Frimley Health NHS Foundation Trust

Frimley 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

Surgery	

Summary of findings

Letter from the Chief Inspector of Hospitals

Frimley Park Hospital along side two other hospitals forms part of Frimley Health NHS Foundation Trust. Frimley Park Hospital is situated in Frimley. The hospital hosts the Defence Medical Group South East, with military surgical, medical and nursing personnel working alongside the hospital's NHS staff providing care to patients in all specialities.

We completed a focussed inspection of the surgery service at Frimley 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.

Our key findings were as follows:

- The service developed and implemented local safety standards for invasive procedures,; however, not all staff were aware of these.
- There was a culture of openness and honesty and service leads encouraged staff to challenge poor practice.
- The service had a positive incident reporting culture, demonstrating, which showed that there was learning from incidents, and was shared learning and sharing both locally and across the trust.
- Governance arrangements were clear and structured ensuring leaders and staff received information to enable them to challenge and improve performance.
- Staff did not adhere to the trust's surgical site marking policy.

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

The trust should:

- Ensure there are clear guidelines on safe patient transfers and responsibilities during patient handovers from all wards to anaesthetic room or theatres. This should include patient safety checks and the patient's involvement.
- Involve all departments in the development of local safety standards for invasive procedures.

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.

Frimley Park Hospital

Detailed findings

Services we looked at
Surgery

Detailed findings

Contents

Background to Frimley Park Hospital

Frimley Park Hospital is one of three hospitals that merged to form Frimley Health NHS Foundation Trust. The hospital provides services including medical care, surgery, critical care, maternity & family planning, services for children and young people and outpatients. The hospital has 720 beds. Frimley Park Hospital was last inspected in August 2014 and was one of the first hospitals to be rated as outstanding overall.

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 before and after our inspection relating to safety incidents reported by the trust.

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

Facts and data about Frimley Park Hospital

This inspection focussed on two key lines of enquiry; "Are services safe" and "Are services well-led". We did not inspect other services or key lines of enquiry.

Surgery

Safe	
Well-led	
Overall	

Information about the service

Frimley Park Hospital provides elective, emergency, inpatient and day surgery case surgical services. There are 18 theatres within the two day surgery units and a main theatre suite as well as designated recovery areas. The service offers a wide range of clinical speciality services which include breast, gynaecology, urology, orthopaedics, ophthalmology, ear, nose and throat (ENT), vascular and general surgery.

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

Summary of findings

Surgical services were not rated as this was a focussed inspection.

The service developed and implemented local safety standards for invasive procedures using the national safety standards for invasive procedures,; however, not all staff were aware of this.

Incidents and learnings from serious incidents were communicated effectively in a timely manner through various communication pathways. We saw that there were changes to clinical practice to reduce the risk of reoccurrence. Staff involved in incidents were given support and additional training if required.

The leadership within the division was good and staff felt that there was open, honest and supportive culture which was encouraged by the divisional leads.

The service had a well-established governance structure. Regular meetings took place with a standard agenda. There was a clear pathway to feed information and concerns up and down the hierarchical structure. Discussions included incidents and the World Health Organisation (WHO) five steps to safer surgery checklists audits.

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.

