# Spire Wellesley 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

## Ratings

## Overall summary

**Surgery – Theatres**

- There was evidence of lessons learned from incidents that had taken place with changes in practice. However the changes to practice were not fully embedded with some development required with staff training and competencies.
- Risks and incidents were shared with staff across the hospital and other hospitals in the provider group through staff meetings and alerts.
- Staff had received equipment training provided by manufacturers with records demonstrating this had taken place. However the records did not sufficiently detail who was trained to use the different equipment models or the content of the training provided.
- Laminated quick reference user guides were attached to safety critical equipment for staff to use when setting up the equipment.
- Theatre staff competency packs were generic and not role specific which limited manager oversight of the completion of competencies required for individual roles in theatres.
- The hospital had a comprehensive asset management register in place suitable for equipment management including staff training. However this was not being used to track staff asset training with a reliance on paper based competencies.
- Theatres had comprehensive risk assessments in place for safety critical equipment.
- The hospital risk register covered all departments to give the senior management team and heads of department oversight of the risk profile for the hospital. The risk entries had an allocated risk owner and action owner.
- There were four theatre practitioner vacancies in theatres that had not been recruited. The hospital was actively advertising these posts.

# Summary of findings

## Contents

# Summary of this inspection

## Background to Spire Wellesley Hospital

Spire Wellesley Hospital is part of Spire Healthcare Limited. Spire Wellesley Hospital offers comprehensive private hospital care to patients from Southend-on-Sea and the rest of Essex.This includes patients with private medical insurance, those who self-pay and patients referred through NHS contracts. Of the surgical procedures carried out by the hospital from April 2016 to March 2017, 49% were for NHS patients.

## Our inspection team

The inspection was undertaken by two CQC inspectors and one specialist advisor.

## Why we carried out this inspection

We completed a focused inspection on the 2nd March 2017 following a statutory notification related to a serious patient injury, which occurred in theatres. The inspection was carried out to ensure the hospital had implemented an action plan to mitigate the risk.

## How we carried out this inspection

Only the theatre department was inspected. We have not rated this service as it was a focussed inspection.

The inspection team inspected one domain to ascertain if services were:

· Safe

## Information about Spire Wellesley Hospital

Hospital facilities include an outpatient service, diagnostic imaging service, a 30 bed inpatient ward, eight day case beds and a three bedded short stay unit. Theatre provision includes four theatres, two with laminar flow and a sterile services department.

# Detailed findings from this inspection

# Surgery

## Safe

### Are surgery services safe?

**Incidents**

- There were 44 incidents reported in theatres from August 2016 to February 2017. The main themes for the incidents were issues with equipment, ineffective communication of clinical information and incorrect documentation. Staff were actively encouraged to report incidents or near miss-events through the electronic incident reporting system.
- There was one never event in theatres in the six months prior to our inspection which related to a wrong site surgery. 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.The theatre team meeting minutes show that the incident and the learning had been discussed with the team. Lessons learned included a further surgical pause if there was a distraction following the timeout phase of the World Health Organisation (WHO) Surgical Safety Checklist and five steps to safer surgery. In addition the incident and learning actions had been discussed at the medical advisory committee (MAC) and the quarterly governance meeting.
- There was a culture of learning from incidents within the theatre department. For example four theatre staff members we spoke with were able to explain learning and changes in equipment use following the patient burn incident in theatres. This showed that the department had systems in place to share learning and actions from incidents to minimise the risk of similar events reoccurring.
- The hospital also shared actions and learning from incidents with other hospitals in the provider group, minimising the risk of similar events reoccurring in other hospitals.
- Learning from incidents was shared with staff during the monthly theatre team meetings and the daily morning briefing sessions. We reviewed the monthly meeting minutes from September 2016 to February 2017. The monthly theatre minutes showed theat the team discussed incidents and the learning resulting from those incidents.
- All incidents were discussed at the quarterly governance meeting which were attended by the clinical heads of department across the hospital. Serious incidents were also discussed in the monthly meetings and learning was shared with staff. Incidents were reviewed and discussed at the quarterly medical advisory committee (MAC) meetings. A review of the MAC meeting minutes for September 2016 and January 2017 showed that incidents and all action taken to mitigate reoccurrence were discussed.
- We reviewed an investigation of an incident that had occurred in August 2016 relating to a patient that sustained a burn from a diathermy plate in theatre. The investigation accurately identified the root cause of the incident with appropriate action plans set out in the report. There were concise records which evidenced that the duty of candour process had taken place face-to-face between the surgeon and the patient on the day of the incident. This was followed up with a copy of the investigation report. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Staff working in theatre at the time of the patient burn incident were offered support from their managers and additional funded external counselling. We spoke to two staff members who were in theatre at the time of the incident and they both felt well supported by their manager.

