# Review of compliance

**East Riding of Yorkshire Primary Care Trust**

<table>
<thead>
<tr>
<th>Region:</th>
<th>Yorkshire and the Humber</th>
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<tbody>
<tr>
<td><strong>Location address:</strong></td>
<td>East Riding of Yorkshire Primary Care Trust Health House Grange Park Lane Willerby Hull East Yorkshire HU10 6DT</td>
</tr>
<tr>
<td><strong>Type of service:</strong></td>
<td>Community and hospital services, including: Acute services (ACS) Hospice services (HPS) Prison healthcare services (PHS) - not inspected Community healthcare services (CHC) Diagnostic and / or screening services (DSS) Long-term conditions services (LTC) Rehabilitation services (RHS)</td>
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## Review of compliance

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<tr>
<th>Regulated activities provided:</th>
<th>Urgent care services (UCS)</th>
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<tr>
<td></td>
<td>Doctors treatment services (DTS) - not inspected</td>
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<td></td>
<td>Mobile doctors services (MBS) - not inspected</td>
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<tr>
<td><strong>Type of review:</strong></td>
<td><strong>Responsive Review</strong></td>
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<tr>
<td><strong>Date of site visit (where applicable):</strong></td>
<td><strong>23/06/2010 - 24/06/2010</strong></td>
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<tr>
<td><strong>Name of site(s) visited (where applicable):</strong></td>
<td>Beverley Westwood Community Hospital</td>
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<td>Hornsea Cottage Hospital</td>
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<td></td>
<td>Alfred Bean Community Hospital, Driffield</td>
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<td></td>
<td>Four Winds, Driffield</td>
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<tr>
<td><strong>Date of publication:</strong></td>
<td><strong>October 2010</strong></td>
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Information for the reader

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<tr>
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Care Quality Commission

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Introduction to our review of compliance

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards that everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards. This is called Guidance about compliance: Essential standards of quality and safety.

CQC licenses services if they meet essential standards and we will constantly monitor whether they continue to do so. We formally review a service when we receive information that is of concern and, as a result, decide we need to check whether it is still meeting one or more of the essential standards. We also formally review services at least every two years to check whether they are meeting all of the essential standards in each of their locations. Our reviews include checking all the available information and intelligence we hold about a provider. We may seek more information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for more information from the provider, and carry out a site visit with direct observations of care.

When we make our judgements about whether services are meeting essential standards, we will decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions, compliance actions or take enforcement action:

<table>
<thead>
<tr>
<th>Improvement actions</th>
<th>These are actions a provider should take so that they maintain continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.</th>
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<tbody>
<tr>
<td>Compliance actions</td>
<td>These are actions a provider must take so that they achieve compliance with the essential standards. Where a provider is not meeting the essential standards, but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.</td>
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<tr>
<td>Enforcement actions</td>
<td>These are actions we take using the criminal and/or civil procedures in the Health and Adult Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.</td>
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How this report is presented

On page 5 below, there is a summary that shows whether the essential standards about quality and safety that were checked during this review of compliance are being met. The section on each outcome is set out in this way:

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Judgement</th>
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<tbody>
<tr>
<td>XX: The outcome number and title</td>
<td>Whether the service provider is compliant, or whether we have minor, moderate or major concerns about their compliance</td>
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</table>

Following the summary, there is a detailed section on the outcomes for each of the essential standards that we looked at. The evidence that we used when making our judgements for each one is set out in the following way:

Outcome XX (number):
Outcome title

Details of the outcome, taken from our Guidance about compliance: Essential standards of quality and safety.

What we found for the Outcome

Our judgement

Our judgement about whether the <service/provider> meets the outcome described in the Guidance about compliance: Essential standards of quality and safety, or whether there are minor, moderate, or major concerns in relation to compliance.

Our findings

A summary of the evidence and findings used to reach our judgement, related to regulated activities as appropriate.

