Spire Murrayfield Hospital

Quality Report

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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

Summary of findings

Letter from the Chief Inspector of Hospitals

Spire Murrayfield Hospital is operated by Spire Healthcare Limited. The hospital has 25 inpatient beds and 17 day-case beds. Facilities include three operating theatres, a pharmacy, a pathology laboratory, a physiotherapy treatment area, a sterile services department for the decontamination and sterilisation of theatre instruments, X-ray, outpatient and diagnostic facilities.

The hospital provides surgery, medical care and outpatients and diagnostic imaging. We inspected some aspects of surgical care services.

We inspected this service using our focussed inspection methodology. We carried out an unannounced visit to the hospital on 21 August 2017 as a follow-up to a warning notice that was issued following the last inspection in September 2016. This was issued due to concerns about the lack of assurance around the robustness of investigations of incidences of venous thrombo embolism's (VTE). We also followed up concerns that had recently been raised with the CQC.

We found the following issues that the service provider needs to improve following the concerns recently raised with the CQC:

- There were incidences of incorrect assessment of grading, according to the American Society of Anaesthesiologists (ASA) as part of patient preoperative assessments as part of NICE guideline NG45 (2016). This meant there was a risk that patients operations had either been cancelled or they should have been treated in a hospital with access to critical care facilities in case of any deterioration post surgery.
- There was no evidence that the provider had reported incidents of patients who had an ASA level 3 who had undergone surgery. This meant there was a risk that potential learning had not been identified to improve services provided. During the inspection, there was no local policy or guidance for clarification for preoperative staff to classify the ASA level for patients to ensure that the hospital could provide the correct level of care post operatively. There were no audits of the accurate completion of preoperative assessments. There was no exclusion policy to assess the suitability of patients treated at the hospital, although the hospital had been working to put this in place.
- There were staff employed in a surgical first assistant (SFA) role who had not received any theoretical training prior to assessment of practical competencies in line with recommended national guidance. Since the inspection the provider has told us that a tailored SFA module with a university has been commissioned to provide additional training.

However, we also found the following areas of good practice:

- We were assured that the provider had addressed the concerns in the warning notice that included a review of the policy for the management of venous thromboembolism (VTE) and completion of root cause analysis (RCA) investigations to help improve practice.
- Processes were now embedded for the management of investigations of venous thromboembolisms (VTE).
- Staff, including health care assistants, were encouraged to develop their role, in theatres, whilst being supported and supervised.

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 two requirement notices that affected surgery. Details are at the end of the report.

Name of signatory

Ellen Armistead

Deputy Chief Inspector of Hospitals

Summary of findings

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Summary of this inspection

Background to Spire Murrayfield Hospital

Spire Murrayfield Hospital is operated by Spire Healthcare Limited. The hospital opened in 1982. The hospital provides services to both NHS and privately funded patients. The hospital primarily serves the communities of the Wirral. It also accepts patient referrals from outside this area.

Spire Murrayfield is registered to provide the following regulated activities:

- Diagnostic and screening
- Family planning
- Services in slimming
- Surgical procedures, including cosmetic surgical procedures
- Termination of pregnancy
- Treatment of disease

The registered manager has been in post since December 2016, although has been employed at the hospital prior to this date in other roles.

Following an inspection of the hospital using CQC comprehensive methodology, in September 2016, enforcement action was taken with a warning notice issued for a specific concern about the lack of assurance around the robustness of investigations of incidences of venous thrombo embolism's (VTE). This unannounced inspection, on 21 August 2017, was focussed on the actions taken by the provider in response to the warning notice. In addition other recent specific areas of surgical services were inspected following concerns raised with CQC.

Our inspection team

The team that inspected the service comprised a CQC inspection manager, a CQC lead inspector and a CQC team inspector. The inspection team was overseen by Amanda Stanford, Head of Hospital Inspection.

Why we carried out this inspection

Following an inspection of the hospital using CQC comprehensive methodology, in September 2016, enforcement action was taken with a warning notice issued for a specific concern about the lack of assurance around the robustness of investigations of incidences of venous thrombo embolism's (VTE). This unannounced inspection, on 21 August 2017, was focussed on the actions taken by the provider in response to the warning notice. In addition other recent specific areas of surgical services were inspected following concerns raised with CQC.

