Plymouth Hospitals NHS
NHS Trust

Report for:	Plymouth Health and Adults Overview and Scrutiny Panel
Report Topic:	Theatre Safety Strategy following recent 'Never Events' and Care Quality Commission Visit
Report date:	07.03.2011
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1. Background

Since 1st April 2010, six 'Never Events' have occurred at Plymouth Hospitals NHS Trust in the following categories:

- Wrong site nerve block performed in April 2010
- Swab retained in August 2010
- Wrong site surgery performed in August 2010
- Swab retained in November 2010
- Swab retained in December 2010
- Throat pack retained in January 2011

The above incidents were escalated as 'Never Events' to NHS Plymouth and the South West Strategic Health Authority (SWSHA) at the earliest opportunity. In line with Trust Policy, each incident has been fully investigated using root cause analysis and the completed investigation reports are currently being reviewed by the SWSHA. No patient has suffered any long-term harm although this is not to underestimate the distress caused. All patients and families affected have received a full apology from the Trust.

A number of immediate actions were taken by the Trust in response to the investigation findings and as an interim measure pending development of a Theatre Patient Safety Strategy which is now being implemented. Immediate actions included: amendments made to the content and structure of the WHO Safer Surgery Checklist with regard to nerve blocks and confirmation that consent form and operating list match; the location and number of swabs retained in a body cavity for any length of time during an operation to be recorded on the theatre whiteboard; trial use of swab 'bag-it' system in theatres to provide a robust process for the accurate counting of swabs and mops, and; amendments made to throat pack insertion and removal process.

The occurrence of these events was discussed in front of the public and media at the Board meeting held on 31st January 2011. At that meeting,

the Board agreed that the Trust should discuss these events with the Care Quality Commission (CQC).

2. Care Quality Commission Visit

As a result of the occurrence of six 'Never Events', inspectors from the CQC visited the Trust on 16th February 2011 – during the visit, they observed the practice of checklists being used and had discussions with staff in a number of different theatres.

The inspectors observed that there was not full and proper compliance with the WHO Safer Surgery Checklist and that, despite actions taken following the most recent event, there remains work to do to improve patient safety within the theatre environment.

Following its visit, on 22nd February 2011, the CQC outlined in feedback to the Trust that that there was not full and proper compliance with safety checklists in a number of our theatres, in particular the Surgical Safety Checklist recommended by the World Health Organisation and the National Patient Safety Agency.

The Care Quality Commission recognised that action had been taken to move forward with the WHO checklist. But they gave a date of 22nd March to achieve full compliance in respect of their findings.

3. Action Being Taken

Prior to the CQC visit on 16th February 2011, the Trust had developed a comprehensive Theatre Patient Safety Strategy to address variations in practice and to provide the safest possible environment for patients undergoing surgery. This strategy was shared with the CQC and outlines the plans for providing full and comprehensive compliance by 22nd March 2011. The Trust has made arrangements to update the CQC on progress against this strategy on a weekly basis.

The Theatre Patient Safety Strategy is based on ten key domains which the Trust feels are essential to provide permanent improvement in patient safety. The domains are as follows:

- Leadership
- Safety culture
- Implementing best practice
- Standardising Trust policy
- Implementing standard operating procedures
- Documentation
- Education and training
- Communication with staff
- Communication with patients and families

- External expertise

The strategy focuses on standardisation of safe practice across all theatres. This includes the processes for completing swab and instrument counts, the completion of the WHO Safer Surgery Checklist and the processes for insertion and removal of throat packs.

The WHO Safer Surgery Checklist is a key indicator of theatre safety culture and an effective tool in providing a consistently safe environment within theatres. The Trust is currently implementing a single, mandatory checklist supported by observational qualitative audit to ensure that the checklist is being properly performed. An accountability framework has also been implemented with immediate effect and a programme of regular feedback and communication with surgical staff is in place to support effective delivery of compliance.

Latest performance figures from w/c 21 February 2011 indicate that a significant improvement has been made in compliance with the checklist with 97% of patients now receiving the complete checklist. The surgical teams caring for the remaining 3% of patients have all been contacted individually to find out why the checklist was not fully completed. In the majority of cases, this status represents an error in recording as all three parts of the checklist were fully completed but the surgical team did not record a time on the first part of the checklist, which has rendered it incomplete.