At the end of the report you will find details of:

- Any improvement and/or compliance action(s) that the service provider should make to maintain or achieve compliance with the essential standards of quality and safety.
- Any formal enforcement action that we are taking against the service provider.
Summary of findings for the essential standards of quality and safety

The table below shows the judgement that we reached for each of the essential standard outcomes that we reviewed.

<table>
<thead>
<tr>
<th>Outcome</th>
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<tr>
<td>9: Management of medicines</td>
<td>Minor concern</td>
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<tr>
<td>21: Records</td>
<td>Compliant</td>
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Summary of key findings:

- East Riding of Yorkshire Primary Care Trust was registered with two conditions in relation to Outcome 9, Management of Medicines. The conditions were applied because the trust did not have Standard Operating Procedures (SOPs) in place across relevant areas of the organisation, and had not defined responsibilities, competencies and training requirements for each service area in relation to medicines management.

- We carried out this review to check whether improvements had been made in relation to these conditions of registration. We also followed up a query in relation to the trust’s records and coding procedures (Outcome 21, Records).

- During the review we carried out an unannounced visit on 23 and 24 June 2010 to Beverley Westwood, Hornsea and Alfred Bean hospitals, talked to people who use services and staff, checked the provider’s records and looked at the records of people who use services.

- The majority of people who use the service that we spoke to told us that their care and the management of their medicines were handled well. When people arrived at the hospital the medication they brought with them was checked in appropriately and they were informed about any new medication they were prescribed, what it was and how long they would need to take it. People spoke positively about procedures for administering medicines, including procedures for administering controlled drugs. They told us that during the administration of their medicines staff asked them relevant questions.

- We found that medicines management in the East Riding community hospitals was being operated effectively. Standard Operating Procedures relating to the ordering, storage, administration and disposal of medication had been introduced, had been widely distributed and were readily accessible.

- The trust had agreed specific responsibilities, competences and training for each staff group handling medicines. The trust had produced a medicines management training plan for 2010/11 to support the staff competencies required for management of medicines.

- Medicines management briefing sessions had been held to introduce the medicines management procedures and over 200 staff had attended one of these sessions. We found staff on the community hospital wards were aware of medicines management procedures and copies of the main SOPs were available and signed off as read by ward staff handling medication.

- The trust has provided sufficient assurance of compliance to remove the registration conditions for Outcome 9, management of medicines.

- Although we judged that the trust had provided sufficient assurance of compliance and that the two conditions could be removed, a minor concern exists and an improvement action is required by the trust. The visit identified some areas of practice where the need for further progress in implementation was needed. These areas of practice will be subject to further review as part of our ongoing monitoring of compliance. We require the trust to develop an action plan to facilitate this.

- The trust response to our query about Outcome 21, Records, allayed our concerns.
What we found for each essential standard of quality and safety

The section below details the findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

Further detail about each of the outcomes described below can be found in the Guidance about compliance: Essential standards of quality and safety.

Outcome 9: Management of medicines

**People who use services:**
- Will have their medicines at the times they need them, and in a safe way.
- Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

**This is because providers who comply with the regulations will:**
- Handle medicines safely, securely and appropriately.
- Ensure that medicines are prescribed and given by people safely.
- Follow published guidance about how to use medicines safely.
What we found for Outcome 9

Our judgement

There are minor concerns with Outcome 9: Management of medicines

Our findings

Summary of findings
In reviewing the registration conditions for Outcome 9, we found that medicines management in the East Riding of Yorkshire community hospitals was being operated effectively. Standard Operating Procedures (SOPs) relating to the ordering, storage, administration and disposal of medication have recently been introduced, have been widely distributed and are readily accessible.

A medicines management training plan had been developed which identified key areas of competence for the different categories of staff handling medicines in the trust. The plan identified the knowledge and skills that individual staff groups should have and how these are to be assessed.

A series of medicines management briefing sessions had been held to introduce the new medicines management procedures and over 200 staff had attended one of these sessions. We found that staff on the community hospital wards were aware of medicines management procedures and copies of the main SOPs were available and signed off as read by ward staff handling medication.

SOPs were supported with additional procedural documentation on specific aspects of medication handling such as the use of syringe drivers, intravenous drug therapy and emergency / resuscitation trolley medicines. An audit of the implementation of new medicines policies and SOPs was due for completion by the end of June 2010.

