WM QRS West Midlands Quality Review Service

NHS

Review of Theatre and Anaesthetic Services

Spire Parkway Hospital, Solihull Health Economy

Visit Date: 2nd November 2017

Report Date: January 2018

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UKAS INSPECTION 8831

CONTENTS

INTRODUCTION

This report presents the findings of the Theatres and Anaesthetics Quality Review visit that took place on 2nd November 2017. The purpose of the visit was to review compliance with the following West Midlands Quality Review Service (WMQRS) Quality Standards:

- Theatre and Anaesthetic Services. Version 2. 2017

The aim of the standards and the review programme is to help providers and commissioners of services to improve clinical outcomes and service users' and carers' experiences by improving the quality of services. The report also gives external assurance of the care, which can be used as part of the organisations internal governance arrangements. For commissioners, the report gives assurance of the quality of services commissioned and identifies areas where developments may be needed.

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Appendix 1 lists the visiting team that reviewed the theatre and anaesthetic services provided by Spire Parkway Hospital. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

This report describes services provided or commissioned by the following organisations:

- Spire Healthcare
- Solihull Clinical Commissioning Group

Most of the issues identified by quality reviews can be resolved by providers' and commissioners' own governance arrangements. Many can be tackled by the use of appropriate service improvement approaches; some require commissioner input. Individual organisations are responsible for taking action and monitoring this through their usual governance structures. The lead commissioner for the service concerned is responsible for ensuring action plans are in place and monitoring their implementation, liaising, as appropriate, with other commissioners, including commissioners of primary care. The lead commissioner in relation to this report is Solihull Clinical Commissioning Group.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS is a collaborative venture between NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews - often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on www.wmqrs.nhs.uk

ACKNOWLEDGMENTS

West Midlands Quality Review Service would like to thank the staff and service users and carers of Spire Parkway Hospital for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

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SPIRE PARKWAY HOSPITAL

THEATRE & ANAESTHETIC SERVICES

General Comments and Achievements

On 2nd November 2017 this review visit looked at hospital-wide and theatre services evidence and visited theatres and anaesthetic services at Spire Parkway Hospital. The hospital had four theatres, one of which had undergone a major refurbishment in 2016. At the time of the review a range of elective surgery was undertaken and there was access to level two high dependency care on site. A medical officer was available on site 24 hours a day, seven days a week. Outside normal working hours the patient's admitting consultant is responsible for providing ongoing care and can be contacted.

Throughout the hospital, theatre and anaesthetic staff were friendly and welcoming. Theatres and anaesthetic services had seen several changes of staffing in the year preceding the review. Anaesthetists and surgeons who met with the reviewing team commented that they felt the theatre service was well organised.
The Association for Perioperative Practice Standards for managing staffing levels in theatres were followed. A daily 'huddle' was held which included the Theatre Manager, Ward Sister and a member of the Reservations Team to ensure that staffing and bed management were appropriate. A theatre coordinator was allocated on a daily basis to oversee the staffing and operational management of the theatre environment.

A working group had been established to develop Local Safety Standards for Invasive Procedures (LocSSIPs) and this group included representation from all areas where invasive procedures were performed.

An Asset Manager Controller and Infection Control Lead had recently been appointed.

The governance team was actively working to improve standards in theatres, but recognised that further work was needed and had plans for this.

Good Practice

1. The anaesthetic room daily check record covered a whole month and it provided a consistent record which was very clear and concise. Reviewers were impressed that the document also included an anaesthetic room closure checklist to be completed at the end of the day.
2. The hospital pharmacist reviewed medication for all patients pre-and post-surgery.
3. Patient information leaflets were informative and clearly set out. The format of some of the leaflets also included a summary of key points for quick reference.
4. The Hospital had a range of patient forums and user engagement processes, which included obtaining feedback about the theatres services provided. Staff had implemented changes as a result of feedback.
5. Staff were very appreciative of the opportunities provided to undertake 'Surgical First Assistant' training. Training was funded by the organisation and, once they had completed the training, staff were allocated an appropriate clinical mentor at the hospital who was able to provide support and monitoring of progression.