Assessing and responding to patient risk

- The service developed local safety standards for invasive procedures using the national safety standards for invasive procedures. A cross-site steering group had lead the development and implementation of the new safety checklists for major procedures within theatres. These were implemented in August 2017. Senior surgery managers said staff had taken to the new procedures well. However, staff in day surgery were not aware of what local safety standards for invasive procedures were, when they had been introduced or whether they were using them. The day surgery unit manager told us the local safety standards for invasive procedures were currently under development but had not been involved in the process. Staff we spoke with expressed an interest in being involved in the development and reviewing of the safety procedures.
- During our inspection, we observed the World Health Organisation (WHO) five steps to safer surgery checklists being carried out on two surgical cases. The checks involved interactive discussions with participation from all theatre staff present. This meant that staff had the opportunity to share any concerns about the patient or procedure and make the rest of the team aware at the earliest point.
- Frimley Park Hospital conducted monthly audit to review the service's compliance with the World Health Organisation (WHO) five steps to safer surgery checklists. The audit reviewed all stages of the process from the team brief to the debrief. Results of the WHO surgical checklist from April 2018 to June 2018 showed a compliance of 99%. The deputy medical director told us the service needed to work on embedding the debrief with some staff stating more work was required for the sign in. Although results met the audit target of 95%, senior staff felt this may not be reflective of actual practice. Some staff said the checklist had become a "tick box exercise". Surgical leads told us it was a challenge to keep the checklist fresh and interesting. The checklist had been adapted locally by removing questions that were irrelevant to the procedure and making it less wordy. This was so it did not become monotonous for staff completing the checklist. This had been changed in June 2018 and the service planned to review if this had any implications for patient safety.
- In September 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 the World Health Organisation (WHO) five steps to safer surgery checklist. The feedback from the review team was positive, stating that the teams worked well to "maintain high quality and safe patient care, embedding the learning from serious incidents and never events into everyday work". The team recommended that the service should continue to make improvements in embedding the culture of the WHO checklist into every procedure so the same focus and attention is given every time.
- During our inspection, we followed the patient pathway from when the porter collected the patient from the ward, through the surgical procedure until the return back to the ward. We observed good patient handovers from theatre staff to the ward staff with a full briefing of what procedure had been undertaken, if there were any concerns and the method of contacting the doctor responsible if needed. However, the handover from the ward staff to the operational department practitioner did not involve the patient. The handover was a transfer of documentation, which was checked by the operating department practitioner for completeness. Ward nurses were unclear of their responsibilities during the handover from ward to the anaesthetic room or theatres. We reviewed the trust policy and it was unclear who the delegate member of staff was and who was to conduct the safety checks.
- Safety checks before leaving the ward such as the marking of the operating site were not completed in accordance to the trust policy. The surgical site marking policy stated, "surgical sites should be marked on the ward/theatre admission lounge or day surgery before the patient is transferred to the anaesthetic room in theatre and the marking should take place before any pre-medication given". This increased the risk of wrong side/site surgery, which can lead to significant harm to the patient.

Incidents

Surgery

- The trust had a policy for the management of incidents, which included the management of serious incidents.
- Staff reported incidents through an electronic online system, which was accessible to all staff via the trust intranet. Staff demonstrated a good understanding of the process of reporting and verbally confirmed this. They understood their responsibilities in reporting, sharing and learning from incidents. We were told at the recent education day, the process of conducting an investigation once an incident had been reported.
- Staff who were involved in incidents were told about outcomes of the investigation and what recommendations were given. This information was also shared with all staff in the department.
- Learning was shared through meetings, communication folders, team briefings, newsletters and displayed on the unit's white board. Staff we spoke with said, immediate feedback was circulated to each team by the band 7 team leader with regular updates added to the communication folder for staff to read. Staff told us they had attended a cross-site patient safety awareness day, which "aimed to get lessons learned to the shop floor". Incidents were also shared in the monthly departmental meetings led by the theatre manager. Minutes we looked at showed incidents were discussed by staff on the unit.
- Staff were aware of incidents that had occurred within the service including incidents that had happened at other surgical sites that were part of Frimley Health NHS Foundation Trust. This showed that learning was effectively shared with all staff. We spoke to seven members of staff including a healthcare assistant, operating department practitioner, and an anaesthetic nurse practitioner. All staff were able to give us an example of a recent incident, showing what they had learned from the incident and whether changes to practice had been made.
- The trust reported 124 serious incidents from April 2017 to March 2018. There were seven 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 April 2018, the trust reported six surgical incidents classified as never events.
- The service was proactive in undertaking investigations after an incident. All never events were fully investigated with recommendations made and actions documented to address the recommendation. The investigation team were selected to undertake the reviews due to the relevance of their clinical expertise and experience of conducting serious incident investigations. For example, we reviewed the investigation report for a never event relating to a retained foreign object. The team consisted of the sterile service manager, consultant orthopaedic surgeon a senior sister for theatres, a quality improvement manager and the deputy head of patient safety. The investigation team attributed the cause of this incident to a failing of the bone ronguers (a surgical instrument used for gouging out bone) which resulted in a screw becoming dislodged. Recommendations from the investigation were for the theatre manager to ensure staff were educated in being watchful when completing the visual inspection of all instrument post procedure. Another recommendation was for the medical staff to promptly review X-rays prior to the patient being transferred or discharge to ensure no foreign objects remained in the patient.

