**Medicines Optimisation**

# Gateshead Health NHS Foundation Trust

Date of inspection: 27 September and 28 September 2022

## Our findings

### Summary of services at Gateshead Health NHS Foundation Trust

**Good**

Gateshead Health NHS Foundation Trust is based in Gateshead in the North East of England. The trust was authorised as a Foundation Trust in January 2005. It provides secondary and community care and older persons' mental health services to a population of approximately 200,000. The trust provides services from the Queen Elizabeth Hospital, Bensham Hospital and Blaydon Urgent treatment centre. The trust is a tertiary centre for gynaecological oncology and a provider of specialist screening services, for breast, bowel and aortic aneurysm. At Bensham Hospital, Gateshead Health run the older persons memory service as well as two mental health wards on site. Community health services for adults are based at Bensham Hospital, Blaydon Primary Care Centre and Queen Elizabeth Hospital.

We carried out this announced inspection as part of a pilot to inspect and rate medicines optimisation as a core service in NHS trusts. This was the second inspection of the pilot.

This is the first rating of this service. We rated it as good because:

- We rated safe as requires improvement, caring and well led as good, effective and responsive as outstanding.
- The service had enough staff to support patients with their medicines. There were many enhanced pharmacy roles in the organisation to improve how medicines were used in the trust, for example the rheumatology pharmacist was joint clinical lead for rheumatology. Staff assessed medicines risks to patients and prioritised them accordingly.
- There was an excellent medicines safety culture embedded in the trust. There was a genuine commitment to learning and making improvements.
- Staff provided good care and treatment and gave patients pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Pharmacy clinical and supply services were available seven days a week.

- Staff worked as part of multidisciplinary teams to optimise medicines for patients and ensure they received the most effective medicines for them. Pharmacist independent prescribers were embedded in the trust, including in planned orthopaedic surgery and had shown to improve quality of care for patients and medicines safety.
- Staff treated patients with compassion and kindness and took account of their individual medicines needs. We saw many examples, where pharmacy staff had gone above and beyond when providing patient centred care.
- The pharmacy department engaged with patients regularly and made service improvements when issues were identified.
- Leaders ran services well using reliable data and performance measures to improve medicines optimisation services where required. Pharmacy staff felt supported with many opportunities for career progression and to diversify their roles to improve patient care. They were focused on the needs of patients and improving the use of medicines in trust.
- The service provided opportunities for staff to identify areas for improvement and make changes. Staff were encouraged and supported to innovate and develop new ideas. For example, a joint heart failure and diabetes clinic had been set up by specialist pharmacists to ensure optimum treatment could be provide to these patients.
- Pharmacy staff worked externally through local and national guidelines to share good practice for medicines. The service worked collaboratively with community services to improve access to medicines.

However:

- The electronic prescribing system was not available in the Accident and Emergency department and critical care. We saw that there had been medicines related incidents when patients had been transferred to wards related to this. This was on the trust risk register.
- Fluids were being prescribed on paper charts as the electronic prescribing system did not have the correct functionality for this. Staff told us that this had led to fluid charts going missing or not being prescribed on time.
- We found oxygen was not always being prescribed on the electronic system, although it had been documented as administered on a separate electronic system.

## Outstanding practice

We found the following outstanding practice:

- The diabetes and endocrinology specialist pharmacist and cardiology pharmacist had adapted national guidance and developed UK's first joint clinic for patients with both heart failure and diabetes. This meant that patients would receive optimum treatment and monitoring for their condition. We were told that this clinic was successful, and the department had received very positive feedback from staff that it had improved patient safety.
- Medicines optimisation was well integrated within the clinical structure of the trust. The trust had appointed a specialist pharmacist prescriber for clinical lead for rheumatology and there were plans to appoint a clinical lead for diabetes and endocrinology.

- Staff identified and participated in quality improvement projects such as reducing opioid prescribing and reducing environmental impact of pharmacy services and certain medicines. A review of patients undergoing elective surgery for hip and knee replacement found a reduced average length of hospital stay when changes to opiate prescribing had been made.
- The service planned care to meet the needs of local people. The pharmacy led anticoagulation clinics took place in the community at 19 sites to provide care closer to people's homes and improve accessibility. The service also co-ordinated home visits for blood tests to support patients who were housebound.
- There was an excellent culture within the trust where staff felt respected, supported and valued. The pharmacy department had a health and wellbeing forum, formed during the Covid-19 pandemic to support staff and create a positive working environment. This included two mental health champions to support staff. Staff told us they enjoyed where they worked.

## Areas for improvement

**Action the trust must take to improve:**

**MUST**

- The trust must ensure that oxygen is prescribed on the electronic prescribing system as per national safety alert and record of its administration maintained.

## How we carried out the inspection

Our inspection was part of a pilot by the Medicines Optimisation team to inspect and report on medicines optimisation as a core service. As the inspection was a pilot it was announced, and the trust had agreed beforehand to be part of the pilot. This was the second inspection in the pilot. We included all our key lines of enquiry (KLOE's). This report will not be published to the public but shared directly with the trust following our approved methodology.