Immediate Risks – None

Serious Concern

1. Equipment management

Reviewers were seriously concerned about the process in place for staff to report issues relating to unclean or damaged equipment. It was unclear as to whether staff were fully aware that these incidents should be reported, and how. In addition, it was unclear how these incidents were then managed and how they subsequently linked into the equipment management and replacement programme. During the visit the reviewers identified a number of unclean or damaged items of equipment in use in the theatre. They considered that these, by their continued use, posed a risk of infection to patients. In one theatre a rusty trolley was in use, another theatre had a tourniquet trolley that was unclean, three operating tables had areas where paint was damaged and there were three anaesthetic trolley mattresses seen by reviewers where the outer mattress covers were torn.

Concerns

1. **WHO 'Safer Surgery' Checklist**

   a. Three different versions of the WHO 'Safer Surgery' Checklist, were in use at the time of the review visit. There was a version on coloured paper from Spire Healthcare, a local checklist and another version that was included in the pre-written care plan document. The care plan document gave the option of completing the checklist in the plan or using other versions. Reviewers were concerned about the safety of the process and thought that there might be confusion for staff from having multiple versions in use. They recommended that a single version of this document should be used.

   b. Inconsistent implementation of the checklist in theatres was also observed by reviewers. In three of the four examples witnessed, staff were observed who were not listening and in one example it was not clear that 'sign out' had been undertaken (although the reviewers did witness the theatre nurse and health care assistant completing a swab count). A 'debrief' was not performed at the end of one theatre session.

   c. Evidence of audits of the implementation of the checklists was 100%, but, the audits did not include observation of the process (as indicated by best practice) and therefore did not include any details of the behaviour witnessed.

2. **Guidelines**

   a. Local Safety Standards for Invasive Procedures: The clinical policy (2016) only included key points from the national guidance and did not include the detail required for implementation, ongoing auditing and reporting for the thirteen National Safety Standards for Invasive procedures (NatSSIPs). A working group was in the process for developing LocSSIPs, but the timeframe for completion of this work was not clear.

   b. Some of clinical guidelines were not yet in place - for example, for management of pre- and post-operative pain, nausea and vomiting.

   c. Anaesthetic guidelines were not easily accessible in all the areas where anaesthetic machines were in use.

3. **Theatre Etiquette**

   a. Reviewers were concerned about the infection control risk to patients by the general use of white coats worn over theatre clothing when leaving the theatre area. Reviewers, who came from several hospitals across the West Midlands, commented that this practice had ceased, and white coats should only be used in an emergency or staff should change their theatre clothing on return to the theatre environment.

   b. The uniform policy did not appear to be consistently implemented, for example a number of staff were wearing jewellery in the theatre areas.

Further Consideration

1. The recovery area only had a curtain to provide separation between adults and children. Reviewers were told that the majority of paediatric surgery was performed as part of designated paediatric operating lists, but that paediatric surgery did take place at other times. Reviewers suggested that further monitoring should be undertaken to identify how often this occurs and what further action may be necessary to ensure appropriate separation of children and adults.
2. The management team may wish to review the hospitals policy for reusing laryngoscope handles. Reviewers suggested that using disposable handles may now be a safer and cost-effective alternative to cleaning and sterilising and, remove the need to maintain records of traceability and usage of reusable equipment.
3. Reviewers suggested that further work encouraging staff to challenge others may be helpful. The issues of compliance with the WHO Safer Surgery checklist and infection control highlighted above were observed by other staff and could have been challenged. Further work on multi-disciplinary review and learning and implementation of the monthly team meetings may also help to build a culture of improvement and compliance with expected standards. Feedback to staff about action taken following incidents, review and learning could also be strengthened through this mechanism.
4. Reviewers commented on a couple of issues that may be helpful in improving consistency of practice across the theatres:
    a. Each theatre had different swab count boards. In the refurbished theatre the swab count board was very clear, but others were either blank or had limited information. Reviewers suggested that the boards should be consistent across all theatres.
    b. The allocation board for staff was very good but was not used and was obscured by paper versions. Reviewers considered that using the board for its intended purpose would provide clear information for all staff and would make it clear which nurse was in charge for the day.
5. Reviewers also heard differing views from the management team and some staff as to whether annual personal development reviews (PDRs) were up to date. A new process for undertaking PDRs was in the process of being implemented. As part of this process it will be important to ensure that up to date records of competence are also recorded.
6. Manual handing training was via ‘e’- learning. Adding practical training and assessments for staff working in the theatre environment may be helpful.
7. Some staff who met with the reviewing team felt that the process for rostering staff was inequitable and that there were often scheduling changes that meant that the rosters were changed at short notice. For some staff this meant that they had to change domestic arrangements or, if requests for off duty were honoured, they would then ‘owe hours’ as theatre lists were not operational when they were available to work. When the regular team meetings are re- established this may be useful forum to discuss these issues.
8. The Theatre checklist documentation, although good and comprehensive, was sixteen pages long and would benefit from being more concise and user friendly.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team		
Dr Nike Akinwale	Clinical Director Theatres, Anaesthetics & Critical Care	Walsall Healthcare NHS Trust
Linda Comyns	Principal ODP Lead Clinical Facilitator	University Hospitals Coventry & Warwickshire NHS Trust
Mr Adel Makar	Consultant Urologist and Lead Cancer Clinician	Worcestershire Acute Hospitals NHS Trust
Jane Minton	Practice Development Practitioner Theatres	The Royal Wolverhampton NHS Trust
Katy Moynihan	Matron Theatres	The Shrewsbury & Telford Hospital NHS Trust
Paula Seery	Modern Matron, Day Surgery Unit / Main Theatres	University Hospitals Coventry & Warwickshire NHS Trust

