Frimley Health NHS Foundation Trust

Wexham Park Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital

Surgery	

Summary of findings

Letter from the Chief Inspector of Hospitals

Wexham Park Hospital is situated in Slough and has been part of Frimley Health NHS Foundation Trust since October 2014. The hospital provides surgical services such as emergency, orthopaedic, trauma, plastic and reconstructive surgery to a population of more than 450,000.

We completed a focussed inspection of the surgery service at Wexham Park Hospital on 3 July 2018. This inspection was in response to information of concern about the safety of the surgical services. The focus of this inspection was to review how the hospital responded to risks, shared learning from incidents and how the service leaders ensured changes were implemented and adhered to. During our inspection we came across a number of concerns relating to the environment, cleanliness and medicines that we followed up on at the time of the inspection.

Our key findings were as follows:

- Substances subject to Control of Substances Hazardous to Health (COSHH) legislation were not always stored securely. We found cleaning tablets stored in an unlocked utility room.
- Access to medicines was not appropriately restricted on the surgical unit. We found prescription only medicines left unattended in an unlocked pharmacy room.
- Accesses to various areas within the service were not appropriately restricted. Doors were left open and unlocked and there was no way of tracking the entering and exiting of visitors into the department.
- Staff were knowledgeable about incident reporting and their responsibilities.
- Lessons learned were communicated widely to support improvement within the service.
- Governance arrangements were clear and structured ensuring leaders and staff received information to enable them to challenge and improve performance.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- The service must ensure there are appropriate systems of medicine management and that staff are of their responsibilities in relation to this.
- The service must ensure safe and secure storage of substances subject to Control of Substances Hazardous to Health (COSHH) legislation.
- The service must ensure the access to surgical areas is restricted to authorised persons.
- The service must ensure the temperature of the blood fridge is checked and recorded regularly in line with national requirements.
- The service must ensure all sections of the WHO surgical safety checklists are performed for every procedure undertaken.

In addition the trust should:

- The service should ensure equipment including sterile supplies are stored safely and securely.
- The service should ensure all policies are up to date.
- The service should display stop before you block information in the anaesthetic room as a visual reminder for staff involved in anaesthetic procedures.
- The service should ensure the environment is free from clutter.

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Surgery		We did not rerate this service as this was a responsive inspection focussing on specific concerns we had received.

Wexham Park Hospital

Detailed findings

Services we looked at
Surgery

Detailed findings

Contents

Background to Wexham Park Hospital

Wexham Park Hospital is situated in Slough and became part of Frimley Health NHS Foundation Trust in October 2014. The hospital provides surgical services such as emergency, orthopaedic, trauma, plastic and reconstructive surgery to a population of more than 450,000.

We last inspected Wexham Park Hospital in October 2016 and rated surgery as good overall.

We undertook a focussed, unanounced responsive inspection of the hospital in July 2018 as a result of number of the never events reported by the trust.w

We did not rerate this service as it was a focussed inspection.

Our inspection team

Our inspection team included two CQC inspectors and a specialist advisor with experienced in theatres.

How we carried out this inspection

We carried out an unannounced, responsive inspection on 3 July 2018. The inspection was focussed on the safety and leadership of the surgery service.

We reviewed data provided by the hospital following our inspection.

We spoke with a range of staff including nurses, anaesthetists and operating department practitioners.

Surgery

Safe	
Well-led	
Overall	

Information about the service

Wexham Park Hospital provides both elective and non-elective surgery. Clinical speciality services include ear, nose and throat (ENT), gynaecology, orthopaedics and general surgery. The hospital was last inspected in October 2015. We rated the surgery service as good overall. In the last year, the hospital has reported an increased number of serious incidents. The hospital has report 74 serious incidents between April 2017 and March 2018.

During our inspection we visited main theatres and day surgery two. We spoke with 14 members of staff including theatre manager, nurses, anaesthetists, practice development facilitator, and operating department practitioners.