We visited clinical areas including Critical care, St. Bedes unit, outpatients, Pharmacy Department, A&E, EAU, SDEC, two surgical wards, maternity two elderly care wards, two mental health wards, Bensham Hospital and Blaydon Urgent Treatment Centre. We reviewed 41 medicines administration records on EPMA and/or related medical records. We spoke to 50 staff via focus groups and interviews and 38 in clinical areas. We spoke with 12 patients and/or relatives. We observed 2 multidisciplinary meetings. After the inspection, we requested further documentary evidence to support our findings.

# Medicines Optimisation

**Good**

# Is the service safe?

**Requires improvement**

This is the first time we have rated this service. We rated it as **requires improvement.**

## Mandatory Training

**The service provided mandatory training in key skills to all staff.**

At the time of our inspection there was no formal mandatory medicines management training programme for staff, however following our inspection the trust had plans to have this in place. Medicines safety training was delivered at the preceptorship programme to newly qualified nursing staff, allied healthcare professionals and pharmacy staff. All clinical staff received training on induction for the electronic prescribing system used by the trust before they were given access.

Pharmacy staff completed a package of mandatory training modules and were compliant against trust target for all areas.

Mandatory training records for all other staff groups were held locally.

## Safeguarding

**Pharmacy staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

All pharmacy staff undertook safeguarding training as part of their mandatory training. 98% of pharmacy staff had completed level 2 training for both adults and children meeting trust targets.

Staff were able to identify when adults or children were at risk of harm and understood the trust arrangements and who to contact to escalate an issue.

## Cleanliness, infection control and hygiene

**The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**

Ward areas where medicines were prepared and stored were clean and well maintained. Pharmacy cleaning records were up to date and demonstrated that all areas were cleaned regularly.

We saw staff who managed medicines followed the correct handwashing procedures and ‘bare below the elbow’ policy. Staff wore personal protective equipment (PPE) in clinical areas.

We observed staff in critical care preparing intravenous medicines for administration. Staff followed safe practices, such as no touch technique for injectable medicines, and all prepared medicines were used immediately so patients received their medicines safely.

The pharmacy had an aseptics department where intravenous chemotherapy under sterile conditions to reduce the risk of infection in immunocompromised patients. Environmental monitoring was carried out regularly. An inspection had been carried out by the local quality control department in May 2022, which demonstrated that environmental standards were satisfactory.

## Environment and equipment

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**

The trust had an electronic prescribing and medicines administration (EPMA) system in all areas except the emergency department and critical care. Medical staff told us that this system improved their prescribing as it alerted them to interactions between medicines allowing decisions for safer prescribing. Prescribing bundles were embedded into the system, so prescribers were prompted to prescribe certain medicines to treat certain conditions, for example for patients admitted with alcohol withdrawal. All clinical staff received training for use of this system before password access was granted.

Medicines including controlled drugs (medicines which are subject to additional controls due to their potential for misuse) were stored securely. On most wards, medicines were stored in dedicated electronic cabinets or refrigerators with access restricted to authorised staff. Temperatures were monitored centrally to ensure medicines were safe to use. If temperatures were out of range staff received alerts via an email or the mobile communication system so that they could take prompt action.

We were told that only one staff member could access the electronic cabinet at a time. This led to queues for access during medicines administration rounds, potentially causing delays in patients receiving their medicines. This had been identified and a quality improvement project was being undertaken to review the process for access to medicines.

The electronic cabinets and robotic dispenser in the pharmacy were maintained under service level agreements with manufacturers.

Critical care used syringe pumps for administration of certain medicines. The database of medicines commonly prescribed within critical care was maintained by pharmacy and the trust medical device team. This ensured that the dose ranges for medicines were accurate to keep patients safe.

The aseptics unit had an EL quality assurance audit in September 2021. The report concluded that the unit was well organised and well run, with low risk to patient safety. The audit had identified some issues, to which the trust had responded with an action plan. A capacity and contingency plan was in place to ensure that staff knew how to assess the demands on the service and how to deal with lack of capacity.

Staff carried out daily safety checks of specialist equipment. On the chemotherapy day unit, the analyser for near patient blood testing was checked three times a day. This ensured that patients' bloods were checked quickly and accurately to allow administration of chemotherapy or administer prompt treatment if the results indicated they were needed.

In the pharmacy led warfarin service, the INR testing equipment (international normalised ratio – a measure for blood clotting) was tested daily to ensure that warfarin could be dosed accurately.

Medicines waste was managed appropriately. Wards had a secure sharps bin and a secure medicines returns bin which was managed by the pharmacy team.

## Assessing and responding to patient risk

**Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff recorded patient's vital signs on an electronic system which alerted the medical team if a patient was identified as deteriorating. In A&E, night staff recorded these vital signs on paper documents.

