Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Derriford Hospital

Derriford Road, Crownhill, Plymouth, PL6 8DH

Tel: 01752202082

Date of Inspections: 30 August 2013
29 August 2013

Date of Publication: September 2013

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Plymouth Hospitals NHS Trust
Overview of the service	Plymouth Hospitals NHS Trust includes an integrated Ministry of Defence Hospital unit. The hospital offers a full range of general hospital services to around 450,000 people in Plymouth, North and East Cornwall and South and West Devon. Care is also provided at a separate off site Child Development Centre. Further details can be found on the hospital's website at: http://www.plymouthhospitals.nhs.uk/ourorganisation/Pages/Home.aspx
Type of services	Doctors consultation service Doctors treatment service
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Management of supply of blood and blood derived products Maternity and midwifery services Surgical procedures Termination of pregnancies Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Derriford Hospital had taken action to meet the following essential standards:

- Assessing and monitoring the quality of service provision

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 29 August 2013 and 30 August 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with staff and were accompanied by a specialist advisor.

What people told us and what we found

We inspected Derriford Hospital in April 2013 and found that for regulation 10 of the Health and Social Care Act 2008, the regulated activity of surgical procedures required some improvements to ensure the safety of patients.

The management of the hospital provided the Care Quality Commission (CQC) with an action plan of how these improvements were to be implemented. We subsequently received an updated action plan each month to enable us to see how the improvements were being met and any timescales remaining for completion of the action plan.

We visited the theatre suites of Derriford Hospital, spoke with staff and patients and reviewed the quality monitoring arrangements for this regulated activity.

One patient told us "they are nice staff and it's a nice unit, staff have kept me updated but I am delayed to the end of the list, I don't think it could be helped".

We spoke to staff who told us they had seen improvements in scheduling, morale and communication since our inspection in April 2013. Staff comments included "There are some very skilled staff here", "The matron and management are very approachable" and "Nobody here wants bad things to happen, we are encouraged to speak up".

We observed staff being supportive, compassionate and reassuring to patients who were upset or anxious. All staff acted in a skilled and professional way which promoted confidence for patients awaiting their operations.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

At our previous inspection we identified concerns around the scheduling of operations, how changes were managed to promote safety and how changes were communicated to theatre staff. We also identified that when 'Never Events' had taken place, changes in practice had not been effective enough to ensure further 'Never Events' took place."Never Events" are defined by the NHS National Patient Safety Agency as "Serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented."

We received an action plan from the trust which detailed how improvements would be made and the timescale for these improvements to be implemented. We have received an updated plan on two occasions to demonstrate how actions undertaken to promote safety and patient welfare had been completed so far.

We saw at our previous inspection in April 2013 concerns around scheduling and operations management. At this inspection, theatre staff identified, assessed and managed the risks relating to health, welfare and safety of patients. This demonstrated an improvement of the systems in place.

We saw that scheduling of operations was planned by either the surgeon or their secretary. Scheduled lists were reviewed by the surgeon and estimates of operation time for each operation were included on the list. These lists were reviewed seven days prior to operation date and again the day before the operations. This was done to ensure that the lists were accurate and achievable.

Each day at 3.00pm a managers' meeting took place. This brought senior staff from theatre, sterile supplies, the cleaning contractor and any other relevant staff together to discuss the next day's operating lists and any issues around scheduling, bed availability and equipment. They took the opportunity to discuss any issues relating to the previous days theatre lists to promote improvements. This demonstrated that learning was taking

place to develop safety for patients using the service. The next day's operation lists were discussed to review if they were achievable and any reasons they may not be. This may be due to staffing levels and skills not being available. We saw staff skills being considered and staff moved from one theatre to another to enable surgery to take place safely.

The next morning the lists were reviewed again by the staff on duty that day to ensure that sufficient beds were available in the hospital for the patients having surgery. This information was then relayed to theatre staff to advise if the operation lists could commence.

