Spire Fylde Coast Hospital

Quality Report

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Date of inspection visit: 2 December 2017
Date of publication: 16/03/2018

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Overall summary

Spire Fylde Coast Hospital is operated by Spire Healthcare Ltd. The hospital has 26 single rooms and 11day care beds which are provided in two single sex bays.

Facilities include three operating theatres, 10 consulting rooms, physiotherapy treatment rooms, medical imaging services and outpatient and diagnostic facilities.

Outpatient clinics are also provided from a small clinic in Lytham, approximately 20 minutes away. Facilities for plain x-ray diagnostic tests are also available in this clinic.

The hospital provides surgery and outpatients and diagnostic imaging services. We inspected surgical services only on this inspection.

We inspected this service using our focused inspection methodology. We carried out an unannounced inspection on 2 December 2017. A focused inspection is targeted to look at specific concerns rather than gathering a holistic view across a service. The reason for this inspection was to follow up concerns which had been shared with the Care Quality Commission anonymously. These concerns were about areas of practice which are in the safe domain therefore this was the only domain inspected at this time.

We asked the question is the service safe. We did not inspect if the service was effective, caring, responsive or well-led on this inspection. Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate. However, for this inspection we did not rate the safe domain as the inspection was focused and evidence was collected against specific key lines of enquiry.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

We did not rate this service but noted the following areas that required improvement:

- The record for controlled drugs was not accurately completed in theatre three.
- Not all theatre records were fully completed.
- The World Health Organisation surgical safety checklists were not fully completed for all patients.
- Documented evidence for the verification of the qualification and competence of the surgical first assistant was not available on site.
- The necessary employment checks were not completed and documented for all staff working in the theatres.

Summary of findings

- On the ward we saw some boxes containing controlled drugs had one end removed. This meant the expiry dates were not on the boxes or some strips of medicines. Therefore there was no assurance these medicines were within their expiry date.
- A log of all staff who had worked as a surgical first assistant was kept. This included doctors who accompanied a consultant and assisted them in this capacity. Not all the information required in this log was recorded as present. For one staff member there was no record of a disclosure and barring service check. For two there was no record of indemnity insurance and two were not signed as required on the record.

We also noted the following areas of good practice:

- Staff knew how to report incidents and received feedback and learning when incidents had occurred.
- Safety performance was monitored and the information used to improve services.
- All areas of the hospital we visited were clean and tidy.
- Emergency equipment was in place and checks recorded.
- Patient records on the wards were fully completed.
- Processes were in place and followed to identify a patient whose condition was deteriorating. This included escalation for medical review.
- There were sufficient numbers of suitably qualified staff on the wards and in theatres to care for the patients.
- There was a process in place to provide appropriate medical cover for patients over a 24 hour period.
- We observed two of these staff members appropriately completing the duties of a surgical first assistant and not working outside that remit

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notices. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North)

Summary of findings

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Background to Spire Fylde Coast Hospital

Spire Fylde Coast Hospital is operated by Spire Healthcare Ltd. It is a private hospital in Blackpool, Lancashire. The hospital has been operating for over 32 years (opening in 1983). It is located 400 yards from a local NHS trust main acute site. It is on the outskirts of the town of Blackpool and about one mile from the seaside promenade. Blackpool and the wider Fylde Coast have a population of around 350,000. The hospital primarily serves the communities of Blackpool and the Fylde Coast; however it also accepts patient referrals from outside this area.

The hospital is registered to provide diagnostic and screening procedures, surgical procedures and treatment of disease, disorder and injury. The hospital has a registered manager who has worked in a managerial post at the hospital since September 2015, working alongside the previous registered manager. The registered manager was appointed in August 2016. A comprehensive inspection took place at this hospital in September 2016. Following that inspection the overall rating for this hospital was requires improvement. It was rated requires improvement in safe, effective and well led and good in caring and responsive.

The hospital also offers cosmetic procedures such as dermal fillers and laser hair removal, ophthalmic treatments and cosmetic dentistry. We did not inspect these services.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and a specialist advisor with expertise in surgery. The inspection team was overseen by Nicholas Smith, Head of Hospital Inspection.

Information about Spire Fylde Coast Hospital

The main service at this hospital was surgery. The consultant surgeons saw patients at this hospital in the outpatient department or in an NHS setting. The patient would then be scheduled for their surgery and have their pre-operative assessment at this hospital. The patient's post-operative care would be provided either as an inpatient or a day case patient at this hospital.

The outpatient department provided an environment for patients to see specialist consultants and have minor procedures if that was suitable within an outpatients treatment area.