**Cleanliness, infection control and hygiene**

- The theatre department was visibly clean, staff wore theatre scrubs with arms bare below the elbows. We saw staff using hand sanitiser with appropriately postioned wall mounted dispensers within the department.

**Environment and equipment**

# Surgery

- Theatre provision includes four theatres, two with laminar flow and a sterile services department. All of the theatres were in operation during our visit. Theatres were normally open between 8am and 8:30pm, with 24 on-call staffing outside these hours in the event of an emergency return to theatre.
- We checked electrical items in theatre including three diathermy units. All of the machines were up-to-date with servicing and had been electrical safety tested.
- Laminated quick reference guidance was attached to larger more complex equipment for staff to use. We saw these quick reference user guides attached to each of the diathermy units giving information about setting up the equipment for safe practice. Four members of staff told us the guides had been in place since August 2016 following the patient burn incident.
- The diathermy units were tested by the manufacturer following the incident and were taken out of action for the duration of the investigation. Records showed that no fault was found with any of the diathermy units following these tests. However the hospital were using single diathermy plates at the time of the incident rather than split diathermy plates as recommended by the manufacturer.
- Prior to the incident generic diathermy plates were used supplied by the provider's regional distribution centre. The split plates required for the diathermy units were only supplied by the manufacturer. The hospital arranged training from the manufacturer to demonstrate the use of split plates to staff.
- The registered manager confirmed that prior to the patient burn incident no staff members had read the user manuals for equipment and staff relied upon manufacturer face-to-face training. We reviewed the user manual for the diathermy units which specified the use of split diathermy plates four times in different sections of the user manual. One member of staff told us that theatre had understood that the diathermy units were an upgrade from the previous model used by the hospital. Staff told us that the manufacturer's representative had trained staff to use the units with single diathermy plates when the units were purchased in 2013. However we found no documentation to support this.
- After the burn incident a designated member of staff was given the responsibility to ensure equipment is used in-line with manufacturer's recommendations for all new and existing equipment. Part of this role was to ensure that all training supplied by manufacturer's representatives reflects the user manual instructions and a record kept for staff to refer to. This formed part of the action plan following the patient burn incident. The MHRA recommends that all users and prescribers should have access to the manufacturer's instructions and that records should be kept of who has received written device instructions, this was not happening.
- Any equipment issues were escalated to the onsite equipment management technicians, however electrical testing was outsourced to an external company through a service level agreement.
- The hospital had a comprehensive electronic asset register which was suitable for the management of equipment including training of staff. However one of the technicians told us that the system was not used to support equipment training or local inventories and the information was rarely requested by other departments.
- A laser protection supervisor (LPS) was present in theatre for all laser procedures and theatres had two laser supervisors.The local NHS trust supplied laser protection advice and staff training under a service level agreement. Staff had access to external laser safety courses if this was required for their role. We saw that local rules were displayed and both members of staff had up-to-date LPS certificates and completed competencies in place. No laser procedures were booked or took place during our inspection.
- The hospital had mechanisms in place to disseminate alerts to heads of department from the Medicines and Healthcare products Regulatory Agency (MHRA) regarding medical devices. The hospital had a nominated member of staff to track and disseminate all information from manufactures and the MHRA.

**Records**

- Patient records were paper based. We reviewed two theatre records for patients which were completed accurately, signed and dated.
- We reviewed the complete patient record for the patient involved in the burn incident. The records were well organised and evidenced that duty of candour process had taken place following the incident. The records included correctly completed risk assessments for example falls risk assessment, Waterlow and malnutrition universal scoring tool (MUST). Follow up care after the incident was well documented with wound healing assessments and dated photographs.