Pharmacists regularly visited the community hospitals and reviewed individual medication administration records for legality, legibility and completeness. Where appropriate, any issues or concerns were being reported back to the prescriber. Pharmacy technicians visited wards regularly to manage stock control of medicines.

We found the trust encouraged the identification and reporting of medication incidents and errors and a systematic approach to analysing these, learning from them, and implementing appropriate changes where necessary.

We found the trust recognised the contribution that the pharmacy teams made to safe medicines management and were looking to recruit an additional pharmacist to strengthen the medicines management team.

Areas of practice identified for improvement
Although we judged that the trust had provided sufficient assurance of compliance and that the two conditions could be removed, a minor concern exists and improvement action is required by the trust. The visit identified some areas of practice where the need for further progress is needed:

• Self administration of medication was not actively promoted to patients who were capable of handling their own medicines, although facilities for medication storage by the
 bedside were available.
• We found no evidence of the pharmacist signing and dating patient’s drug charts (drug prescription and administration charts) to demonstrate that prescriptions met current professional and clinical guidelines.
• The audit trail for disposal of medication was not complete. Disposal of Patient’s Own Drugs (PODs) was fully recorded but no records were maintained when stock medicines are sent for disposal and the relevant SOP did not require this.
• The quantity of medication given to patients on discharge was variable across the trust and did not always provide a minimum of 14 days treatment in line with the trust policy for the Management and Administration of Medicines. In addition, the draft service level agreement for pharmacy services to some of the community units specified only 7 days supply. We were informed that this issue was being addressed.
• In treatment rooms where medication is stored, temperatures of the rooms were not being monitored, although there was consistent recording of medicines fridge temperatures.
• At Hornsea Hospital the treatment room was secured with a digital lock and we were informed that the code was not regularly changed. Although all medication within the treatment room was secured in locked cupboards or a locked fridge, arrangements were not in place to change the entry code regularly, or to fit a key-operated lock.
• At Alfred Bean Hospital staff informed us that on two recent occasions patients had been transferred from acute hospitals without a supply of current medication and / or a current medication administration record chart, which had led to delays in maintaining their treatment. A report to the Medicines Management Group (May 2010) had identified eight patients in a three month period where patients were admitted from local acute hospitals without medication and outlined an action plan to address this.
• Within the Physiotherapy department at Beverley Westwood Hospital, no audit trail was being maintained of the ordering and receipt of medication and the stock control and receipt of medicines were not managed in line with the relevant SOP.
• Guidance within the SOPs and on the front of the drug chart required all prescriptions to be written in block capitals although we found that some prescription entries did not comply. Some medication entries on ward drug charts were written in longhand.
• SOPs did not include guidance relating to the practice of transcribing medication. Some medication was transcribed from one full chart to a new chart, but it was not obvious that these new entries had been checked and signed by the prescriber before subsequent administration of medicines took place.
• For some medicines to be prescribed when required, we found there was a lack of protocols. This meant that staff did not have clear directions about the frequency and length of time required between doses.
• We found instances in the medication administration records (MAR) of codes with medication omitted, the actual dose administered when a graded dose was prescribed and the dose of a controlled drug entry on a syringe driver monitoring chart which didn’t match the controlled drugs book.
• We found recording inconsistencies in Syringe Driver monitoring forms.
• Care plans did not consistently identify self-medication arrangements that were in place.
• Refresher training for staff for the administration of patches that deliver slow release forms of medicine was required.
These areas of practice will be subject to further review as part of our ongoing monitoring of compliance. We require the trust to develop an action plan to facilitate this.

**Observations on visits to wards and departments**

**Community wards at Westwood, Hornsea and Alfred Bean Hospitals**

We found that ward staff were familiar with the new SOPs on medicines management and had attended one of a number of briefing sessions, organised by the trust, to raise awareness of the new and updated policies and SOPs. These briefing sessions had been widely publicised across the trust and were held in a variety of locations. Attendance records indicated that approximately 200 staff had attended one of these briefing sessions. We were informed that approximately 600 staff work across the trust. Printed copies of the relevant medicine management SOPs were located on each ward, and records were maintained to demonstrate that staff handling medicines had read and understood the new guidance.