In the chemotherapy day unit, a 'door-to-needle' one stop protocol had been developed. This allowed nursing staff to administer one dose of an antibiotic for patients with suspected sepsis using a patient group direction (PGD - a written instruction for the sale, supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). This meant that patients would receive treatment without delay (within 60 minutes according to NICE guidance).

We saw examples of documented assessments and completed monitoring for these patients as per trust policy.

The protocol had last been audited for oncology patients in May 2022 and showed an average of 56 minutes from assessment to treatment time. Oncology nurse practitioners worked closely with medical and nursing staff in A&E to ensure that patients identified as septic would receive treatment quickly.

Medicines reconciliation (the process of accurately listing a patient's medicines and comparing it to what has been prescribing during the hospital admission) was completed within 24 hours of admission for 80% of patients. Pharmacists assessed patient's medicines associated risk and communicated this via an internal pharmacy dashboard so patients could be prioritised accordingly.

We saw evidence of pharmacy staff intervention to avoid medicines errors. During the inspection, we observed dispensary staff had identified errors in a discharge prescription written by a doctor. Dispensary staff liaised with the ward pharmacist who understood the patient's needs, to correct the discharge prescription immediately, ensuring that the medicines were safe for the patient to go home with.

The electronic prescribing system had an alert to ensure that patients had been assessed for venous thromboembolism (VTE – blood clot in the veins) and were prescribed prophylactic medicine where appropriate. A monthly audit was carried out for VTE assessments within 24 hours and this was consistently above the trust target of 95% for the 5 months prior to the inspection.

On inspection we found oxygen had not always been prescribed for patients who had been administered this. We raised this during the inspection and were told the trust were awaiting an EPMA update so this would be a mandatory requirement. After the inspection, we received information about a quality improvement project which was taking place to improve the prescribing of oxygen in the trust.

## Pharmacy Staffing

**The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.**

The pharmacy had a clear workforce and service plan, which could be adjusted to meet demand. Specialist pharmacists, technicians and assistant technical officers were employed to ensure that a clinical service was maintained at ward level. There were some gaps in dedicated service provision for example, the special care baby unit and maternity. However, this had been risk assessed and pharmacists could be contacted for medicines advice and support via the communication system if required.

Assistant technical officers received a comprehensive induction, rotating through all sections of the pharmacy. This gave staff an understanding of the whole department and ensured staff could work in all locations as required,

Pharmacist prescribers were responsible for 14% of all items prescribed in the trust and were well integrated into multidisciplinary teams in clinical services.

There were many pharmacists in specialist roles providing input into the governance structure of various clinical areas. For example, the rheumatology pharmacist was joint clinical lead for rheumatology..

The trust had an antimicrobial pharmacist for who worked with the microbiology team and had a clear remit to improve antimicrobial stewardship.

The service had re-evaluated many job roles within the pharmacy department and allowed staff to diversify their roles where appropriate. For example, a technician had trained as a releasing officer for aseptic services to oversee the manufacture of chemotherapy.

Patients undergoing planned orthopaedic surgery were reviewed by a pharmacist independent prescriber who reconciled their medicines and prescribed them before they were admitted. Post-surgery the patients were then supervised on the ward by the pharmacist prescriber alongside a nurse prescriber to ensure their medicines were safe to take. Audit results showed that this improved the quality of care provided to patients, as 100% of medicines were correctly prescribed within 12 hours of arrival compared to 20% prior to the pharmacist independent prescriber being in place. This resulted in safer prescribing, patients receiving their medicines on time as appropriate and improved efficiency of the healthcare team.

## Staffing

**The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.**

Staff received medicines training specific to their roles. For example, critical care nursing staff completed an annual medical devices assessment, and practical assessments for use of syringe drivers and total parenteral nutrition.

Nurses administering chemotherapy had completed an accreditation course demonstrating their competency, which was reviewed annually.

Nursing staff in areas where PGDs were in use, for example, A&E, Blaydon Urgent Treatment Centre and Bensham had been authorised and assessed as competent. A PGD learning package was also available to support staff.

Non-medical prescribers were embedded throughout the trust and pharmacy supported with training and governance.

## Records

**Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.**

The trust used paper and electronic system for documenting patient's care and treatment.

The pharmacy had an IT team that were responsible for training, maintaining and updating staff using the EPMA system. The process was robust and ensured all staff prescribing or administering medicines were competent to use the system and record medicines safely. As staff left the trust the team would remove access to mitigate risk.

Nursing and medical staff used a separate electronic system to document patient observations and care notes. These notes could be accessed via handheld devices held by nursing staff, to allow them to view and document observations quickly. Patient notes were comprehensive, and staff could access them easily.

When patients were prescribed antimicrobials, we saw that the rationale and duration had been documented clearly.

Patient records we checked had both the weight and allergy status recorded, which meant that medicines could be prescribed safely.