Our previous inspection highlighted concerns that change in theatre lists were not always well communicated to staff. At this inspection we saw that information was well communicated to staff about what operations were to take place and the management of the surgery.

We observed pre-surgery team briefing meetings for several operations which were led by the surgeons. This briefing was undertaken in each specific theatre to discuss the operation list for the day. All the team members present discussed each of the patients' planned operations, positioning, relevant medical history, anaesthetic issues, equipment issues and staffing issues. This practice promoted teamwork and safety.

We observed patients arriving in the anaesthetic room for each theatre and checks being done to ensure the patient's identity, surgical procedure and anaesthetic safety were confirmed. The patient was made to feel as comfortable as possible and reassured by the compassionate behaviour of the staff. We saw at all times the World Health Organisation (WHO) surgical safety checklist was completed fully to ensure the safety of each patient. We saw a formalised approach with all staff present who engaged with the process. It was important for the provider to ensure that any non-compliance with measures such as WHO checklists, briefings and any practices put in place as a result of analysis of risks were dealt with appropriately and we saw evidence that they were. We observed staff being reminded to listen and be part of the process. We heard examples of how staff were supported to ensure this check was taken seriously, this included all staff being included and being encouraged to speak up if they had any concerns. All stages of the checklist were recorded when completed. This information was then analysed and was reported on in a formal way to capture themes and develop practice as needed. This meant that surgery was undertaken safely with the correct checks undertaken.

Staff told us that the WHO list was always completed and that they were required to participate in the process. This included a 'Time Out' for all staff before any operation started. They were required to stop what they were doing and ensure that all checks were in place. One medical staff member told us "We get told off if we speak during Time Out. There is no wriggle room on completing the WHO list". They told us they thought this was strength at this hospital.

We observed a general surgery team brief led by a senior trained nurse. The details of the team brief were documented on a form which would later be collected at the 3.00pm operational meeting in order to have any problems analysed, monitored and fed back to staff. Human factors were an item for discussion during the briefing. Human Factors were the concept of understanding how workplace factors and human characteristics affect behaviour in relation in safety. These could include if staff were anxious or unhappy about anything.

In one instance we noted a short delay to treatment as a piece of equipment was not

readily available and staff had to leave to find it from another location. The WHO surgical safety checklist sign-in had been completed indicating that patient monitoring equipment was available. This indicated a discrepancy from the information recorded and the equipment actually available. There was also a short delay in surgical equipment being available. This delay was fed back at the 3.00pm meeting and clarity provided about who was responsible for checking equipment. The registered provider may find it useful to note that clarity and a consistent approach was needed as it appeared that there was confusion over whether it was the responsibility of the scrub practitioner or the sterile services department to have raised the issue prior to the patient being prepared for theatre.

At our previous inspection we identified that the actions taken to address incidents was not sufficient to prevent further reoccurrence of those incidents. At this inspection we saw that analysis of incidents was taking place to identify the need for changes in the treatment or care provided when necessary.

All staff spoken with told us they were encouraged to raise any issues and report any risks.

The provider showed us evidence that as part of the overall improvement plan, it was implementing its surgical safety improvement plan within agreed and reasonable timescales. For example the teaching of human factors and the briefing and de briefing audit to theatres central staff was ahead of schedule. No elements of the surgical safety improvement plan were behind schedule. Whilst it was evident that not all outcomes on the surgical safety improvement plan have been met, staff explained the clear plan in place to achieve all the identified goals.

We saw evidence that the provider was engaged in the programme of reviewing outstanding patient safety issues. The National Patient Safety Agency (NPSA) seven steps to patient safety promoted the integration of incidents, serious incidents requiring investigation, patient complaints and litigious claims. The first meeting was scheduled for the day we arrived to inspect. The matron leading this piece of work told us about the need to analyse and identify themes as areas to target for improvement. A lead person for governance had been allocated to work with the Matron from theatres to ensure immediate action was taken for any areas of identified risk. The provider showed evidence that learning had occurred from a previous incidents and never events.