We saw additional written medication guidance at ward and department level, for example, procedures for the handling of Patients’ Own Drugs (PODs) and guidance on the use of syringe drivers. There was a good standard of record keeping on ward areas. Staff on the wards confirmed that they received regular weekly visits from a pharmacist to review prescriptions and to liaise with nursing staff and prescribers. The pharmacist involved (the primary care trust community pharmacist or a pharmacist from the acute trust) provided a pharmaceutical service to the hospital concerned. However, we found no evidence of the pharmacist having signed the drug charts to demonstrate that medicines met current professional and clinical guidelines.

Nursing staff informed us that when patients were admitted to a ward, a doctor attended promptly to review and reconcile the person’s medication. In addition, nursing staff contacted the patient’s surgery, immediately prior to admission, to obtain a print out of the current medication.

We found staff on the wards had access to medicines information, via the trust community pharmacist, supplying community pharmacies or acute trust delivering the pharmacy service (to Alfred Bean Hospital).

We found Patients’ Own Drug (PODs) schemes in operation at Westwood and Hornsea hospitals, supported with clear guidelines. Staff were observed handling PODs in line with these guidelines and using the appropriate documentation to record medication reconciliation and to confirm that medication was suitable for use in the hospital. Patient consent to participating in the POD scheme was regularly recorded.

All medicines were securely and appropriately stored and fridge temperatures were being monitored regularly. Keys to the treatment room and medicines cupboards were held by the nurse in charge of the ward. However, monitoring of the temperatures within treatment rooms was not undertaken. Stock control was being managed with weekly visits from a pharmacy technician to remove old or excess stock and reorder further supplies of medicines. Records were maintained for all medicines received, although the disposal of stock medicines which are out of date, for example, was not documented. SOP 5 covering the disposal of medicines did not require this to be done. The disposal of any PODs was fully recorded.

We found that administration of medicines was restricted to registered nurses and competences for this process were agreed within the trust. We observed part of a medicine administration round at Westwood. The trolley had been well prepared for both oral medicines and insulin syringes. The nurse wore a ‘do not disturb’ tabard during administration and followed good practice guidance throughout the administration process.
There were very few patients self-administering their own medicines and we were told that this mainly reflected the patients' lack of ability to administer their own medications safely. One patient was self-administering some medicines at Westwood. We were told that the patient did not retain access to the medicine locker but that this was opened at the designated medicine administration times by a nurse.

Health care assistants helped in the administration process for controlled drugs after receiving specific training and assessment of competence, which included checking controlled drugs.

We found that controlled drugs were fully recorded with two signatures for receipt, administration and disposal. A range of daily and weekly checks on controlled drug stock were recorded with at least three monthly checks undertaken by the PCT community pharmacist. We found that the PCT community pharmacist was undertaking monthly checks at Hornsea following a recent discrepancy.

We found that a trust-wide standard drug prescription and administration chart was in use at all three community hospitals. Guidance within the SOPs and on the front of the drug chart required all prescriptions to be written in block capitals although we found that some prescription entries did not comply. We found there were no gaps on the selective sample of drug charts examined and non-administration codes were used appropriately. All prescription entries were handwritten, usually by the prescriber. However, we were told that it was sometimes necessary to rewrite a drug chart when the original chart was full and a nurse may undertake this task. We found that a second nurse checked each entry for completeness and accuracy and both staff involved initial and date the entries. We observed the occasional drug chart which had been re-written but not countersigned by a second nurse. It was not obvious that transcribed prescriptions had been checked and signed by a prescriber before further medication had been given.

There was some variation in the quantity of medication given on discharge. This was meant to be 14 days supply of medication, but staff told us that this was not always met. The policy for the Management and Administration of Medicines stated that 14 days supply of medicines should be given to patients discharged from Westwood, Hornsea and Withernsea, but gave no guidance in relation to patients discharged from Alfred Bean or Bridlington. The service agreement (draft) for pharmacy services to Alfred Bean and Bridlington specified 7 days medication to be given on discharge.