# Surgery

**Training (theatres)**

- The mandatory training completion rate for theatre staff was 100% in the mandatory training report for 2016 with all staff members RAG rated green as complete. Mandatory training included fire safety, health and safety, infection control, safeguarding children, safeguarding adults, equality and diversity, manual handling and compassion in practice.
- Each staff member was expected to complete core competencies. The induction assessment covered general competencies such as hand washing, control of substance hazardous to health (COSHH) and moving and handling. The peri-operative competences included basic life support, communication and health safety and security.
- Staff competencies were not role specific. Some of the documentation was left blank when not required for an individual role leaving gaps in the compentency record. An example of this was the peri-operative core competencies which were the same for scrub practitioners and non scrub practitioners. We reviewed six staff records and of these two were fully completed and signed by the manager. However four of the staff records had gaps in both the induction competencies and the peri-operative competencies. It was unclear if the competencies were not required for the staff roles or whether they were outstanding actions. We escalated this to the deputy theatre manager and the hospital manager during our inspection.
- The equipment competency records for staff were paper based and covered all of the relevant equipment in the theatres. However rather than having one record for each model of equipment, each record would often pertain to several models, with the title of the record describing a group of models by the name of a manufacturer or a category of equipment. Where a member of staff was trained on only a subset of the group this was indicated by annotating the record, by for example, circling the relevant model. This meant the records were difficult to readily understand and initially caused us concern that training was not taking account of differences in the individual models of equipment. This was escalated to the deputy theatre manager and the hospital manager during the inspection.
- We also noted that the description of the models were different to those used in the electronic asset register which has potential for confusion should for example, a device alert have both a maintenance and training component.

**Assessing and responding to patient risk (theatres)**

- The hospital completed the World Health Organisation (WHO) five steps to safer surgery checklist for each surgical procedure undertaken. We observed the completion of the checklist, which staff and surgeons completed correctly for each of the steps.
- The patient who sustained the burn injury was transferred to the local burns centre for further treatment. The transfer followed hospital policy for the transfer of a patient, which was last updated in April 2016 and due to be reviewed in April 2019.
- Risk assessments were available for safety critical equipment, for example break in insulation of mono-polar diathermy forcep and skin damage to patients whilst using power tools. The risk assessments were up to date and relevant risks were assessed.
- There was one risk register for the hospital with all risks included, there were not separate risk registers for each department. The risk register could be filtered to department level as required. Each risk entry had an allocated risk owner and action review date. Theatres had 11 identified risks of these only one entry was rated as high risk, this was for aging ears nose and throat (ENT) and ophthalmology equipment. The registered manager was in the process of actioning this risk at the time of our visit and the equipment was added to in the asset replacement register.

**Nursing and support staffing**

- Theatres had four staff vacancies. The vacancies included two peri-operative practitioners, one surgical first assistant trainee and one first assistant practitioner. One operating department practitioner (ODP) had been recruited but had not started at the time of our visit.
- Theatre used bank and agency staff to fill vacant shifts the agency usage rate was 5% between September 2016 and February 2017. The deputy theatre manager and the governance lead told us that the hospital had regular agency staff to fill vacant shifts to maintain continuity. The theatre manager checked the training

and competency records for all new agency staff prior to their first shift. The deputy theatre manager reported that agency staff were paired with a permanent member of staff until they were familiar with the department.

- Induction checklists were completed for all agency staff at the start of their first shift. Agency staff were talked through theatre equipment used by the hospital on their first shift at the hospital.
- The theatre staffing met the association for perioperative practice (AfPP) guidelines for theatre staffing.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider MUST take to improve

- Ensure that staff are competent to use safety critical equipment in line with requirements of their role.

### Action the provider SHOULD take to improve

- Develop role specific competencies for staff in theatre.
- Ensure that equipment training records include the equipment model and a summary of the training provided.

This section is primarily information for the provider

# Enforcement actions

## 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 |
|---|---|
| Surgical procedures | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>Surgical procedures<br><br>Regulation 12 (1) (2)(b)(c)(e)<br><br>Care and treatment must be provided in a safe way for service users by doing all that is reasonably practicable to mitigate any such risks, ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to so safely,ensuring that the equipment used by the service provider is used in a safe way.<br><br>The service was unable to evidence that all staff had the necessary training for all medical devices in use. There was no clear process to ensure that persons providing care or treatment to service users had the competence and skills to do so safely. Staff were not properly trained and competent to use the diathermy machine.<br><br>The service failed to assess the risks to the health and safety of service users of receiving care or treatment because the risks of using the single plate accessory were not assessed. |