Members of the trust's board were engaged in safety walkabouts. They and the executive team had visited theatres in order to show a visible message that commitment to safety had strong leadership. This was as a result of learning that good communication was needed between the hospital executive board and staff in theatres. Staff told us that they had seen this take place once and appreciated the visit from the trust board.

We saw that an independent review of theatres had taken place to gather professional and expert advice of the management of surgical procedures. This had been instigated by the trust and was undertaken by an independent professional to provide a further insight into the safety and management of theatres at Derriford Hospital. Some of the recommendations from this report had begun to be addressed. Minimising the changes to the list order in which patients would have their surgery performed was recommended because changing the order of the operating list could increase the chances of wrong site surgery. All of the lists we saw with one exception remained as planned and the order had not been changed. The one change seen was as a result of patient anxiety and the changes were communicated to the ward to enable the correct changes to be made. This showed learning and effort to respond to safety concerns highlighted by the previous inspection.

We found that since our last inspection systems had been put in place to regularly assess and monitor the quality of the service provided.
We saw a summary of all reported incidents which had been completed over the previous year and we saw examples of when learning had occurred from incident reporting. For example we saw an incident form reporting a split endotracheal tube (a piece of equipment used in surgery) which was unexpected and could have resulted in patient harm. Learning had been promoted by including this incident in a safety bulletin produced for the anaesthetists.

We were told that audits of WHO checklists were on going to identify any shortfalls in practice. Audits of any changes in list order were also taking place to identify the reason for this. We also saw audits taking place of time "over runs" in the recovery department, to enable a change of staffing to meet high demand times.

The hospital's surgical safety improvement plan was being followed and weekly feedback of findings to a Theatre Board was provided to enable the board to overview progress being made. The areas covered included risks, workforce and morale. These meeting were recorded to provide an audit trail of all areas discussed and enabled the board to monitor progress.

A clinical governance commitee who meet to review all of the audits taking place remained planned to review and monitor the quality of services provided from October 2013. In the interim time governance was being managed by two staff members to ensure no areas of concern were being missed. We have been assured that whilst some areas of the surgical safety improvement plan have been recorded as met, further revisiting of those issues will be on going to ensure that systems now in place are sustained and remain well managed.

We saw that as a result of audits having taken place, systems were in place to support staff making decisions. This meant that those staff making changes felt involved and supported to implement appropriate changes.

Senior staff told us that they felt supported by the trust board to make changes and improve the service provided. Staff also explained that they now felt supported by the Human Resources department of the hospital to manage staffing issues. Staff skills were also currently being audited with a view to developing and widening skills to enable staff to be able to move between scrub/theatre/ recovery areas of the department and so increase flexibility of staff working.

The inspection team was assured that the provider was willing to respond to quality and safety initiatives raised by staff. Involving and engaging staff in safety initiatives was a fundamental factor/step in the NPSA's seven steps to patient safety. In the cardiac catheter suite a recent quality and safety questionnaire revealed some staff concerns regarding patients having to agree their consent to an operation and have a cannula (This is a tube that can be inserted into the body) fitted whilst in the corridor just outside the cardiac catheter theatres. Staff felt that this was undignified and inappropriate. Staff recommended the practice being undertaken by a newly employed radiologist. This involved the cannulation of patients in the pre-operative area and consent agreed in the pre-operative clinic. We fed this back to senior management about promoting this change in practice and they agreed to look into this issue.

We saw that theatre, anaesthetic and recovery newsletters were being provided to staff. There was also a weekly email update available. However, it appeared from comments by staff that information related to the surgical safety improvement plan and details of the

improvement work the department was undertaking including the recovery department, was unknown to some staff. Some staff told us that the changes were 'difficult' to manage. The provider may find it useful to note that not all staff felt well informed of the outcome of their involvement in change.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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