Summary of findings

- Substances subject to Control of Substances Hazardous to Health (COSHH) legislation were not always stored securely. We found cleaning tablets stored in an unlocked utility room.
- Access to medicines was not appropriately restricted on the surgical unit. We found prescription only medicines left unattended in an unlocked pharmacy room.
- Accesses to various areas within the service were not appropriately restricted. Doors were left open and unlocked and there was no way of tracking the entering and exiting of visitors into the department.
- Staff were knowledgeable about incident reporting and their responsibilities.
- Lessons learned were communicated widely to support improvement within the service.
- Governance arrangements were clear and structured ensuring leaders and staff received information to enable them to challenge and improve performance.

Surgery

Are surgery services safe?

We did not re-rate well-led as this was a focussed unannounced inspection, looking at certain aspects of the surgery service.

Cleanliness, infection control and hygiene

- Sharps bins were dated when opened but the temporary lid closure was not used in line with environment and sustainability health technical memorandum 07-01: safe management of healthcare waste. There was a risk of health workers being exposed to diseases or viruses carried by blood from a needlestick injury. We also saw a used syringe resting on top of a sharps bin with blood on it, in the scope room. The nurse in charge dealt with this immediately when it was brought to their attention.
- We asked the head of theatres what the cleaning arrangements were for the department. We were told that housekeeping staff carried out a monthly cleaning audits and fed back to the department matron. We were told that theatre staff were responsible for the overnight cleaning and there was a daily cleaning schedule for staff which was subject for review during the weekly peer reviews. However, there seemed to be a lack of any real set process and means of identifying who was responsible for what and when.
- Boxes were stacked on the floor in the sluice room. The corridors around theatres were cluttered and untidy though all routes were accessible without restriction. This meant adequate cleaning was difficult.

Environment and equipment

- Accesses to various areas within the surgical department were not appropriately restricted. We were also shown the dirty utility room (sluice). This room was not locked and could be opened by anyone passing by. There was an increased risk as during our inspection, there were five recovery beds, away from the main recovery area that were being used as escalation beds for surgical and medical patients. We were told that these patients were allowed visitors so both patients and visitors could have unauthorised access. We were told that the keys to lock the door were kept in the office. The room was untidy with boxes stored on the floor in the corner.
- We found a container with hazardous cleaning tablets (chlorine based) on top of the macerator. We reviewed the control of substances hazardous to health (COSHH) assessment sheet for the tablets. The storage requirements state the tablets should be stored in the original tightly closed container, in a dry, cool and well ventilated place. Although this does not say they should be locked away, it is poor practice to keep the tablets where they are easily accessible due to the hazards associated with the tablets such as the irritation of the respiratory system. We raised this issue with the head of theatres and the trust produced an action plan to address this concern. Actions taken included placing an advisory notice on the door to remind staff to keep it locked and to install digital locks. Assurance of this was to be evidenced through the weekly peer review audits undertaken by the service.
- Opposite the recovery bay we saw a door to the stock room labelled pharmacy. This was not locked. There were locked cupboards within pharmacy room but some medicines such as lignocaine were left on top of the worksurfaces unattended. This meant that medicines were easily accessible to anyone who gained access to the pharmacy room. We reported this to the head of theatres. An action plan to address this issue was provided by the trust. Staff were reminded not to leave medicines unattended. Lignocaine was to be kept in a separate lockable cupboard and this was to be added to the theatre standard operating procedure. We were told the head of theatres was responsible for ensuring the service was complient through daily checks and weekly peer review monitoring.
- Authorised staff had access into theatres and the associated areas by using their swipe cards; however, anyone could leave the department at any time by pressing the large green exit button. There was no way of tracking the entry or exit of visitors as there was no reception area or a member of staff manning the entrance.There was also a risk of non-authorised people tailgating to gain access to the unit.
- The surgical service had a dedicated sterile equipment room where surgical instruments were kept. This room was unlocked and we were told that the keys were in the office. This meant there was a risk of equipment being stolen or tampered with, as there was open access to visitors or patients being cared for in the escalation beds

nearby. All the equipment in the room had a barcode that was tracked to show that it was available in the room,. however However, there were no assurances on how stock was managed. We saw when equipment was removed from the room, it was not tracked again until it had been used, cleaned, and placed back in the sterile equipment room. This meant that the tracking system could show that equipment was in the room when it had actually been removed. Staff told us there was a check at 4:30pm every day to see what equipment was needed for the next day and this was the only way they would realise if a piece of equipment was not available.