WMQRS Team		
Rachael Blackburn	Assistant Director	West Midlands Quality Review Service
Sarah Broomhead	Assistant Director	West Midlands Quality Review Service

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APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varies depending on the nature of the service provided. Percentage compliance also takes no account of 'working towards' a particular Quality Standard. Reviewers often comment that it is better to have a 'No, but', where there is real commitment to achieving a particular standard, than a 'Yes, but' where a 'box has been ticked' but the commitment to implementation is lacking. With these caveats, table 1 summarises the percentage compliance for each of the services reviewed.

Table 1 - Percentage of Quality Standards met

Service	Number of Applicable QS	Number of QS Met	% met
Hospital – Wide	6	3	50
Theatre and Anaesthetic Service	41	24	59
Spire Healthcare	**47**	**27**	**57**

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HOSPITAL-WIDE

Ref	Quality Standards	Met? Y/N	Reviewer Comments
XC-101	**Patient Support after 'Never Events'** The organisation should ensure that support is offered to patients who have experienced a 'Never Event', and to their carers.	Y	Support following never event was in place, however the 'duty of candour' letter covered complications following surgery rather the process for offering support following a 'never event'.
XC-201	**Executive Lead for Safety of Invasive Procedures** The organisation should identify an Executive Lead with responsibility for implementation of Local Standards for Safety of Invasive Procedures.	N	
XC-202	**Staff Support after 'Never Events'** The organisation should ensure that support is offered to staff who have been involved in a 'Never Event'.	Y	Documentary evidence was not available at the time of the visit to show compliance with the QS. Reviewers were told that staff were debriefed following any 'never event'
XC-601	**Areas where Invasive Procedures are Performed** The organisation should identify all areas in the organisation in which invasive procedures are performed.	Y	
XC-701	**Development of Local Safety Standards for Invasive Procedures** The organisation should ensure that Local Safety Standards for Invasive Procedures (QS XG-203 & XG-501) are developed and implemented in all areas in which invasive procedures are performed.	N	Local safety standards for invasive procedures had not yet been developed. A group was in place with responsibility for developing local standards.
XC-702	**Reporting of Local Safety Standards for Invasive Procedures Audits** The Board or Quality Committee should receive regular reports on the results of audits of the implementation of Local Safety Standards for Invasive Procedures (QS XG-702).	N	Detailed Local Safety Standards for Invasive Procedures were not yet in place. Safer Surgery audit data was reported.