In critical care and urgent and emergency care, medicines were prescribed on paper charts. When patients were transferred to a ward with EPMA, medicines were prescribed on EPMA with a discharge letter to handover patients, detailing medicines that needed to be reviewed. Some medicine incidents had been reported due to the transfer of information from paper to EPMA. This had been identified by the trust and was on the risk register. There were plans in place to extend electronic prescribing safely to these areas, but current mitigations included increased vigilance and medicines reconciliation on transfer.

When patients were discharged an electronic discharge summary was created, which was clinically checked by pharmacists before medicines were dispensed. We saw that discharge letters contained comprehensive information about changes to medicines and a summary of the patients stay in the hospital. Discharge summaries from inpatient wards were sent to GPs in a timely manner with 74% being sent within 24 hours of discharge between March and September 2022.

## Incidents

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses**. **Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

All staff knew what incidents to report and how to report them. The trust used an electronic system for recording incidents. All staff we spoke to knew how to report incidents using this system. Staff told us they felt confident reporting incidents and there was an open reporting culture.

Staff we spoke to understood that duty of candour meant being open and honest with patients and family when things go wrong. We saw an example of when duty of candour had been followed, following an incident involving a medicine which was dispensed incorrectly.

The trust employed a medicines safety officer (MSO) and a medicines safety technician who had a clear remit. The medicines safety team investigated medicines incidents and collated themes which were then escalated to medicines governance groups. The MSO had been nominated for the trust rising star awards for their work on medicines safety across the trust.

We saw many examples of learning from incidents, which were cascaded in various innovative ways. This included a medicines safety roadshow, teaching sessions with medical and nursing staff as well as trust wide medicines safety bulletins. Staff we spoke to in clinical areas had good awareness of medicines safety and incidents, demonstrating that the trust were engaged with improving medicines safety. On the Emergency Assessment Unit (EAU), the pharmacist was part of the MDT that held monthly governance meetings where incidents were investigated, and actions taken.

When national patient safety alerts were received, these were recorded, and the appropriate actions taken.

A Trust-wide safety triangulation group had recently been formed, which was multidisciplinary and included the MSO. In this group all incidents were discussed including whether duty of candour had been followed and safeguarding referrals.

Omitted doses were monitored monthly and were better than the trust target <1%, showing that patients received their medicines as prescribed.

# Is the service effective?

**Outstanding**

This is the first time we have rated this service. We rated it as **outstanding.**

## Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance**

The service provided care and treatment based on national guidance and evidence-based practice. Staff were able to access resources via EPMA to support prescribing, for example, the trust formulary and the British National Formulary.

The diabetes and endocrinology specialist pharmacist and heart failure pharmacist had adapted national guidance and developed UK's first joint clinic for patients with both heart failure and diabetes. This meant that patients would receive optimum treatment and monitoring for their condition. We were told that this clinic was successful, and the department had received very positive feedback from staff that it had improved patient safety.

Pharmacists were involved in formulating and reviewing trust guidance, which was then ratified by the medicines governance group. For example, during the Covid19 pandemic, the critical care pharmacist had written specific guidance for safe treatment of patients with Covid19.

The antimicrobial pharmacist provided specialist advice for antimicrobials. They were well embedded within the microbiology department. The pharmacist produced quarterly antimicrobial updates which was submitted for national audits. These audits demonstrated that the trust was significantly below national average for antimicrobial use and the lowest user of 'watch and reserve' antibiotics in the region, demonstrating good antimicrobial stewardship.

The trust had a pharmacy technician led anticoagulant clinic. Technicians received training for when changes to national guidance for anticoagulants were made so they could counsel patients and enable them to make informed decisions.

The pharmacy department were proactively taking steps to reduce their carbon footprint. This included a review of their pharmacy services and clinical and medicines optimisation practices to identify areas where there may be a negative environmental impact for example, the use of certain medical gases.

## Nutrition and hydration

**The service used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.**

Intravenous fluid management guidelines were in place. However, fluids were prescribed on paper charts as the EPMA system did not have the correct functionality. Some staff told us, this often led to confusion and misplacement of paper charts, resulting in fluids not being given.

In critical care, we saw nursing staff consistently recorded fluid balances and knew to seek advice from pharmacists for patients who had limited fluid intake.

Patients requiring TPN were assessed by a dietician and medical consultant. The team assessed the patients clinical and nutritional status to prescribe the appropriate formulation. There were robust procedures in place to obtain TPN on the ward and a procedure for checking this was correct. We saw that there was good documentation of TPN on the critical care charts and the administration line checked daily to ensure that it was safe to administer.

The medicines management policy provided staff with information to support patients with their medicines with certain religious, cultural and other needs. For example, there was advice available on how to support patients observing Ramadan and where to source information about ingredients such as pork gelatine used in some medicines. Staff we spoke to understood to seek advice from pharmacy for advice for these patients.

## Patient outcomes

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**

The service audited patient outcomes when changes to treatment pathways were made.