During the inspection, we visited the inpatient ward and operating theatres. We spoke with 11 staff including; registered nurses, health care assistants, therapists, medical staff, anaesthetists, operating department practitioners, and a senior manager. We spoke with two patients. During our inspection, we reviewed seven sets of patient records including medication charts.

There were 141 consultants who worked at the hospital under practising privileges. There were two regular resident medical officers (RMO) who worked on a week on and week off rota.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are surgery services safe?

Incidents

- Staff we spoke with knew how to report an incident. They gave us examples of what they would report and these included clinical incidents and other practice issues such as cancelled operations.
- Staff had received online and face to face training in the completion of incident reports. 93% of staff had completed this training. This included healthcare assistants and one told us they had not thought incident reporting was part of their role until this training, but now were happy to do this.
- Nursing and medical staff told us they got feedback about incidents, both ones they had reported and others that had occurred in the unit. If they had been directly involved they had a discussion with their line manager or a more senior manager as appropriate. However, they described this as a learning exercise and not a blame culture.
- Incident investigations were monitored through the clinical audit and effectiveness committee. The report for November 2017 showed there were 183 open incidents and 112 of these were overdue. The majority of overdue incidents (58) were awaiting final approval. The information we received did not specify the severity of the incidents.
- Three staff members had been trained in completing root cause analysis with this training planned for a further three staff.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- Safety performance on both the ward and in theatres was monitored monthly through peer audits. This included completion of records, clinical management of patients such as fluid management and completion of the surgical safety checklist. This information was used by the head of clinical services to target clinical improvement activity.
- A clinical scorecard was completed on a quarterly basis and the information was reported through the clinical audit and effectiveness committee. The information provided is RAG rated (Red, amber or green) and compared to the other hospitals within the organisation. This information included safety measures such as falls and monitoring of patient observations.
- Of the 17 measures reported for quarter three this hospital was as good as or better than the organisation for 10 measures. There was an ongoing clinical review action plan, which had 89 ongoing actions in November 2017. These were reviewed on a monthly basis and the number had decreased from 154 actions, which were was overseen by the hospital manager..

Cleanliness, infection control and hygiene

- The areas we inspected were visibly clean and tidy.
- We observed staff washing their hands between patient contacts.
- Refurbishment of some bedrooms was underway and an additional handwashing sink was being installed in these rooms. The provider was asked to consider this provision at the last inspection.
- Staff in theatres and on the wards wore appropriate personal protective equipment.
- When patients were discharged they were asked to complete a questionnaire about their wound. This was part of the monitoring of surgical site infections which was being completed at the hospital.

- We observed the equipment in theatre being cleaned appropriately between patients.
- At the time of the inspection 91% of staff were up to date with infection control training.

Environment and equipment

- All areas of the hospital were on the ground floor. Work was being undertaken at the time of our inspection to address the recommendations made in our last inspection report.
- Emergency equipment on the ward included anaphylactic management kit and resuscitation equipment. These were easily accessible to staff.
- The equipment in theatre, including the anaesthetic equipment and the emergency equipment was checked pre-operatively. Staff used a checklist which was in line with guidance from the Association of Anaesthetists for the safe management of anaesthetic related equipment.
- On the wards the daily checklist for the resuscitation equipment included the date and time and the reference number of the seal, which kept the trolley securely closed. The trolley was opened monthly and the contents checked, including expiry dates. Written records of these checks were seen and were up to date.
- To reduce the risk of contents expiring between monthly checks there was a list of expiry dates of all equipment on the outside of the trolley.
- In theatre the emergency transfer kit was seen to be in full working order.
- Implants were checked and recorded pre-operatively.

Medicines

- In the wards and the theatres medicines were stored securely. Where temperature controlled medicine storage was needed this was provided and the temperatures monitored and recorded. The records we reviewed showed they were within the correct temperature range.
- On the ward we saw some boxes containing controlled drugs had one end removed. This meant the expiry dates were not on the boxes or some strips of medicines. Therefore there was no assurance these medicines were within their expiry date. We escalated this issue to the hospital at the time of our inspection who took immediate action to address this.
- In theatre when an anaesthetist had prepared emergency medicines these were clearly labelled.
- The record for controlled drugs in theatre three was not accurately completed. There was no record of the amount administered for two medicines on one occasion and the amount supplied and destroyed for another medicine on one occasion. This had been brought to the provider's attention at the last inspection and was escalated during this inspection.
- The record for controlled drugs on the ward was accurately completed. Controlled drugs were securely stored.
- In theatre when two staff members were required to check medications prior to administration we observed this being done and recorded.
- We reviewed five medicine administration records and all were completed. This included allergies and all required signatures.