Information about Spire Murrayfield Hospital

During the inspection, we visited areas within the pre-operative clinic, ward and theatre. We spoke with 11 staff including; operating department practitioners, registered nurses, medical staff, and senior managers. During our inspection, we reviewed five sets of patient records.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found the following issues that the service provider needs to improve following concerns raised with the CQC:

- Patient preoperative assessments included grading according to the American Society of Anaesthesiologists (ASA). There were incidents when reassessment of patient ASA levels meant patient operations either being cancelled or they should have been treated in a hospital with access to critical care facilities in case the patient deteriorated.
- There was no evidence that the provider had reported incidents of patients who had an ASA level 3 who had undergone surgery. This meant there was a risk that potential learning had not be identified to improve services provided

However, we also found the following areas of good practice:

- We were assured that the provider had addressed the concerns in the warning notice that included a review of the policy for the management of venous thromboembolism (VTE) and completion of root cause analysis (RCA) investigations to help improve practice.

Are services effective?

We found the following issues that the service provider needs to improve following the concerns raised with the CQC:

- There were staff employed in a surgical first assistant (SFA) role who had not received any theoretical training prior to assessment of practical competencies as recommended in national guidance. Since the inspection the provider has told us that a tailored SFA module with a university has been commissioned to provide additional training.
- There were no audits of the accurate completion of preoperative assessments.

However, we also found the following areas of good practice:

- Staff were encouraged to develop their role, in theatres, whilst being supported and supervised.

Are services caring?

Not inspected

Are services responsive?

Not inspected

Summary of this inspection

Are services well-led?

We found the following issues that the service provider needs to improve following concerns raised with the CQC:

- There was no exclusion policy to assess the suitability of patients treated at the hospital, although the hospital had been working to put this in place.
- There was no policy or guidance for preoperative staff to classify the American Society of Anaesthesiologists level (ASA) for patients. This would help ensure that patients received the correct post-operative care.

However, we also found the following areas of good practice:

- We were assured that, following the issuing of the warning notice for the lack of robust systems for managing and investigating venous thromboembolism (VTE) events, systems were now in place.

Surgery

Safe	
Effective	
Well-led	

Are surgery services safe?

Incidents

- During the inspection in September 2016, it was noted that Spire policy stated that any incidence of venous thromboembolism (VTE) should be investigated using a root cause analysis (RCA) approach. (A VTE is the formation of blood clots in the vein. When a clot forms in a deep vein, usually in the leg, it is called a deep vein thrombosis. If that clot breaks loose and travels to the lungs, it is called a pulmonary embolism.)
- A RCA is used to examine the full history of occurrences when an incident occurs so that the root cause can be identified and improvements made where required. It was found, however; that not all incidences of VTE's had been investigated using a RCA.
- Following the last inspection, in September 2016, CQC identified that the incidences of VTE's had not always been reviewed and investigated fully in line with their policy. The provider was completing documentation for Serious Adverse Events (SAE), however; these did not include any actions for improvement. These incidences highlighted at inspection were retrospectively reviewed, by the provider using a root cause analysis approach, however; the templates were not fully completed and did not show any learning. A further review and change of national policy and documentation showed improvement.
- Between January 2017 and August 2017, there were five incidences of VTE reported; four were diagnosed as pulmonary embolism (PE) and one as a deep-vein thrombosis (DVT). Since the last inspection, a specific RCA template for VTE's had been developed and implemented. Each of these incidences had RCA's completed with an action plan in place with actions that were either completed or in progress. This meant that any lessons had been identified to help monitor and improve patient care. Assurance was provided that the concerns in the warning notice had been addressed.