For example, guidelines for the treatment of pain for elective patients undergoing knee or hip replacements had been changed as part of national targets to reduce opiate use so patients were prescribed immediate release opioid medicines instead of modified release preparations. Surgical pharmacists carried out an audit, which found that the average length of stay for patients admitted with knee and hip replacement was reduced following the change in opioid treatment. Furthermore, patients reported better pain control.

The trust submitted medicines optimisation information nationally for CQUINS (Commissioning for Quality and Innovation framework) for antimicrobial usage and discharge medicines service. National standards were met consistently demonstrating positive outcomes for patients.

A medicines optimisation assurance dashboard was monitored regularly, with various data collated and reported on to ensure monitor performance and improve patient safety. For example, medicines reconciliation figures were monitored monthly. Figures from August 2022, showed 78% of patients had their medicines reconciled within 24 hours in the weekday, exceeding the trust target. Pharmacist and pharmacy technician time spent on clinical activities was reported at 90% and 46% respectively. These parameters demonstrated that patients' medicines were managed well.

Matrons carried out regular environment and safety assessments around wards to ensure patients were kept safe and received optimum care. This included medicines management and completion of fluid charts. Action plans were in place if these assessments identified any issues.

## 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.**

Although medicines management was not part of trust mandatory training the pharmacy team delivered various training related to medicines throughout the trust. For example, the urgent and emergency care pharmacist delivered regular medicines training to medical and nursing staff working in the emergency department and emergency assessment unit. These were well attended by staff and promoted good working relationships between health care professionals.

The pharmacy department had a good clinical supervision programme. Pharmacy staff felt well supported to develop their roles through regular appraisals and clinical supervision of their work. Group clinical supervision for pharmacist prescribers was carried out regularly where incidents and difficult prescribing decisions were discussed.

Clinical technicians discussed near misses and areas for improvements in safety forums. Staff described the benefits of peer discussion groups in creating an open and honest culture to learn from others and improve their own practice.

## Multidisciplinary working

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Medicines optimisation was well integrated into the clinical care structure of the trust. The trust had 21 out of 32 pharmacists that were independent prescribers and were integral to the trust.

The specialist rheumatology pharmacist was the first allied healthcare professional appointed as joint clinical lead within the trust. This role involved working collaboratively with specialist nurses to drive quality improvement and clinically reviewing patients to escalate or deescalate treatment.

Ward rounds were multidisciplinary and there were good working relationships between the healthcare professionals. Nursing staff and doctors could seek prescribing and administration advice easily.

The EAU pharmacist facilitated weekly quizzes for the ward team, which focussed on medicines hot topics and provided a shared learning environment. We were told the service line manager in EAU was visible and supportive of staff initiatives and team working was strengthened with social media team groups.

## Seven-day services

Clinical pharmacy and medicines supply services were available seven days a week. Latest figures for medicines reconciliation rates on the weekend were reported at 83% exceeding the trust target at 48%. This indicated that if patients were admitted over the weekend, it was more likely their medicines would be accurately prescribed.

Outside of core working hours an on-call pharmacist was available to provide advice. Staff understood how to contact pharmacy for advice.

In A&E, patients could go home with medicines out of normal working hours using prescribed pre labelled medicines.

## Health promotion

**Staff gave patients practical support and advice to lead healthier lives.**

As part of a rapid improvement project, a pharmacy technician had been placed on the discharge lounge to process discharges promptly and counsel patients to ensure they understood changes to their medicines. Feedback from this project was positive with a patient stating “Professional and caring staff, explained everything to me in plain language” We spoke to some patients in the discharge lounge who said that they were happy with the treatment they received and were well informed about their medicines.

We saw that patients and carers who attended the specialist memory hub, were given comprehensive information to provide diagnostic and social support.

During the inspection we saw patients receiving advice and guidance from the smoking cessation team in EAU. The team worked with the pharmacist who prescribed appropriate treatment.

The mental health wards had an activity coordinator, who advised patients on smoking cessation and reasonable alcohol intake. They also gave an example of where they advised on good hydration when issues were identified with poor fluid intake. Patients who were discharged from these wards were provided with a detailed care plan containing information with contact details for follow up support.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately. Staff protected the rights of patients subject to the Mental Health Act 1983.**

Patients who had been assessed as lacking mental capacity and were receiving their medicines covertly had appropriate documentation. There was clear advice from pharmacists when medicines could or could not be crushed and liquid alternatives were sought where possible.

We saw that staff on the mental health wards discussed patients' medicines with them and involved them with discussions about treatment plans.

Staff had access to patients' summary care records. We saw that patients were asked for their consent before these records were accessed.

A rapid tranquilisation policy was in place and medicines were appropriately prescribed and monitored. Staff used appropriate de-escalation techniques before rapid tranquilisation would be administered. We reviewed an audit of the use of rapid tranquilisation on the two mental health wards, which showed all patients had been appropriately monitored after this had been administered.

Patients prescribed sedatives were reviewed regularly to avoid excessive use.