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THEATRE AND ANAESTHETIC SERVICE

Ref	Quality Standards	Met? Y/N	Reviewer Comments
XG-102	**Procedure Information** For each procedure, patients should be offered written information, and the opportunity to discuss this, covering: a. Preparation for the procedure b. Types of anaesthesia available c. Any side effects	Y	Written information for patients was provided in a clear format, and an admission pack was also sent to patients prior to surgery. Patients also had the opportunity to discuss procedures at other times e.g. during the pre-operative assessment, during, classes for those undergoing joint surgery (if appropriate) and on the day of surgery.
XG-103	**Privacy, Dignity and Security** Patients' privacy, dignity and security should be maintained at all times, including security of clothes, dentures, hearing aids and personal belongings during examinations and procedures.	Y	
XG-104	**Communication Aids** Communication aids should be available to help patients with communication difficulties to participate in decisions about their care**.**	y	
XG-196	**General Support for Service Users and Carers** Patients and carers should have easy access to the following services, and information about these services should be easily available: a. Interpreter services, including access to British Sign Language b. 'Compliments and complaints' procedures	Y	
XG-199	**Involving Patients and Carers** The service should have: a. Mechanisms for receiving feedback from patients and carers about their treatment and care b. Mechanisms for involving patients and carers in decisions about the organisation of the services, including the development and review of Local Safety Standards for Invasive Procedures c. Examples of changes made as a result of the feedback and involvement of patients and carers	Y	
XG-201	**Leadership** Theatre and Anaesthetic Services should have a Clinical Director, Lead Nurse, Lead Operating Department Practitioner and Lead Manager with responsibility for staffing, training, guidelines and protocols, service organisation, governance and liaison with other services.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
XG-202	**Service Leads** Leads for, at least, the following areas should be identified: a. Critical care, including high dependency care and outreach b. Acute pain c. Obstetric anaesthesia d. Care of children e. Chronic pain f. Safety g. Major incidents h. Admissions and day care i. Pre-operative assessment j. Recovery k. Equipment	Y	
XG-203	**Staffing Levels** The service should have sufficient staff with appropriate competences to deliver the expected number of assessments and procedures for the usual case mix of patients within expected timescales (QS XG-602), including: a. Local Safety Standard for Invasive Procedures for the workforce needed to deliver safe patient care in each operating theatre and invasive procedure area b. An escalation policy that ensures flexibility of staffing in response to fluctuations in demand and availability of staff Staffing levels should be based on a competence framework covering staffing levels and expected competences (QS XG-208), and should ensure an appropriate skill mix of consultant anaesthetists, other anaesthetic medical staff, physicians' assistants, operating department practitioners, theatre assistants, theatre nurses and porters.	Y	
XG-204	**Emergency Service** Staff with appropriate competences should be available outside planned sessions including: a. On call consultant anaesthetist b. On-site anaesthetist of grade CT3 or above (or equivalent) c. Emergency theatre service Competences for emergency work should be maintained through appropriate Continuing Professional Development and/or daytime job-planned work.	Y	Consultants and anaesthetists provided cover for their own patients and would arrange cover if required. An on-call rota was in place for theatre and High Dependency Unit staff.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
XG-207	**Acute Pain Team** An acute pain team should be available, which should include: a. Consultant anaesthetist with sessional commitments to the team b. Specialist nurse with specific competences in the management of acute pain c. Other medical, nursing and operating department practitioner staff as required for the number of patients and the complexity of their needs d. Pharmacist with sessional commitments to the team e. Physiotherapist with sessional commitments to the team	N/A	Clinical management of individual patients was the responsibility of the admitting consultant. However, the reviewers considered that guidance to ensure consistency of approach in terms of managing pre and post-operative pain should be developed and monitored (see XG-504)
XG-208	**Competence Framework and Training Plan** A competence framework should cover expected competences for roles within the service. A training and development programme should ensure that all staff have, and are maintaining, these competences. The competence framework and training plan should cover at least: a. Local Safety Standards for Invasive Procedures b. Human (non-technical) factors c. Moving and handling in the theatre environment d. Drug administration e. Plastering f. Resuscitation g. Use of equipment h. Care of children and young people	N	Competences for 'a' were not yet in place. Moving and handling training was through 'e'-learning, and staff did not have competences assessed. Not all staff had attended human factor training. 'e' was not applicable. A theatre competency matrix was in the process of being implemented.