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

- Following concerns raised with the CQC, it was identified that, there was an admission and discharge policy that had been reviewed in April 2017, however; there was no exclusion policy. The provider had identified a need for a policy and was in the process of its development. It is important for providers to assess if they have all facilities required to treat patients safely, for example; if a provider considers that a patient may require critical care facilities, post-surgery, then an independent hospital, may not be able to treat the patient. In this case, the patient would most likely need to be treated in a NHS hospital. An inclusion / exclusion policy clearly identifies the level of care that a hospital can safely provide.
- Patients attended pre-operative clinics where standardised paperwork was completed that included risk assessments. One of the assessments was to score the patient according to the American Society of Anaesthesiologists (ASA) in line with NICE guideline NG45 (2016). TheASAphysical status classification system is a scale for assessing the fitness of patients before surgery. Level one is a heathy person, level two there is mild systemic disease and level three there is severe systemic disease. It is important that patients are assessed pre – operatively to identify any other chronic health issues that may affect their recovery and also assess if there are all the necessary resources available at the hospital. A patient assessed at ASA level three may be more likely at risk of developing complications post surgery.
- We found, however; that there was no written process for staff to follow, in the preoperative documentation part of the patient's journey. Staff provided us with evidence that they followed NICE guideline NG45 (2016) for determining which investigations were required pre-operatively which included the ASA classification levels. Nice guidance did not include examples of conditions to support the assessment of the ASA level.

- We were told, by senior managers, that patients assessed as ASA level one or two, only, would be eligible for surgery at the hospital as a patient assessed as ASA level three may need access to critical care beds in the event of them requiring extra support or deteriorating post-surgery as outlined in National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (2011) Royal College of Surgeons (2011) guidance.
- There was a process in place for discussing the ASA level at the multi-disciplinary team brief prior to surgery. From reviewing records of the team brief we found this was not always recorded.
- On the day of inspection, we were told that a surgical patient had been reviewed by the anaesthetist and the ASA level increased from level two to three prior to the operation, however; the patient's records showed that the ASA score was recorded as level two. On a previous admission in March 2017, the same patient had been assessed as ASA level three, as recorded in the patient's documentation, and underwent surgery at that time.
- We were given an example of a patient who had been assessed as ASA level two, at preoperative assessment, however; on the day of admission the patient was identified as ASA level three. The patients operation was cancelled. We were told, by senior managers, that any incidences of level three patients would not be recorded as incidents, although; any patient whose operation was cancelled prior to surgery, on the day of admission would be recorded in the electronic incident reporting system in line with the providers incident reporting policy.
- Post inspection, we were provided with details of cancelled patients between January 2017 and August 2017. There were 52 incidences when operations had been cancelled on the scheduled day of the surgery, although; the providers incident reporting system did not identify if any were due to the ASA level being assessed as level three.. Senior managers were unable to state accurately why they considered three of the cancellations were potentially as a result of a change in a patients ASA score from the initial assessment of ASA level two at preoperative clinic to ASA level three on the day of surgery. We were not assured that the recording of ASA levels was being monitored effectively.
- We reviewed a preoperative assessment completed by a nurse, who was not a dedicated preoperative nurse. The nurse had recorded that the ASA level of a patient had not been assessed. We were therefore, not assured that all patients were being correctly ASA level assessed. This meant there was a risk that the appropriate level of post-operative care was not in place
- On the day of inspection, we were told, by the senior nurse in the preoperative clinic, that two further patients assessed as not suitable for surgery, at the hospital, were discussed with the anaesthetist. We were also told, by senior managers, that if a nurse assessed a patient as level three ASA, these would be highlighted to the anaesthetist.
- We reviewed five patient records for patients on the ward on the day of the inspection and saw that all patients had an ASA score of level two recorded in their preoperative assessment records

Are surgery services effective?

Competent staff

- Following concerns raised with the CQC, it was identified that, preoperative clinic staff maintained a record of competencies to carry out daily tasks that included preoperative tests. On the day of inspection, the preoperative nurse was not on duty but a nurse previously assessed as competent was undertaking the role. Following the inspection we were provided with evidence that any temporary staff undertaking the role of pre-operative nurse had received the appropriate training to assess patients as outlined in the providers assessment of competence of preoperative nurses for 'pre-assessment of patients for surgery.'
- Post inspection, in response to our concerns raised, the provider forwarded CQC a copy of an action plan that included immediate implementation of triage system for referrals to the hospital. The outpatient manager had been allocated to identify all patients that may have additional risk factors such as co-morbidities, social concerns or complex needs to ensure they could be accepted for further pre-assessment review. This meant that any immediate concerns could be referred back to the original referrer to find a more suitable provider for the patient.
- In theatres there were staff employed as surgical first assistants. (A surgical first assistant (SFA) is a registered healthcare professional who provides continuous competent and dedicated assistance under the direct

supervision of the operating surgeon throughout the procedure, whilst not performing any form of surgical intervention). The SFA role involved assisting consultants with key skills such as retraction and the movement of internal organs during procedures.