During discussion with a nurse at Alfred Bean we were informed that two patients had been admitted within the previous two weeks without any accompanying drug charts, which caused delay in maintaining continuing care for these individuals. The nurse had reported these and previous related incidents via the trust adverse incident and serious untoward incident reporting process.

Nursing staff were familiar with the procedure for reporting drug errors and incidents.

At Alfred Bean Hospital we found that the actual dose given was not always stated on MAR charts. We found an instance where the MAR also indicated the dose of medicine for the patients syringe driver, but where a recording error rather than an administration error had been made. In another instance, the care plan did not contain protocols for administering the medication.

At Hornsea Community Hospital a patient was self-administering eye drops which were not recorded in their care plan. A risk assessment for self-medication was in place which stated that the patient was able to instil eye drops herself. However, a staff member told us there was no scope for patients to self-medicate on the ward. They did not agree that instilling eye drops was self medicating. The patient was admitted from the acute hospital. The patient notes stated that the ward needed to contact the hospital as no drug chart had been received.

We found a MAR chart for one patient which specified '24 hours via driver' where there
were significant gaps and discrepancies in recording what was administered. The syringe driver monitoring form was not consistently recorded with the amount of medicine remaining at each check.

**Physiotherapy Departments**

Within Physiotherapy departments we found that adherence to SOPs on the ordering and receipt of medication was variable.

**Physiotherapy dept, Beverley Westwood Hospital**

The ordering system had recently changed so that injections required for use by specific physiotherapists were ordered via the ward requisition book rather than, as previously, through the minor injuries unit. When drugs arrived at the department they were received by an administrator and locked in a cupboard in the physiotherapist’s office. There was no clear recording system for checking the injections matched the order. A signature section on the invoice form for receipt was blank.

We found the stock audit was not robust and differed from the systems at the other hospitals. Amounts were not being identified. The secretary / administrator with access to the Physiotherapy medicine cupboard keys informed us that she often ordered and received medication. We found that there was no record of actual stock counts, which are required to be done weekly and the stock sheet was ticked against any medicine where stock levels were adequate, rather than the actual quantity of medication remaining in stock being recorded. It was not possible to reconcile some medication orders with medication received because records were incomplete and not appropriately organised. The administrator with access to the medication cupboard had not received training, although the SOP states ‘authorised staff’ are able to keep keys. There was no indication of who the ‘authorised staff’ were.

The treatment room (Room 21) contained a locked wall mounted medicine cupboard. We found no record of what it should have contained. The cupboard contained a vial of medicine which had the seal removed and therefore was compromised. It was found out of its box but inside the cupboard. It was unclear if it had been used.

**Physiotherapy dept, Hornsea Cottage Hospital**

At Hornsea Physiotherapy unit we found that stock was being counted weekly, although the stock control sheet had only recently been started. A staff list contained signatures of those who could administer injections. We found there was no record of drugs received into the unit or when used or removed from the cupboard. Two medicines in the drug cupboard had not been detailed on the stock sheet. The British National Formulary was dated 2004. There was no thermometer in the room so the storage temperature could not be monitored.

**Physiotherapy dept, Alfred Bean Community Hospital, Driffield**

At Alfred Bean Physiotherapy unit we found that stock control records were comprehensive with a full audit trail and it was easy to reconcile medication ordered with delivery notes. Patient Group Directions (PGDs) were in place at Alfred Bean to enable named physiotherapists to administer specified medication by injection in the absence of a doctor. Documentation followed national standards for PGDs in terms of content and style. They were up to date and had been approved through the trust clinical governance process. Additional written medication guidance was available in the Physiotherapy department to guide physiotherapists on the administration process and a procedural checklist was in use to standardise the administration process. Rapid access to administration records was
possible because all doses administered were recorded electronically and this was used to help support stock reconciliation.