XG-209	**Multi-Disciplinary Training** Staff training in the following areas should be undertaken on a multi-disciplinary basis: a. Local Safety Standards for Invasive Procedures b. Human (non-technical) factors	N	Multi-disciplinary training was not yet in place covering the requirements of the QS. Some staff had attended training covering the National Safety Standards for Invasive Procedures and human factors training.
XG-210	**New Starters and Agency, Bank and Locum Staff** Before starting work in the service, local induction and a review of competence for the expected role in assessments and procedures should be completed for all new starters and agency, bank and locum staff.	N	The checklist used for agency staff did not include use of equipment. The induction booklet for new staff did cover the competences expected.
XG-211	**Staff Monitoring** Arrangements should be in place for monitoring and reviewing staff sickness, vacancy and turnover levels.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
XG-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available during working hours to support all aspects of theatre and anaesthetic services, including the acute pain team.	Y	
XG-301	**Support Services** Timely access to the following services should be available: a. IT support b. Hospital porters c. Patient transport d. Security e. Cleaning f. Linen supplies g. Logistics and sterile services h. Pharmacy, covering advice and supply of drugs and medical gas testing i. Infection control advice j. Medical records k. Pathology l. Imaging m. Plastering (if not part of theatre and anaesthetic service) n. Electronic and bio-medical engineering	Y	
XG-302	**Blood and Transplant** Appropriate arrangements should be in place for: a. Supply and storage of blood products b. Other NHS blood and transplant storage requirements (if applicable)	Y	
XG-401	**Facilities** The service should have appropriate facilities to deliver the expected number of assessments and procedures for the usual case mix of patients within expected timescales (QS XG-602). Facilities should comply with all relevant Standards and should ensure appropriate: a. Privacy, dignity and security for patients (QS XG-103) b. Separation of children and adults c. Control of infection	N	The recovery bay for children was only separated by a curtain. See main report.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
XG-402	**Equipment** Equipment and consumables required for the usual case mix of patients should be available and appropriately maintained, and should include: a. Immediate availability of resuscitation equipment for children and adults, checked in accordance with Hospital policy b. Sterile supplies c. Moving and handling aids d. Specialist equipment including implants and prostheses e. In-theatre imaging f. Equipment, moving and handling aids and patient gowns to meet the needs of all patients including: i. Bariatric patients ii. Adults and children with physical disabilities	N	See serious concern section of the report on the management of equipment. Other aspects of the QS were met.
XG-404	**Equipment Management** The service should have arrangements for equipment management covering: a. Procurement and management of equipment and consumables b. Installation assurance c. Calibration, operation and performance of equipment and recording of checks d. Equipment maintenance (service contracts and maintenance schedules) covering planned maintenance and 24/7 breakdown or unscheduled maintenance e. Contingency plans in the event of equipment breakdown f. Monitoring and management of equipment failures and faults g. Ensuring safety warnings, alerts and recalls are circulated and acted upon within specified timescales h. Programme of equipment replacement and risk management of equipment used beyond its replacement date	N	All but 'h' were met. See main report about management of damaged equipment.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
XG-405	**IT System** IT systems for storage, retrieval and transmission of patient information should be in use. Theatre and anaesthetic staff should have access to: a. Pre-assessment information b. Theatre management system c. Hosptial Patient Administration System d. Emails and the Hospital intranet and policies e. On-line medical and other relevant information System connectivity should be sufficient to ensure that patient details are entered once only.	Y	All records were paper-based and added to electronic theatre system retrospectively.
XG-501	**Local Safety Standards for Invasive Procedures** Local Safety Standards for Invasive Procedures should be in use in all theatres and invasive procedure areas and should cover at least: a. Scheduling and list management b. Handovers and information transfer c. Procedural verification of site marking d. Safety briefing e. Sign in f. Time out g. Prosthesis verification h. Prevention of retained foreign objects i. Sign out j. Debriefing k. Use of WHO Surgical Safety Checklist	N	Detailed Local Safety Standards for Invasive Procedures (LocSSIPs) were in the process of being developed. Reference to the overarching principles of the LocSSIPs was included in the hospital clinical policy.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