- Two of the six SFA's had completed an externally accredited course as per the Association for Perioperative Practice (AFPP) 2014 guidance. The Perioperative Care Collaborative (PCC) 2012 recommends that the role of the SFA must be undertaken by someone who has achieved a recognised programme of study, however; four of the SFA's had not received any theoretical training. In addition, the providers policy 'Assisting with surgical procedures' (2016) included: "The role of the surgical first assistant with extended skills can be undertaken by a practitioner who has successfully completed both a theoretical and practical skills course." Following the inspection senior managers told us that this hospital did not employ staff in this extended role.
- The management team were unable to provide written evidence of staff achieving these competencies. This meant that we were unsure if staff had been assessed as being competent to perform this role by an appropriate person. However, a log book was kept by staff which was a record of the frequency of SFA skills used. Each member of staff also had a named mentor and these log books monitored practical procedures that contributed to their annual appraisal.
- In addition, there was a bank nurse who carried out SFA duties and there was no record of any competencies. Following the issues raised on inspection, a risk assessment was completed that stated that the bank nurse was supervised by a qualified member of staff. A copy of the bank nurse's previous experience was also forwarded to the inspection team after the inspection. This included experience of scrub and recovery duties; however, there was no evidence of any qualifications or competency assessments for an SFA role. Following the inspection, senior managers told us that competency assessments had been completed when recruited, however; had not been reviewed recently. In addition, we were told us that the nurse was not permitted to work unsupervised until competencies were signed off.
- Staff identified as health care assistants (HCA), in theatre, were able to extend their role. This included a scrub role which could involve assisting in surgical procedures and preparing patients for recovery. We were told, by senior managers, that there was always another registered scrub nurse who supervised and was accountable for the practice of a HCA; and assistance was limited to minor surgery. Theatre rotas reviewed indicated that a HCA was allocated with a registered scrub nurse for major surgeries..

Are surgery services well-led?

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- Following the inspection in September 2016, a warning notice was issued as the provider was found to be non-compliant for managing and investigating venous thromboembolism (VTE) events.
- During the last inspection it was found that the provider's policy for VTE's stated that incidents that occurred within 30 days of surgery would be investigated. The provider reviewed the policy and issued: 'reducing the risk of deep vein thrombosis and pulmonary embolism (venous thromboembolism) in patients admitted to hospital' in November 2016. This included that following a confirmed VTE, "an initial review of the patient's notes must be completed to assess whether this is hospital associated thrombosis (i.e. occurred within 90 days of hospital admission…" This was now compliant with the national VTE prevention programme.
- During the inspection we found that there was no preoperative guidance for the classification of ASA levels or process to assess the suitability of patients for surgery at the hospital in the pre-operative assessment paperwork. In addition, there were no audits of ASA classification.
- In response to the issues raised at the inspection, the provider forwarded a copy of their 'standard operating procedure and local work instructions for pre-operative ASA classification system' with an issue date of August 2017. The provider forwarded a copy of their 'pre-assessment guidelines for registered practitioners', although; this had not yet been issued. The provider explained that this was included as part of their responsibilities for commissioning for quality and innovation (CQUIN).

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that robust policies and procedures are in place for all preoperative assessments including monitoring and evaluating practices.
- The provider must ensure that surgical first assistants (SFA) have received the appropriate training and have the necessary competencies to carry out their duties they are employed to perform.

Action the provider SHOULD take to improve

- The provider should ensure that competencies are recorded accurately for all staff.

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
	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person must ensure that robust policies and audit procedures are in place for staff to follow to enable them to carry out the duties they are employed to perform. Regulation 17 (1)(2)(d)

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent skilled and experienced persons must be deployed. They must receive such appropriate support, training, professional development and supervision as necessary to enable them to carry out the duties they are employed to perform. Regulation 18(1)(2)(a)(b)