**Minor Injuries Unit (MIU), Alfred Bean Community Hospital, Driffield**

We found that most medication was supplied via designated nurse prescribers using FP10 prescription forms although some PGDs were in use to enable designated non prescribers to administer and supply specific medicines. A medication audit trail was in place, with records of individual medicines used or supplied and providing effective control of FP10 prescription forms. All medication supplied for patients to take away was pre-labelled by the supplying pharmacy and patient information leaflets were included. A system was in place to manage prescription charges where applicable, by completing a form, signed by the patient, which was then sent to the Finance Dept. for processing.

We looked at PGDs in place and found that they followed national standards in terms of content and style and had been approved through the trust clinical governance process. However, we found one of these, selected at random, had expired in December 2009. We were shown a record book by the staff nurse which demonstrated that there was a process in place to replace expired PGDs and an email had been sent several months earlier to a senior nurse at trust headquarters requesting a replacement PGD.

**Views of people who use services**

People told us that when they arrived at the hospital the medication they brought with them was checked in their presence and locked in the cupboard in their bedroom.

People told us that they had been informed about any new medication they were prescribed, what it was and how long they would need to take it. A comment from one person was, ‘it's a new water tablet and I may have to take it for some time’ and ‘every alternate day I have a strong water tablet’.

People told us that during the administration of their medicines staff asked them specific questions such as their name and whether they are able to take particular medicines, ‘they always read out from the chart, look at the bottle and read it to me’, ‘It is a controlled drug so I have to give my name and date of birth’ and ‘they tell me when I am near the end of my course (of antibiotics)’.

Apart from one person, patients made positive comments about the general care that they received from staff: for example, ‘my care couldn’t have been better’ and, ‘they are looking after me exceptionally well’.

The care of one patient and the management of their medicines fell short of expectations. A patient at Beverley Westwood Community Hospital told us that they had requested pain relief but through a mixture of communication shortfalls, busy staff and ward cleaning plans, action was delayed. This resulted in the person experiencing, ‘considerable pain’ and distress for one hour and twenty-five minutes.

The patient told us they were not asked routinely on admission if they wished to self-medicate despite a POD system in place, facilities for self medication and a willingness and ability on the part of the patient. However, the patient requested to self-medicate when an 8 am medication was not administered on the first morning until 9 am and this delayed their physiotherapy treatment. The patient also stated that all their medicines were late during the first few days of admission and was continually told by staff, ‘the drugs round is on its way’ when they asked for them. The patient was very aware of their medical condition and knew when they needed to take medicines.

The patient also described an incident when a skin patch was due to be changed. The patient had taken the old patch off in readiness and two nurses arrived to administer the new patch. One of the nurses, ‘slapped it on and there were bubbles in it - it was not
smoothly applied as it should be’. During a hospice admission the patient had been
instructed in how to apply patches and knew this was not the correct way to obtain the full
effect of the medicine. When the patient mentioned this, one of the nurses was about to
pull it off to re-apply it. The patient had to tell them this was not the best way, as it would
affect the adhesiveness and the bubbles had to be smoothed out. The patient stated the
nurses said they did not know much about the application of patches.

The patient also stated that no-one asked them if they were in any pain and on one
occasion a nurse asked who they were and what they were admitted for. The patient felt
that there had been a lack of communication between some staff, for example with their
request for pain control and a lack of knowledge about their condition. They also felt that
some staff did not have specific skills and this affected their confidence in how they were
cared for.

A patient at Hornsea Community Hospital told us that they were being looked after
‘exceptionally well’ and that they had never had to wait for important medication. They
described good administration procedures including checks of the MAR chart, the patient
and the bottle containing the medicine. They also described clearly the procedure for
administering controlled drugs.

We talked to a patient at Alfred Bean who stated he was happy with his care, ‘couldn’t be
better’. He described how staff asked for his name prior to administration of medicines,
how medications were kept in the cupboard in the bedroom and how staff always tell
patients what the drugs are. The patient stated how new medication was prescribed and
how he knew what it was for and when to take it.