Patients subject to the Mental Health Act 1983 had the appropriate authorisation forms, and staff checked these before prescribing and administering medicines. This meant that staff were assured that all mental health medicines were administered legally. However, it was not always clear if a person had capacity due to wording in the paperwork. We reported this to a staff member on inspection.

## Pain relief

**Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain**.

Staff used pain tools to assess pain and record on the electronic care system which they could access via their handheld devices. The system had the ability to create an alert for nurses to reassess patients if they had been assessed as having a high pain score. This allowed for timely review of any pain relief administered for effectiveness.

On the palliative care ward, we saw that staff used appropriate tools to assess pain for patients who were unable to communicate when in pain. The rationale and outcomes for pain relief was documented.

Patients we spoke to told us they received pain relief when they needed it. One patient told us that they were admitted with a lot of pain. They felt well informed of the treatment options discussed by the medical team and the ward pharmacist and now their pain was much better controlled.

In response to a key performance indicator (KPI) to reduce opioid prescribing in line with national priorities, an opioid stewardship group had been set up to identify areas of overprescribing. As part of this group, day case surgery protocols had been changed so that medicines were given according to the procedure patients had received. This meant that patients were receiving targeted opioid intervention and reduced unnecessary prescribing of these medicines.

The EPMA system did not have alerts to warn staff not to administer paracetamol doses too close together, and it was dependent on staff to ensure a four-hour gap was observed. This was raised during the inspection and action was taken immediately by the pharmacy team.

# Is the service caring?

**Good**

This is the first time we have rated this service. We rated it as **good.**

## Compassionate care

**Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients said staff treated them well and with kindness. Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

We were given examples where the pharmacy team had provided compassionate care. For instance, the department were able to source and import a specific brand of a medicine for a patient who was visiting the area.

## Emotional support

**Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**

All staff we observed interacting with patients with regards to their medicines, treated patients with compassion and kindness and took account of their individual needs, explained who they were, what their roles were and explained any medicines administered to them.

There was a strong sense of patient focussed care with staff who we spoke with.

We saw many examples of staff nominations for trust awards and commendations following compassionate care provided to patients. For example, a nurse stated pharmacy 'staff had gone above and beyond' to coordinate a complex discharge and ensure medicines were ordered and supplied.

### Understanding and involvement of patients and those close to them

**Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. There were processes in place to ensure patients were counselled about their medicines. We spoke to patients who said they felt involved in decisions about their medicines and treatment. Staff on the elderly care ward were able to give examples where they asked family members to assist patients when taking their medicines or asked how they usually liked to take them.

Medicines information was provided to patients and their carers in a way they could understand. For example, at the specialist memory hub, care plans were formulated in the first language of patients.

There were processes in place for pharmacy to dispense medicines in compliance aids if this was necessary.

## Is the service responsive?

**Outstanding**

This is the first time we have rated this service. We rated it as **outstanding**

### Meeting people's individual needs

**The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**

The dispensary took account of the trust rapid discharge protocol and had a system to prioritise prescriptions for people leaving the hospital on an end of life pathway.

Staff on the elderly care ward regularly made use of the handheld device to set reminders when patients were due their time sensitive medicines. This ensured that patients received their medicines at the time they needed it rather than it being set to routine medicine administration rounds.

Patients were given further information about receiving support with their medicines following discharge for example referring to community pharmacists or being given the contact number for the trust where patients could speak directly to a pharmacist using the trust communication system.

Staff regularly liaised with external care providers to ensure that patients' care was appropriately handed over when patients were discharged. This involved speaking with care homes and GP surgeries.

If a patient routinely used compliance aids for storing their medicines at home, the pharmacy department facilitated the continuation of this practice to provide familiarity and safe medicines use.

Where patients had certain cultural beliefs, staff sourced alternative medicines so patients' individual preferences could be met. For example, the aseptic department were in the process of sourcing an alternative preparation for one patient who was sensitive to alcohol present in a chemotherapy agent

A new policy had been developed for hospice at home to allow administration of oral medicines to palliative patients by health care assistants. This allowed more patients to be accepted by hospice at home, who would have previously been refused if they were on oral medicines. This allowed patients to be cared for in the comfort of their home.

The pharmacy outsourced provision of some outpatient medicines to a local homecare provider which meant medicines were delivered to patients' homes and reduced the workload of trust staff.

## Access and flow

**People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.**

Staff at the trust used a personal hands-free communication device that allowed all staff to contact others in the trust directly. We saw examples of medicines enquiries and advice and guidance being provided by pharmacy staff during the inspection. The ability to contact prescribers in this way meant patients receiving appropriate medicines faster.

Audits showed for omitted doses for critical medicines and all medicines were better than the trust target, demonstrating that patients received their medicines as prescribed.

The data provided by the trust showed that 83% of patients' discharge medicines were prepared within two hours of the prescription being sent to the pharmacy. This was slightly lower than the trust target of 85%.