- We were shown the endoscope drying room. An endoscope is a flexible tube with a light source and camera used to look inside the body. This room was accessed using a swipe card. We were told how the clean and dirty scopes were processed. Scope technicians were responsible for all parts of the process of cleaning, drying, and removing dirty scopes. Although when we first entered the endoscope room the door was shut, when we passed it again ten minutes later, the door had been left open.
- The blood fridge had not had the temperature had not been checked since 29/06/18. The temperature must be checked regularly and maintained within a specific range to prevent the deterioration of blood cells. We were told that this was a check that was performed by the 'pathology lab' not theatre staff. This showed there was poor understanding and oversight of responsibilities. We revisited the blood fridge an hour later and the date had been completed with an incorrect date of 3 June 2018.

Records

- We observed a briefing in the elective gynaecology theatre. The clinical lead for the surgery discussed and named each patient on the surgery list. The briefing included the medical history of the patient using the pre-assessment paperwork for this information. There were clear instructions of equipment required for each procedure.
- However, there was no team brief or team debrief document to accompany the WHO checklist. This meant that there was no documentation on a standardised pro-forma for other discussions, checks, and issues not routinely addressed by the WHO checklist. There were particular issues on the day of the inspection with a lack of porters, which caused hold ups with theatre flow. As there were no team brief/debrief forms, this was not documented. This meant the unit could not audit such issues in order to make improvements, as there was no data to refer to.

Assessing and responding to patient risk

- The surgical service had streamlined an effective WHO checklist and we observed it being used well. The checklist took five minutes to complete, the surgeon led, and staff were attentive and engaged.
- The trust conducted a monthly WHO surgical safety checklist audits. The audit reviewed all stages of the process from the team brief to the debrief. Trust data showed the compliance with the WHO surgical safety checklist from December 2017 to July 2018 was 99%, meeting the target of 95%.
- We observed a good 'time out' led by the anaesthetist. The "time out" is the final stage of checks to prevent severe harm being done to the patient. At the "time out" stage all staff must stop and listen whilst the relevant checks are undertaken before starting the operation. Noise and interruptions should be minimised. We observed that all staff were present and all paused for the time out. There was a thorough prosthesis (artificial body parts) check with three members of staff each confirming the name, type, and size of the implant. However, this implant was not written on the theatre white board at the time of checking but completed after. This meant that the recording of this on the board was not completed at the same time as the visual check.
- It was difficult to ascertain the order of patients on the theatre list once changes were made to the original list. The theatre coordinator moved patients about the operating list and relied mainly on the verbal handover to communicate changes. The updated list was printed on the same coloured paper as the original list and we were confused about which was the current list. We saw that a patient who was in theatre was not on the list being used.
- There were no 'stop before you block' posters in theatre. The posters act as a visual reminder for staff to pause

and check what they are doing before proceeding with the procedure. This meant there was a risk of the anaesthetic team continuing with the needle insertion before reconfirming the correct site.