We talked to an in-patient (several months) who was about to be discharged. The patient
was physically unable to self administer medication and confirmed this. The patient was
prescribed medication to be taken when required. The patient was satisfied with the way
his medication was being managed, and confirmed that he received his medicines at the
times he preferred. He was particularly pleased with the way a particular dose had been
titrated to improve his condition. At the time of the visit a representative from the care
service scheduled to provide his support on leaving the hospital was in attendance to
discuss in detail with him his ongoing treatment and care requirements.

Discussion with trust staff
A pharmaceutical service was provided by a neighbouring acute trust to Bridlington
Hospital and Alfred Bean where patients-own-drugs are in use and all medication was
supplied by the hospital pharmacy. We were shown a service agreement (draft) for the
provision of pharmacy services to these units which specified delivery of a full medicines
supply service, provision of medicines information, access to medication and advice out of
hours via an emergency duty hospital pharmacist and regular ward prescription monitoring.
Work was underway to finalise and sign off the agreement although these services were
already in operation.

We reviewed medication incidents reported to the trust for quarter 3, October to December
2009 and quarter 4 January to March 2010. We found that open reporting was encouraged
and all reported incidents were recorded and analysed before being reported through the
trust clinical governance process. Medication incidents were being reviewed regularly by
the trust Medicines Management Group which was tasked with undertaking any action to
address medication issues. We found that in quarter 4, half of the non administration
medication errors related to patients being admitted to community wards from other
hospitals outside the trust, without accompanying medication, leading to disruption in
ongoing treatment of the individuals. We were informed that various steps had been taken
to resolve this problem, including sharing the concerns with staff on acute wards in the
hospitals where patients were transferred from.
Management and staff recognised that there were still discrepancies across the trust in relation to the quantity of medicines provided on discharge, but were moving towards a trust-wide minimum of 14 days supply on discharge.

Medication alerts, such as those from the National Patient Safety Agency, were being widely distributed across the trust and we found a process in place for monitoring of implementation and reporting through the trust clinical governance processes.

Staff confirmed to us that when the pharmacist visits the community wards, any prescription queries were being communicated to the prescriber via a note, or telephone call, but the drug charts were not being marked to highlight any concerns, or to indicate that the prescription had been clinically checked.

Staff confirmed that approximately 200 staff had attended one of the medicines management briefing sessions out of a total of 600 plus staff in the trust. Attendance lists confirmed these numbers. Arrangements were in place to train the remaining staff during 2010-11 and this was ongoing.

We were told that prescribers were encouraged to select medicines in line with the prescribing formulary operated across the acute hospitals in Hull and surrounding area. In addition, the trust had recently completed a project to assess and implement a wound and dressings products formulary to help promote good practice and rationalise product range.

The trust had agreed specific responsibilities, competences and training for each staff group handling medicines. A medicines management training plan for 2010/11 had been produced by the trust to support the competency framework for medicines management.

The trust had established (in 2009) a medicines management group to lead and oversee developments in relation to medicines, including a sub group to review all reported medication incidents. Managers explained that the trust had identified that there was insufficient pharmacist resource to support both community services and the wider medicines management issues and consequently an additional full time pharmacist post was established. We were informed that the trust had been unable to recruit to this new post, but because it was regarded as being essential to improving medicines management, alternative ways of filling the vacancy were being pursued.
Outcome 21: Records

People who use services can be confident that:

- Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
- Other records required to be kept to protect their safety and well being are maintained and held securely where required.

This is because providers who comply with the regulations will:

- Keep accurate personalised care, treatment and support records secure and confidential for each person who uses the service.
- Keep those records for the correct amount of time.
- Keep any other records the Care Quality Commission asks them to in relation to the management of the regulated activity.
- Store records in a secure, accessible way that allows them to be located quickly.
- Securely destroy records taking into account any relevant retention schedules.
What we found for Outcome 21

Our judgement

The provider is compliant with Outcome 21: Records

Our findings

A summary analysis of risks in the quality and risk profile (QRP) had shown a 'Very High' (High) risk rating for Outcome 21. CQC analysis had identified the high risk rating for Outcome 21 as likely to be caused by a coding related issue. It was ascertained prior to the site visit that the mechanisms for testing management of medicines, did not need to be modified to reflect analysis of records on site. We talked to managers to gauge the extent of any likely problem with records coding.