Pharmacy staff provided cover seven days a week. This allowed medicines to be reviewed and patients to be treated efficiently. Medicines could be accessed outside normal working hours and stocks of regularly used medicines were available in take home pre labelled packs

Out of hours, staff could find where medicines were located on the trust electronic cabinet locator, so they could access medicines that were required urgently. An on-call pharmacist was available to provide advice. Staff reported they had no issues accessing the medicines they needed.

Discharge coordinators worked well with the pharmacy team to prioritise patients going home, so that their medicines could be processed, and information provided to them.

The dispensary prioritised patients' medicines according to need. For example, a process was in place to fast track palliative patients who were going home on end of life care medicines.

## Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**

We saw information leaflets in several locations that offered guidance on how to make a complaint and who to contact if unhappy with the service. The hospital had a Patient Advice and Liaison Service (PALS) team who were the main contact for the patient or relative who wished to complain.

Complaints and compliments were reviewed regularly. We saw an example of one complaint received by the Queen Elizabeth Hospitals Pharmacy outpatient pharmacy. This complaint had been dealt with in a timely manner, with an appropriate response to the patient. Following on from this, there had been some actions highlighted which were then addressed.

# Is the service well-led?

**Good**

This is the first time we have rated this service. We rated it as **good.**

## Leadership

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**

The chief pharmacist reported to the medical director who was responsible for medicines optimisation at board level. There were strong working relationships between the chief pharmacist, medical director and chief nurse to help deliver and implement the core medicines optimisation principals.

The chief pharmacist and senior leaders within the pharmacy team were recognised as leaders for medicines within the organisation.

Pharmacy leaders were seen to be supportive of staff with many opportunities for career progression. There were many examples of staff who had progressed to specialist positions from training roles. However, some technical staff felt they weren't always aware how they could progress into newer roles.

Staff we spoke to felt they were able to create their own roles, lead and participate in innovative improvement projects. For example, the 'greener pharmacy services' project, aimed to identify and implement proactive offset carbon initiatives in respect of Queen Elizabeth pharmacy services.

Pharmacy managers understood and managed the priorities of the medicines strategy and issues the service faced and were able to allocate resources appropriately to keep patients safe. There was an operational plan which detailed the levels of staffing required in all areas, with contingencies in place should there be any staff shortages.

For example, the trust had recently appointed a pharmacy technician for medicines safety following identification of gaps in provision of the service.

## Culture

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**

The appraisal rate for pharmacy staff was 96%, which met trust targets.

Pharmacy staff felt respected, supported and valued. Results of the staff survey were positive and there was an action plan for issues identified. The inpatient pharmacy had a positive team working approach and staff were skilled and willing to assist each other in their roles as the work dictated.

There was a good culture within the trust and ward staff spoke highly of the pharmacy department. We heard consistent comments from staff about the culture of openness and working together at the hospital.

Cross-site culture within the medicines teams was good and most staff reported good collaborative working. Staff we spoke to on the wards spoke highly of the support they received from pharmacy staff.

However, some pharmacy staff felt that their rotations were too short, not allowing them enough time to feel integrated into ward teams. We spoke to some nursing staff who did not know who their ward pharmacist/pharmacy staff was because of this.

A wellbeing and health forum had been set up within the pharmacy department which was very positive to support staff wellbeing and strengthen positive working relationships. The trust had recognised this programme and the pharmacy department had won a star award for it.

The service had an open culture where patients, their families and staff could raise concerns without fear. Medicines safety culture was very well embedded on wards, and staff knew how to report medicines incidents. The medicines safety team were responsive and acted on concerns promptly.

## Vision and Strategy

**The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**

The trust had a Medicines Optimisation strategy that was approved by the board and was aligned to the trust strategy. Plans were in place to review this strategy regularly to ensure it reflected the changing landscape of healthcare.

Other key strategies including medical and nursing had had input from the key members of the pharmacy department to ensure that medicines safety priorities were aligned.

The medicines optimisation strategy had been displayed within the pharmacy department and staff were aware of the key priorities, this was then cascaded to trust staff via pharmacy staff.

## Governance

**Leaders operated effective governance processes, throughout the service and with partner organisations. 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**.

There were clear lines of communication for medicines optimisation to the trust board, who had good oversight of medicines optimisation performance and awareness of key risks.

Medicines optimisation KPIs and the controlled drugs assurance report were presented to the board quarterly.

There was a robust reporting system for medicines optimisation processes, and this was submitted to the board quarterly. The trust board were well engaged and responsive to incidents, with medicines safety seen to be a crucial aspect of patient safety.

The trust had a service level agreement to dispense outpatient prescriptions with Queen Elizabeth Facilities Pharmacy, which was a wholly owned subsidiary of the trust. The trust chief pharmacist held formal meetings with the superintendent pharmacist to review KPIs, medicines incidents, complaints and projects.