XG-502	**Patient Pathway Guidelines** Guidelines should be in use covering: a. Pre-assessment, including antenatal referrals b. Pre-operative care c. Assessment prior to anaesthesia and procedure d. Range of anaesthetic techniques normally offered for each procedure e. Anaesthetic assistance throughout the procedure f. Monitoring during anaesthesia and recovery g. Post-operative care h. Post-surgery review i. Recognition and treatment of complications, including involving other services as required j. Anaesthesia in the CT and MRI environment k. Use of ultrasound during anaesthesia l. Anaesthesia in the plaster room These guidelines should be explicit about: 1. Responsibilities at each stage of the assessment and procedure 2. Handover between stages of the patient pathway 3. Indications and arrangements for day case and short-stay surgery and enhanced recovery 4. Documentation	N	Guidance was not yet in place covering recognition and treatment of complications, including involving other services as required. All other aspects of the QS were covered in the pathway guidelines. 'j', 'k' and 'l' were not applicable as anaesthesia for these procedures was not undertaken on site.
XG-503	**Consent** The organisation's consent procedure should be in use.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
XG-504	**Clinical Guidelines** Clinical guidelines should be in use covering at least: a. Management of patients with allergies b. Management of pre- and post-operative pain c. Post-operative management of epidural anaesthesia and peripheral nerve catheters d. Blood transfusion including blood component therapy, intra-operative cell salvage and management of massive haemorrhage e. Management of suspected anaphylaxis during anaesthesia f. Perioperative management of bariatric patients g. Management of patients with diabetes h. Management of malignant hyperthermia i. Management of post-operative nausea and vomiting j. Management of patients with trauma k. Management of sepsis l. Management of acute unplanned surgical care m. Conditions requiring antenatal referral to an anaesthetist (available to both obstetricians and midwives) n. High risk surgical care for patients with a predicted hospital mortality of >10% o. Perioperative management of frail older people	N	Clinical guidelines for 'b' and 'e' were not yet documented. The policy for Patient Controlled Analgesia did cover anaphylaxis whilst a PCA was in operation but not management of anaphylaxis for other reasons. Guidelines covering 'a', 'c', 'd', 'g' 'h' 'k' and 'l' were in operation. Guidelines covering 'j', 'l', 'm', 'n' and 'o' were not applicable.
XG-505	**Transfer** Guidelines on transfer of patients should be in use, covering at least: a. Transfer to and from critical care services within the hospital b. Transfer for critical care or other specialist care outside the hospital Guidelines should be specific about communication, staffing, equipment and transport during the transfer, and governance responsibility.	Y	The policy was not specific about who should take responsibility for transferring patients, but in practice staff were clear that it would be the consultant caring for the patient.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
XG-506	**Infection Control** Guidelines on infection control should be in use, including guidelines on: a. Cleaning b. Care of patients with suspected or confirmed contagious and communicable diseases and/or suppressed immune systems, including patient care before, during and after their procedure c. Decontamination of equipment and environment, including before and after use by patients with suspected or confirmed contagious or communicable diseases d. Use of single-use, disposable equipment	N	See earlier comments regarding wearing of jewellery, uniforms and equipment in earlier text (p6).
XG-507	**Resuscitation Policy** The organisation's resuscitation policy should be in use.	Y	
XG-509	**Management of Drugs and Anaesthetic Agents** Guidelines on the management of drugs and anaesthetic agents should be in use, covering at least: a. Roles and responsibilities b. Security and storage c. Prescription, including prescription of unlicensed medicines d. Preparation and administration e. Identification and management of extravasation f. Identification and management of patients at risk of adverse reactions g. Management of continual infusion and patient-controlled analgesia h. Restricted use of open systems for injectable medication i. Prescribing of drugs to take home for day case patients j. Control of waste anaesthetic gases	Y	There was also evidence of an audit process that demonstrated that action plans were monitored and implemented. All patients had their medication reviewed by the hospital pharmacist on a daily basis.
XG-510	**Management of Controlled Drugs** Protocols should be in use covering the prescription, administration and disposal of Controlled Drugs.	Y	
XG-511	**Health and Safety** The organisation's Health and Safety Policy should be in use, including specific reference to the response to clinical incidents.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
XG-601	**Operational Policy** A Theatre and Anaesthetics Service Operational Policy should be in use covering at least: a. Availability of services, including 24/7 availability b. Visitors and visiting by relatives and others c. Staff clothing d. Professional behaviour in the theatre environment e. Management of staff who are new or expectant mothers f. Preparation of clinical areas g. Safe handling and positioning of patients h. Communication and liaison with hospital bed management, surgical teams, obstetrics, imaging and pathology services i. IT security j. Management of clinical waste k. Safeguarding children and vulnerable adults in the operating theatre l. Death of patients in the theatre environment and organ donation m. Arrangements for obtaining feedback from hospital clinicians and for involving referring GPs and hospital clinicians in decisions about the organisation of the service n. Response to a Major Incidents	N	The operational policy did not include all aspects of the QS.