Records

- We reviewed seven patient records including medical, nursing, theatre records and observation charts. These were mostly fully completed. However not all areas of theatre records were fully completed. This included parts of the WHO surgical safety checklist for three patients and sections of the pre-operative anaesthetic record for one person.
- The records were easy to follow with the nursing and medical records being easily identifiable. The patient's observation charts were kept in their own rooms for ease of completion.
- All records were paper based. We saw they were securely and confidentially stored on the ward area.
- The five pre-operative assessments we reviewed were not all dated. Three had the date the surgery was due to take place recorded and not the date the assessment had been done.
- The fluid intake and output charts we reviewed had been completed.

- The medical staff completed the venous thromboembolism risk assessments. Those we reviewed had been completed and where indicated preventative measures were taken.

Safeguarding

- Staff we spoke with knew what would constitute a safeguarding concern and how to report any concerns internally. The policy was to contact the nurse on call who would make the appropriate referral to social services.
- We saw posters informing staff that the head of clinical services was the safeguarding lead for the hospital. Details of support they offered and how to report concerns was included.
- Staff received level two safeguarding training. In September 2017 88% of staff were up to date with safeguarding adults training and 86% had completed safeguarding children training. This was in line with the hospital's rolling target.
- The service had a safeguarding lead who was trained to level three in adults and children's safeguarding training. The resident medical officer had also been trained to level three in adults and children's safeguarding training.

Mandatory training

- Information provided during the inspection showed 85% of staff were up to date with all mandatory training in September 2017.This was in line with the hospital's rolling target.
- Resuscitation training was reported separately and the report for September 2017 showed 135% of staff had completed intermediate life support. This was because more staff (27) had completed this training than the number identified as necessary (20) within the minimum staffing requirements of the hospital.
- Additional specific training had been identified from the ward audits and through incident investigations.15 out of 27 staff identified as requiring this training in the management of acute kidney injury and sepsis management had completed it.
- Nursing staff were assisted to maintain their competence in clinical procedures with refresher training being provided such as venepuncture (obtaining intravenous access).

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- The pre-operative assessments consisted of either a face to face appointment or a telephone assessment. This depended on the individual risk factors and the surgical procedure being performed. We saw records of these assessments and where risk factors had been identified medical advice was obtained and actions taken to reduce the risks.
- We saw records that other health professionals such as general practitioners had been informed when risks had been identified at the pre-operative assessments.
- We reviewed five patient records and the early warning scores had been completed in line with the policy for all patients. This included within the frequency identified in the patient care area, such as theatre recovery.
- We observed and saw records of a patients observations being escalated appropriately to the resident medical officer when their early warning score triggered a medical review.
- Patients were accommodated in single rooms and as such were not easily observed by nursing staff. This meant if their condition deteriorated it may not be identified unless staff checked them frequently. An intentional rounding tool was in use, which was a record of staff observing a patient at least every two hours. Staff asked them about their general comfort and pain levels and provided refreshments. We observed this to be carried out within the timescales and records were completed.
- Staff told us acute illness management training had been introduced in the past six months.
- Medical staff told us if patients' observations showed a risk of sepsis they would begin the sepsis management by completing the first hour treatment on site. They would then discuss the patient and their condition with the consultant at the nearby NHS acute hospital and transfer them if required.

- Patients received written information on discharge following a surgical procedure. This included the symptoms of sepsis and actions they should take.
- An incident report was submitted for any patient whose condition had deteriorated following surgery. These patients were identified and the head of clinical services was informed. An investigation into their care was completed. This included any patients who had been transferred to the nearby acute NHS hospital.
- In order to reduce the risk of wrong site surgery a four step checklist was in place for surgical site marking. This consisted of the area being marked and checked by four different staff teams and each check was recorded. This had been fully completed in the records we reviewed.
- The provider audited completion of the World Health Organisation's safety checklist. This showed improving compliance, between 91% to 100%, in all three areas. We observed the World Health Organisation's surgical safety checklist to be completed in theatre. However, three of the five records we reviewed had not been fully completed with the sign out sections being incomplete or blank. For one patient no record could be found. This was discussed with the senior manager on site for immediate action to be taken.
- Since the last inspection a fridge for the safe storage of blood products had been provided. This meant blood was available in the event of a major haemorrhage. We saw the temperature of this fridge was monitored and recorded and there was a system in place for checking products safely prior to transfusion.
- A falls risk assessment was one of the risk assessments completed on admission. When a high risk of falls was identified a high visibility wrist band was worn by the patient.
- Where a patient had an additional risk factor due to a medical condition this was identified, recorded and a risk assessment completed. We saw records that these risks had been discussed with the patient as part of their consent to treatment.
- We observed thorough handover of information about a patient between the areas of care. This included from the ward staff to theatre staff, between the medical staff in the theatre and recovery area and between nursing staff on the ward. Risks were discussed as part of this handover process.
- We observed high risk procedures, such as extubation of a patient (the process of removing a tube from the airway following anaesthesia) was carried out in the most suitable area by staff competent to do so.