In discussion the trust identified that as payments are issued against block contracts the coding issue was unlikely to involve financial or patient safety issues. The trust undertook to use the CQC analysis for the QRP to process map against the coding structures used. The trust subsequently contacted CQC by email (6 July 2010) to confirm that the issues identified were associated with Secondary Uses Service (SUS) data quality. Following review of the data, the trust had ascertained that a majority of the errors had been eradicated since going ‘live’ with implementation of the community hospitals module of its new computer system.

Some issues remained with coding which the trust undertook to address by reviewing its internal quality data checking processes. The trust anticipated that this would result in a significant reduction in data coding errors.

On 7 July 2010 CQC’s analyst team confirmed by email that the trust’s reply of 6 July 2010 was as an appropriate response to the concerns highlighted in the QRP, and that further investigation would not be required.
## Improvement actions

The table below shows where improvements should be made so that the service provider maintains compliance with the essential standards of quality and safety.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>Why we have concerns</td>
<td>The trust has demonstrated that it has defined responsibilities, competencies and training requirements for each service area relevant to medicines management, and has Standard Operating Procedures in place for each service area relevant to medicines management. Therefore the specific conditions relating to regulation 13 may be removed. However this area remains a minor concern for the following reasons:</td>
<td></td>
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<tr>
<td></td>
<td>• Self administration of medication was not actively promoted to patients who were capable of handling their own medicines.</td>
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</tr>
<tr>
<td></td>
<td>• Pharmacists’ were not signing and dating patient’s drug charts (drug prescription and administration charts) to demonstrate that prescriptions met current professional and clinical guidelines.</td>
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<td></td>
<td>• The audit trail for disposal of medication was not complete.</td>
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<tr>
<td></td>
<td>• The quantity of medication given to patients on discharge was variable.</td>
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<tr>
<td></td>
<td>• In treatment rooms where medication is stored, temperatures were not being monitored.</td>
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<tr>
<td></td>
<td>• At Hornsea Hospital the treatment room was secured</td>
<td></td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>The outcome for people that should be achieved</td>
<td></td>
</tr>
<tr>
<td>People who are capable of handling their own medicines will be able to do so</td>
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<td></td>
</tr>
<tr>
<td>People will have their medicines administered in a safe way</td>
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<td></td>
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<tr>
<td>When they are admitted from another hospital, people will be assured that their medication and the information about their medication is correct.</td>
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<td></td>
</tr>
<tr>
<td>People will be assured that records about their medicines are maintained consistently</td>
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<td></td>
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<tr>
<td>People will be assured that their medicines are stored safely</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People will be assured that their medicines are disposed of safely</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When discharged from hospital, people will be issued with their medication in consistent quantities.</td>
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<tr>
<td>Diagnostic or screening procedures</td>
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<tr>
<td>Nursing care</td>
<td></td>
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<tr>
<td>Family planning</td>
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</tbody>
</table>
with a digital lock and the code was not changed regularly.

- Some patients were being admitted from local acute hospitals without a supply of current medication and / or a current medication administration record chart.

- In the Physiotherapy department at Beverley Westwood Hospital, no audit trail was maintained of the ordering and receipt of medication.

- Prescription entries in drug charts did not comply consistently with guidance within the SOPs.

- SOPs did not include guidance relating to the practice of transcribing medication.

- For some medicines to be prescribed when required there was a lack of protocols.

- The medication administration records (MAR) and Syringe Driver monitoring forms included recording inconsistencies.

- Refresher training for staff for the administration of patches that deliver slow release forms of medicine was required.

We will re-assess these areas of practice for regulation 13 as part of our ongoing monitoring of compliance. We require the trust to develop an action plan to facilitate this.

The trust must send CQC a report about how they are going to maintain compliance with this essential standard.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The report should be sent within 28 days of this report being received.

CQC should be informed in writing when these improvement actions are complete.