**Report for:** Plymouth Health and Adults Overview and Scrutiny Panel

**Report Topic:** Theatre Safety following recent 'Never Events' and Care Quality Commission Visit

**Report date:** 20.07.2011

---

## 1. Background

Between 1st April 2010 and January 2011, six 'Never Events' 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 was fully investigated using root cause analysis and the completed investigation reports were reviewed by the SWSHA. No patient suffered any long-term harm although this is not to underestimate the distress caused. All patients and families affected received a full apology from the Trust.

A number of immediate actions were taken by the Trust in response to the investigation findings including the 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. First Care Quality Commission Visit

As a result of the occurrence of the '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.

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. Second Care Quality Commission Visit

Inspectors from the Care Quality Commission revisited Derriford Hospital on Monday 28 March 2011 to carry out an unannounced inspection to check that the improvements had been made. They found that since their first visit, the patient safety checklist, as recommended by the World Health Organisation (WHO) and the National Patient Safety Agency (NPSA) was now being used effectively in all operating theatres in Derriford Hospital.

In informal feedback, the inspectors told the Trust that it was "like visiting a different hospital."

The Care Quality Commission formally reported on 1st April 2011 that it was "satisfied that surgical teams at Plymouth Hospitals NHS Trust have made safety improvements which were required in its operating theatres. Inspectors who made an unannounced visit to Derriford Hospital this week found that important check-lists recommended by the World Health Organisation (WHO) and the National Patient Safety Agency (NPSA) were now being effectively used in all operating theatres."

## 4. Continued Monitoring

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 has implemented 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 and a programme of regular feedback and communication with surgical staff is in place to support effective delivery of compliance.

There is strong governance throughout the organisation around safety within theatres: a monthly Theatre Safety group meets to discuss all aspects of safety. This group reports into the Theatre Safety Strategy

group which in turn reports to the Trust's Safety and Quality Committee, which feeds into the Trust Board. This ensures that the Trust Board is kept fully informed of latest performance in this area.

Latest performance figures reported to the Trust Board on 24 June 2011 showed that compliance with the WHO checklist in theatres is now running at 98%. Where the checklist is not fully completed, an explanation is always sought and this often relates to emergency cases.

## 5. Sharing Best Practice

Plymouth Hospitals NHS Trust is now seen as demonstrating best practice in the implementation of the WHO Safer Surgery Checklist and our staff have been asked to share their learning and expertise with a number of other hospitals around the country where a similar problem has subsequently been identified.