- We observed some staff checking patient ID against the patient's wristband whilst the patient was prepped and draped for surgery. The anaesthetist was not in the room at this point. The consent form was not checked against the patient's wristband. This was not good practice because of the risk of potential patient identity errors. It was also not in line with the WHO surgical safety checklist where everyone should be present and confirming the patient's identity.
- We saw that not all staff were present in the theatre for the patient consent check. The operating department practitioner was not present for 'sign out'. We observed a pre-briefing for general theatres that was vague. This occurred in an office before the start of surgery. The staff member leading the briefing did not name the patient. The patient's medical history and planned surgery were discussed as 'case one' but it was not clear who that person was. There was a risk of wrong patient errors happening and this was not in line with the WHO surgical safety checklist sign in which states that there should be a verbal patient identity verification. Nursing staff were asked to prepare various medications, the details of these were written on scraps of paper pulled from their pockets which could be easily lost.
- We observed poor communication between the ward nurse and theatre nurse during the handover when the patient arrived for surgery. There was a risk that valuable information would not be passed to the relevant staff, as there was no dedicated nurse caring for the patient throughout the patient pathway.
- In December 2017, the service underwent an external review led by the Clinical Commissioning Groups in partnership with Frimley Health NHS Foundation Trust. The purpose of the visit was to observe safety procedures and team-working, particularly in respect of the WHO checklist. The team recommended that the service should review the practice of conducting pre-list briefing in the small office space outside theatres as this was not the best place for a full team briefing. A further recommendation was to look at the availability of porters as it was noted that the nurse undertook portering duties while pre-op briefings were taking place.

Incidents

- The trust had an electronic system for reporting incidents. Staff understood the process and this was confirmed verbally, both at junior and senior level. The incident reporting form was accessible for all staff to complete and staff received feedback on incidents from the theatre matron or team leaders.
- The hospital reported 74 serious incidents from April 2017 to March 2018. There were 15 incidents belonging to the surgical/invasive procedure category.
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- From April 2017 to March 2018, the trust reported six surgical incidents classified as never events.
- At the time of our inspection, all never events had been fully investigated, with action plans identified to reduce the risk of reoccurrence. In relation to the never event relating to wrong site nerve block, the investigation panel attributed the root cause to the failure of staff to 'stop before you block' in order to check the site and the side of the body to insert the nerve block. The panel recommended that local safety standards for invasive procedures should be designed for local anaesthetic procedure, documenting the procedure for the administration of regional anaesthetic. A further recommendation was for the service to consider whether the marking of patients specifically for regional anaesthesia should be introduced into practice.
- The practice development nurses had been formally in post since 1 April 2018. However, they had undertaken a number of tasks associated with the role of practice development nurses before that date. The appointment covered all three sites across the trust. The decision to introduce the role was a strategic one, based on the need to get consistency and parity in practices across all sites. One of the first roles was for the practice

development lead was to look at the trends from the serious incidents and never events. The practice development lead organised a cross site patient education day for 100 staff. All band 7 nurses attended this so staff who could not be accommodated on the training day could have key messages fed back to them.

- A review of the team communication folders (purple folder) showed that they all contained information relevant to their teams as well as information relevant to the whole department. We saw theatre dashboards, team meeting minutes and an incident report breakdown by category and area.

Are surgery services well-led?

We did not re-rate well-led as this was a focussed unannounced inspection, looking at certain aspects of the surgery service.

Leadership

- Staff told us, under previous arrangements, there was "a lot of talk from managers but not a lot of action". Communication between staff and managers was poor and minimal but this had changed for the better in the last two years.
- The theatre manager had taken over the running of the theatres at Wexham Park Hospital following a period of working at Frimley Park Hospital. Staff reported that there was no real structure to the service and difficulties with communication between managers and staff. The manager said leadership issues had been addressed which were deemed to be part of the issue with incidents and learning from incidents.
- The theatre matron had redesigned the staffing structure. This was due to be implemented in September 2018 and would mean each sub-team was managed by a band seven nurse. The plan was to have two band seven nurses managing the general surgery team. Two band seven nurses managing the orthopaedic team. Two band seven nurses in recovery and 1 band seven nurse in anaesthetics. The restructure of the department had involved a period of consultation with staff. This was done in conjunction with staff side representatives (representatives from trade unions) and human resources.
- We spoke with members of the leadership team including the matron and the head of theatres. It was clear that they understood the challenges the service faced and were working to address the issues. This included the never events reported.
- The head of theatres had undertaken a number of 'listening into action' (listening into action is about re-engaging with employees and unlocking their potential so they can get on and contribute to the success of the organisation, in a way that makes them feel proud) sessions with staff.
- The theatre manager had made it a priority for theatre leads to engage with staff. They spent a week 'on the floor 'working alongside staff to understand what staff frustrations were. It was found that staff were not having regular appraisals or return to work interviews after a period of sick leave. This meant staff were not provided with the necessary support to prevent further illness or have adjustment made to help them adapt and return to work safely.
- The theatre team had won a trust leadership award 2018 for collaborative teamwork. All staff we spoke with told us that the department was a good place to work. Staff were generally happy in their work and felt that they were respected by their leaders and colleagues.