## Management of risk, issues and performance

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had**

**plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**

There was a separate medicines management risk register which detailed medicines risks. These were reviewed regularly with clear plans to address these. For example, a few incidents related to incorrect medicines on discharge had been reported. This had been reported on the risk register and an action from this was to have pharmacy technician input in the discharge lounge. This had recently been implemented.

On inspection we identified instances where patients were administered doses of paracetamol within 4 hours of the previous dose on EPMA. The trust had responded to this risk by creating an alert to notify staff. A working group had also been set up to look at how this could be resolved.

The trust had a robust audit programme to monitor compliance against their quality standards. We reviewed the information and found that the trust department met their standards on most quality standards.

A medicines safety forum met regularly where incidents were discussed, and themes collated. Learning from this group was cascaded appropriately, and there were many examples of communication shared within the trust. A quarterly report was presented to the medicines governance group which was then escalated to the board.

## Information Management

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**

Using the EPMA system, the Trust was able to gather and analyse data on medicines to make service improvements. A team of pharmacy staff were responsible for management and updates of all trust staff using the EPMA system.

A quarterly performance and quality report was provided to the appropriate governance groups. This report provided data on prescribing, KPIs and benchmarking with other trusts. The use of informatics to support medicines optimisation at the trust was well embedded.

Staff were able to prioritise review of patients based on clinical parameters identified on EPMA. This was communicated on an internally created pharmacy dashboard, where pharmacy staff could assign a priority score for patients. Patients were deemed as high priority if they had been transferred from a non EPMA area, for example, critical care and if they were on high risk medicines.

Trust policies and guidance were available on the trust intranet. However, some staff told us that they weren't always able to find these easily. This had been recognised by the pharmacy senior team and steps had been taken to improve this.

The trust acted rapidly to ensure patients were kept safe considering alerts or highlighted risks. In addition to this practice, the trust proactively used electronic systems to complete internal deep dives into prescribing, for example the palliative care team had conducted an audit to check opioids had been prescribed according to renal function with appropriate dose ranges. The audit outcome was positive demonstrating that patients were prescribed opioids safely.

The pharmacy team used systems to review prescribing on FP10 forms from community nurses and hospitals. Information from this informed prescribing practice, which was cascaded to clinical teams to ensure safe prescribing could be supported.

## Engagement

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

Pharmacy staff were proactively engaged in service improvements; this included engagement internally on how to improve the service but also externally through local and national networks to share good practice. For example, the diabetic pharmacist sat on the North East and North Cumbria diabetes steering group and was involved in writing guidance for the treatment of type 2 diabetes.

The trust provided support to the community. For example, the antimicrobial pharmacist had recently set up a clinic to supply anti-viral treatment for patients with Covid-19. These patients were assessed via a telephone clinic by a prescribing pharmacist with the medicine delivered to the patients' home within five days of a positive result.

Technician led anti-coagulation clinics took place in the community at 19 sites including GP practices and care homes. Staff worked with district nurse teams to provide an optimised service.

The Controlled Drug Accountable Officer for the trust attended Local intelligence network meetings and the medication safety officer participated in regional and national meetings. This meant that they were actively involved in sharing information to improve medication safety.

The pharmacy service proactively engaged with the public regarding their experiences of the service. This included an annual anticoagulant patient survey for the pharmacy led anticoagulation service. The patient satisfaction survey for 2022 showed that 100% of patients were either satisfied or very satisfied with the service provided.

The trust will be attending the Great North Research Collaborative in 2023, where many projects or posters will be presented.

The palliative care pharmacist had strong links with community services and worked collaboratively with primary care to improve access and safety for end of life care medicines. For example, they worked with GPs to develop a template to guide dosing for opioid medicines for palliative patients with renal impairment. This allowed district nurses to make dose adjustments at point of care to allow prompt treatment.

## Learning, continuous improvement and innovation

**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**

The trust benchmarked their performance against equivalent hospitals using the national data collection programmes. The pharmacy service performed well, achieving targets for example the World Health Organisation antibiotic stewardship.

We saw evidence of changes to patient care implemented following analysis of an error by the medicines safety team.

A joint clinic for heart failure and diabetes had been set up, which was UK's first clinic of its kind. This allowed for a holistic approach when determining treatment for this cohort of patients.

A weekly safety triangulation group had been set up which involved input from pharmacy for mortality reviews. This meant that all aspects of a patient's care could be reviewed, and learning identified to improve services and prevent incidents.

There were many improvement projects in place, and audit data proved benefits of these projects. For example, an audit on elective general surgery wards took place to review the prescribing of regular medicines. Following the results of this, an independent prescribing pharmacist was placed on the wards to review medicines and prescribe as appropriate. The audit showed that this was effective at reducing the risks to patients from not having their medicines prescribed in a timely manner

This section is primarily information for the provider

# Requirement Notices

**Action we have told the provider to take**

The table below shows the regulations that were not being met. The provider must send CQC a report that says what action it is going to take to meet these regulations.

| | |
|---|---|
| Treatment of disease, disorder or injury. | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment |