes for rotating medicines, actions taken to address when temperature falls outside acceptable range, managers weekly check of temperature logs and designated areas for medicines to be discarded. We reviewed minutes of the medicines management committee and saw this was reported to them in May 2020. The service presented detailed reports and action plans to address audit outcomes at this meeting.

Following our inspection in December 2019 the service commissioned an independent audit of the action they had taken to address the breaches of regulation. This reported the action plan was in place and was reported to and reviewed by relevant committees.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. The trust’s pharmacy team were available to provide advice.

Staff stored and managed medicines and prescribing documents in line with the provider’s policy. We checked resuscitation trolleys on the gynaecology ward. They were stored in line with Resuscitation Council (UK) guidelines with the drawers sealed with a tamper evident tag. We checked emergency medicines kits on the trolleys and found they were secure and all medicines in date.

The service had an electronic system ‘MyKitCheck’ to ensure compliance with emergency and resuscitation trolley checks. Following our last inspection, the service changed resuscitation trolleys in all areas and added a advanced airway bag to the emergency trolley in theatres. The service provided information for compliance with checks for May to July 2020. This showed compliance across the service with daily checks as 98% for the period. The service analysed the gaps in compliance and took action to address this.

On the gynaecology ward we found controlled drugs were stored in line with best practice and the register maintained appropriately. All controlled drugs were in date and tallied with the stock count in the register.

Staff followed current national practice to check patients had the correct medicines. The service provided medicines management training for all clinical staff via online learning. The service reported compliance of 93.1% against a target of 95%.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The service had a safety and governance ‘huddle’ meeting weekly. During this meeting managers discussed any medicines incidents and learning and outcomes of audits. Information was shared with staff via communication board and book in the staff office. Information from the huddle was fed into the medicines safety meeting.

The service issued a weekly bulletin to staff called ‘Medicines Management Monday’. This focused on medicines managements issues or key topics such as discharge processes and to take home medicines.

Managers made appropriate changes to standard operating procedures and policies regarding medicines and communicated changes to staff through an email communication bulletin. All procedures and policies were available on the intranet for staff to access.

Matrons from the service attended the medicine safety group which was established in May 2020 and included pharmacy staff. They reviewed any medicines related risks and incidents at this group and reported to the safety senate. There were clear lines of reporting from this group through to the quality committee and trust board and we saw medicines management updates were reviewed in minutes of both the safety senate and quality committee. Risks relating to medicines management were reviewed by the trust risk committee. We reviewed minutes of the medicines management committee and saw risks and incidents were reviewed and action identified.

Neonatal services

Summary of this service

We did not rate neonatal services at this inspection. We only looked at those areas where we had found breaches of regulations and wanted to check that the service had improved. We did an unannounced focused inspection of safe, looking at how the service ensured the safe and secure management of medicines.

We found:

- The service had improved systems and processes to safely prescribe, administer, record and store medicines.

Is the service safe?

We did not rate safe. We found:

- The service had improved systems and processes to safely prescribe, administer, record and store medicines.
- The service now had robust processes to ensure oversight of the safe and proper management of medicines by senior staff and managers.

Detailed findings from this inspection

Is the service safe?

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. At our last inspection we found out of date medicines in emergency medicines kit in low dependency neonatal unit. We also found the system to monitor and check the kit had not been followed by staff. We did not find this at this inspection. Medicines were stored safely. Emergency medicines were easily accessible, in date and checked regularly.

The four prescription charts we saw evidenced that medicines were safely prescribed and administered. The pharmacist had not clinically checked all newly prescribed medicines on the charts we saw.

Following the last inspection, the service acted to ensure emergency equipment and medicines were up to date. Matrons audited compliance twice weekly. Results from the audits were shared to the divisional board for review. The service introduced ‘safe and secure’ medicines audits conducted by pharmacy.

Following our inspection in December 2019 the service commissioned an independent audit of the action they had taken to address the breaches of regulation. This reported the action plan was in place and was reported to and reviewed by relevant committees.

Senior managers told us prescribing errors were reviewed regularly and staff with two consecutive prescribing errors were stopped from prescribing until additional training and competency assessments were completed.

The service provided medicines management training for all clinical staff via online learning. The service reported compliance of 96.23% against a target of 95%.

Neonatal services

The service conducted ‘safe and secure’ audits of medicines management. We reviewed the audits for April to June 2020. These showed one of poor compliance with logging temperatures of fridges used to store medicines. We reviewed minutes of the medicines management committee and saw this was reported to them in May 2020. The service presented detailed reports and action plans to address audit outcomes at this meeting.

The service carried out ward medicines management audits, twice each week on the neonatal intensive care unit and weekly on transitional care and the low dependency unit. We reviewed the audit for June 2020 and saw there were no areas of non-compliance. Actions had been identified to address areas of poor compliance and learning shared with staff.

Staff reviewed babies’ medicines regularly and provided specific advice to babies’ parents about their medicines. A clinical pharmacist visited the unit daily. The service had recognised the need for specialist pharmacy support and was in the process of recruiting a lead in neonatal pharmacy at the time of our inspection.

Staff stored and managed medicines and prescribing documents in line with the provider’s policy. We checked resuscitation equipment on the low dependency unit and neonatal intensive care unit. They were stored in line with Resuscitation Council (UK) guidelines with the drawers sealed with a tamper evident tag. We checked emergency medicines kits and found they were secure and all medicines in date. We saw evidence of appropriate storage of medicines. Medicines were managed in accordance with trust policy.

Staff followed current national practice to check babies had the correct medicines. Medicines were frequently reviewed.

The service had systems to ensure staff knew about safety alerts and incidents, so babies received their medicines safely.

Matrons from the service attended the medicine safety group which was established in May 2020 and included pharmacy staff. They reviewed any medicines related risks and incidents at this group and reported to the safety senate. There were clear lines of reporting from this group through to the quality committee and trust board and we saw medicines management updates were reviewed in minutes of both the safety senate and quality committee. Risks relating to medicines management were reviewed by the trust risk committee. We reviewed minutes of the medicines management committee and saw risks and incidents were reviewed and action identified.

Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines. Medicines for sedation were used appropriately in response to clinical need.

Our inspection team

The team that inspected comprised a CQC lead inspector, one other CQC inspector (not on site), a specialist medicines inspector and a specialist advisor with expertise in governance. The inspection team was overseen by an inspection manager and Judith Connor, Head of Hospital Inspection.