Culture

- Staff were committed and enthusiastic which was obvious during conversations and from observing them at work. We spoke to five nurses and one health care assistant who told us that their managers supported them and listened to their concerns. For example, there was a plan to make changes to the layout of the theatre which included the addition of a reception area and a receptionist to make the entrance more welcoming for patients and visitors. Staff had been consulted on their views of this.
- One nurse said previously staff found it difficult to challenge some surgeons but there had been a change as 'patient safety first' was paramount and all staff recognised the need to work together to achieve this. The practice development nurse told us that the willingness of staff to challenge what was happening in theatre had improved. The head of theatres had implemented an open-door culture where all staff were free to challenge. They had involved the 'freedom to

speak up' guardian as part of this. Staff felt empowered to speak up if they believed something was not being done correctly. This was confirmed by the head of theatres and corroborated by the staff we spoke with.

- We spoke with a surgeon who said that inconsistent staffing had been an issue at the site but thought this had improved over the 'past few months'. He did not believe that theatre staff were reluctant to challenge and that he encouraged challenge from all staff.

Governance

- The trust had an integrated theatre governance group across all three sites. There was effective sharing of practice and learning by having joint governance meetings. We reviewed a sample of clinical governance meeting minutes provided by the trust. There was consistent content, clear structure and set agendas.
- We asked to see the policies used in the department and we were directed to a large cupboard was filled with files and folders. These contained outdated paperwork. For example, the policy on surgical safety was dated 2012. There was a risk of staff referring to outdated policies and potentially using unsafe out of date practices. We were shown the trust intranet and where we saw updated policies were available.
- At our inspection, we found some concerns with medicine management, security of the premises and infection control procedures. It demonstrated a risk to patient safety, poor governance of medicine management and lack of ownership of responsibility. The trust provided us with an action plan for all issues identified during the inspection, which included, reminding staff of their responsibilities in the department and monitoring compliance through weekly peer review audits.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The service must ensure there are appropriate systems of medicine management and that staff are of their responsibilities in relation to this.
- The service must ensure safe and secure storage of substances subject to Control of Substances Hazardous to Health (COSHH) legislation.
- The service must ensure the access to surgical areas is restricted to authorised persons.
- The service must ensure the temperature of the blood fridge is checked and recorded regularly in line with national requirements.
- The service must ensure all sections of the WHO surgical safety checklists are performed for every procedure undertaken.

Action the hospital SHOULD take to improve

- The service should ensure equipment including sterile supplies are stored safely and securely.
- The service should ensure all policies are up to date.
- The service should display stop before you block information in the anaesthetic room as a visual reminder for staff involved in anaesthetic procedures.
- The service should ensure the environment is free from clutter.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The door to the pharmacy room was not locked which meant that medicines were easily accessible to all. We found prescription only medicines were left unattended and on the top of work surfaces. The blood fridge temperature had not been checked since 29/06/18. The temperature must be checked regularly and maintained within a specific range to prevent the deterioration of blood cells. The patient identification procedure was not in line with the World Health Organisation surgical safety checklist where it states everyone participating in the procedure should be present and confirming the patient's identity.

Regulated activity	Regulation
Surgical procedures	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Accesses to various areas within the surgical department were not appropriately restricted. Doors to the utility and equipment rooms were left open allowing easy access into these areas. There was no form of tracking the entry and exit of visitors into the department.