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 said service leads who included the various chiefs of services associated to surgery, theatre manager and the team leaders and practice educators were available, visible within the division, and approachable. Leadership of the service was good; there was good staff morale despite the run of never events. Staff told us they

felt supported by their leaders during this difficult period. They were able to access support such as retraining and one to one meetings when they required it.

- Staff who were involved or affected by a serious incident were encouraged to have a debrief with clinical leads. One member of staff told us they had a debrief meeting after a serious incident with their manager and felt it was a useful tool to reflect and learn from. Where training needs were identified, staff underwent practice development to boost their confidence and a reassessment of competence to ensure they were performing at the required standard.
- Staff said team leaders requested feedback on training or any areas staff felt they required assistance. They felt that it was a collaborative approach to improving the service.

Culture

- Staff in theatres told us they felt well supported by their leaders and that the leadership team were approachable. The theatre manager explained that there had been a positive change in culture of the unit over the last couple of years.
- The service leaders encouraged a culture of openness and honesty. Staff told us they were able to raise concerns and felt there was a no blame or punitive culture. The practice development practitioner told us leadership workshops had taken place with attendance from the freedom to speak up guardian and external speakers. This had helped staff feel confident to speak up if they observed poor practice or had suggestions to improve practice.
- Staff said they were confident to step in if they saw poor practice and it was often well received. We were given examples of staff raising concerns for example, a concern relating to a member of the nursing staff challenging a doctor for not placing an artery clip on the tail end of a vaginal swab in accordance with the trust policy. We saw that the nurse reported this incident to the theatre manager and this was escalated to chief of service. An email from the chief of service was shared with all theatre staff reminding them of the never event that had happened in a similar case earlier in the year and the correct procedure of managing retained swabs/ tampons.
- Staff spoke positively about the service they provided for patients. They told us they were proud to be part of a supportive team and felt there was a willingness to help each other.

Governance

- The service had a well-established governance structure. The clinical governance group met every two months. Agendas and minutes from the clinical governance meetings were standardised and in depth. We reviewed the joint anaesthetics clinical governance group meetings for January and May 2018. Discussions included but were not limited to learning from never events and serious incidents, audit compliance and clinical guidance updates.
- There was a clear pathway to feed information and concerns up and down the organisational structure. Departmental meetings fed into the clinical governance meetings through weekly heads of the department meetings, and monthly anaesthetic meetings. We reviewed minutes from these meetings and saw incidents and the World Health Organisation (WHO) five steps to safer surgery checklists audit were discussed across all sites. This ensured that information was filtered down to the various theatre teams; the same message was passed on to all staff at different levels and at different sites within the directorate. Cross site, learning was encouraged by the sharing of practice and incidents therefore unifying the service.
- The service had made efforts to address the increase in never events. Surgical staff conducted a cross site peer reviews with colleagues from Wexham Park Hospital and Heatherwood Hospital. The review looked at a range of topics including, environment, medicine storage, World Health Organisation (WHO) five steps to safer surgery checklist audits, hand hygiene and staff competence. Staff said the advantages of these reviews were that it was conducted by senior staff from the sister sites with a fresh pair of eyes who could identify poor practice. They received instant feedback to act upon. We reviewed results of the June 2018 peer review conducted by theatre staff from Heatherwood Hospital. Results showed when the service was non compliant or could improve, the reviewing team provided additional comments for the theatre team to work on.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- The service should ensure surgical site marking is completed on the ward or day surgery before transferring patients to theatre.
- The service should ensure there are clear guidelines on safe patient transfers and responsibilities during patient handovers from all wards to anaesthetic room or theatres. This should include patient safety checks and patient's involvement.
- The service should involve all departments in the development of local safety standards for invasive procedures.