XG-602	**Capacity Management** The service should have a capacity management plan covering: a. Expected timescales for response to emergency, urgent and planned demand b. Response to unexpected fluctuations in demand c. Response to delays in surgery and recovery d. Medical arbitration on priority of theatre cases e. Daily access to theatres for reconstructive microsurgery (Major Trauma Centres only) f. Escalation procedures when theatre and recovery capacity is insufficient for expected need	Y	Only 'b' was applicable, and processes were in place to manage fluctuations in demand.
XG-603	**Risk Assessment and Management** A system for risk assessment and risk management should be in use covering risk assessment, risk management and review of risks. Risks and actions should be recorded in an up to date Divisional Risk Register. The risk management system should include feedback to staff about risks identified and action taken.	N	A process for managing risks was in place; however, staff who spoke to reviewers were not clear about which risks were on the department risk register. Some staff commented that they did not always receive feedback after reporting issues.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
XG-604	**Hazardous Substances** The service should have an up to date report showing compliance with Control of Substances Hazardous to Health (COSHH) Regulations.	Y	The latest health and safety report was not seen at the time of the visit. Compliance is based on the hospital's self-assessment.
XG-605	**Service Improvement** The service should have systems for on-going review and improvement of quality, safety and efficiency, including at least: a. Theatre utilisation b. Staff utilisation c. Review of clinical pathways with referring GPs and hospital clinicians	Y	
XG-606	**Service Development Plan** The service should have a development plan or strategy which brings together the staffing, training, equipment and facilities plans for the next five years in support of the organisation's business plans.	N	A service delivery plan was not yet in place to support the clinical strategy. The clinical strategy was reviewed annually.
XG-701	**Data Collection** Regular data collection and performance monitoring should cover: a. Theatre utilisation, and theatre session over-runs, under-runs and late starts b. Activity levels c. Timed clinical events along the patient pathway d. Achievement of agreed timescales for responding to emergency, urgent and planned demand e. Operations on 'high risk' surgical patients carried out under the direct supervision of a consultant surgeon and consultant anaesthetist f. Operations on patients with a predicted mortality of ≥10% where a consultant surgeon and consultant anaesthetist are present for the operation	N	Data on theatre overruns were not monitored, and from discussions with staff, agreed timescales for responding to planned demand were not adhered to.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
XG-702	**Audit and Monitoring** The service should have a rolling programme of audit of compliance with at least: a. Equipment management (QS XG-404) b. Implementation of Local Safety Standards for Invasive Procedures (QS XG-501) c. Documentation of invasive procedures (QS XG-502) d. Cleanliness and infection control (QS XG-506) e. Management of Drugs and Anaesthetic Agents (QS XG-509) f. Management of Controlled Drugs (QS XG-510) g. Staff clothing and professional behaviour in the theatre environment (QS XG-601) Feedback should be shared through multi-disciplinary review and learning arrangements (QS XG-798) and with patient representatives (QS XG-199).	N	Auditing covered all but 'b' as the clinical polices did not yet include the detail required for implementation, ongoing auditing and reporting for the 13 NatSSIPs. WHO 'Safer Surgery' audits were undertaken (see concern 1 about implementation of the process) Multi-disciplinary review and learning was not yet in place, but feedback was shared via other mechanisms, see comment at XG-798
XG-704	**Monitoring of Key Performance Indicators** Key performance indicators (QS XG-701) and audit results (QS XG-702) should be reviewed regularly with hospital management and with commissioners.	Y	
XG-798	**Multi-Disciplinary Review and Learning** The service should have appropriate multi-disciplinary arrangements for reviewing and implementing learning from: a. Positive feedback, complaints, outcomes, incidents and 'near misses' b. National Patient Safety Agency alerts c. Published scientific research and guidance relating to theatre and anaesthetic services	N	Uni-disciplinary meetings did take place and there were plans to re-start multi-disciplinary team meetings in January 2018. Learning was shared by other mechanisms such as the Clinical Effectiveness Committee, governance newsletters and safety bulletins.
XG-799	**Document Control** All policies, procedures and guidelines should comply with the organisations document control procedures.	N	Marked as no due to concerns over WHO checklist (see earlier comments). However, other document control was considered appropriate

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