Nursing and support staffing

- At the time of the inspection there was no theatre manager and no ward manager in post. A theatre manager had been appointed and was due to start work in January. Staff we spoke with in both areas told us they had not experienced any issues due to the lack of managers because there were senior managers who had worked clinically and provided support and guidance when required.
- There were sufficient numbers of qualified nurses on the ward to care for the number and needs of the patients. This included additional staff whilst the operating lists were completed.
- Nurses told us they worked at one nurse to five patients however this would depend on the needs of the patients. They gave us examples of when this had been increased in advance when they knew there were patients to be admitted with additional needs.
- Nursing staff told us they did not use agency staff on the ward unless they had exhausted every other opportunity. We observed them looking to change shift patterns to avoid the use of agency staff on the night of the inspection.
- Agency staff worked in the theatres on most shifts. However they were regular agency staff whom the management team knew and were familiar with. They reported no issues as the agency theatre staff worked well with the rest of the team.
- The high use of agency staff in theatres was recognised by the senior managers and work was ongoing to recruit permanent staff.
- When we arrived at the hospital staff explained that three agency staff for the operating theatres had not arrived on site. We saw this was managed well and no

operations were cancelled. One manager changed their shift to work in theatres and another staff member came in from home whilst the operation list was altered to accommodate less staff in the first few hours.

- The numbers of staff in each theatre and recovery area met the Association for Perioperative Practitioners (AFPP) guidelines.
- At the time of the last inspection the competence of the staff working as the surgical first assistance could not be verified. At this inspection we were told one staff member had completed a university accredited course. The record of this was not available at the time of the inspection. There were two agency staff who worked regular shifts and they had also completed the course. For one of these staff members there was verification of the course completion and competence from the agency who employed them. The other had completed the course within the past two months and they had not received their certificate although a copy had been viewed electronically.
- We observed two of these staff members appropriately completing the duties of a surgical first assistant and not working outside that remit.
- A log of all staff who had worked as a surgical first assistant was kept. This included doctors who accompanied a consultant and assisted them in this capacity. Not all the information required in this log was recorded as present. For one staff member there was no record of a disclosure and barring service check. For two there was no record of indemnity insurance and two were not signed as required on the record.
- The policy for assisting with surgical procedures had been reviewed in November 2017 and it was in line with the AFPP guidance.
- We spoke with agency staff who told us they had been involved the production of a written information guide for other agency staff. This included the policies and procedures of the hospital and the relevant documentation. They had used their experience as agency staff to make a positive contribution to this work.

Medical staffing

- There was one resident medical officer (RMO) on duty 24 hours per day. There were two RMOs who worked on a rota basis of week on week off.
- Nursing staff told us they would escalate any medical concerns about a patient to the RMO. The RMO said if they had ongoing concerns about a patient during normal working hours he would contact their own operating consultant to discuss their condition. Out of these hours there was a consultant physician at the nearby acute NHS trust who was assigned to the hospital. They would contact them for advice or transfer the patient to this hospital if they required urgent treatment.

The anaesthetist on site for an operating list was then on call for 24 hours following that list and would be contacted if there were any concerns or queries about patients who had been operated on during their list.

Are surgery services effective?

Are surgery services caring?

Are surgery services responsive?

Are surgery services well-led?

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that the World Health Organisation surgical safety checklist is fully completed for every surgical procedure.
- The provider must assure itself that the record of controlled drugs in theatre three is correctly completed.

Action the provider SHOULD take to improve

- The provider should consider how to provide documented evidence of the qualification and competence of surgical first assistants.
- The provider should assure itself that the record of staff coming in to the hospital to assist in theatre, such as doctors brought in by consultants, contains all the required information to show it safe for them to be working in this position.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12 (1)(2)(b) Safe Care and Treatment **How the regulation was not being met:** The World Health Organisations surgical safety checklist was not completed for all surgical procedures. Records relating to controlled drugs were not fully completed in theatre. The hospital's staff did not have assurance methods in place to ensure controlled drugs were not past their expiry date. Regulations 2014, Regulation 12 (1)(2)(b)