Alder Hey Children's NHS
NHS Foundation Trust

Reference Number: FOI202223/016
From: Private Individual

Date: 06 April 2022

Subject: copy of the most recent Association for Perioperative Practice (AFPP) report

Q1 As the Health and safety committee has been cancelled on Monday 11th April and as requested/discussed on the last health and safety committee on 10th February by staff side H&S representatives can we please receive a full, unredacted copy of the AFPP report (The Association for Perioperative Practice) that was produced after their visit raising concerns?

Requested under the safety representatives and safety committee regulations 1977 and Health and safety consultation with employee's regulations 1996. Regulation 2 (4) and Regulation 7 (1) (2).

A1 Please see attached document: *FOI016 Response*

Certain information has been redacted following exemptions applied:

Section 38 – Health and Safety
Section 40 – Personal Information

Theatre Review Alder Hey Children's NHS Foundation Trust

The Alder Hey Children's NHS Foundation Trust is one of Europe's busiest children's hospitals, providing care for over 330,000 children each year. Alder Hey is a designated national centre for head and face surgery and a centre of excellence for heart, cancer, spinal and brain disease. Alder Hey is a designated major trauma centre and is one of four national surgical centres for children's epilepsy. Alder Hey is also a leading Paediatric Research Centre.

Background:

The Trust have experienced a number of Never Events related to the delivery of surgical services. Following these events, NHS England and NHS Improvement mandated that the hospital undertake an external review of their facilities with a view to assessing what they believe to be a team-based problem.

This report is provided following an observational assessment within the operating theatres undertaken by two objective perioperative consultants over a two-day period in April 2021. This general assessment focused on the perioperative environment and the staff, to determine general awareness and the level of adherence to existing procedures and perioperative standards.

The role of the assessor is that of an outside observer to provide expert feedback to senior management and staff which can inform and enable the changes required to address issues identified. It is recognised that an outsider can observe aspects that the workforce cannot see, as they have accepted them as the norm. When you see the same thing every day, it becomes part of the landscape, and you don't notice it. When someone from outside raises questions, it becomes visible again. The feedback in this report is provided with a view to enabling those who work in the operating theatre to make sense of their workplace and their individual roles within it, without raising any judgement.

A further Never Event had been recorded three weeks prior to the review. This brings the total number of Never Events to eight; the previous seven had occurred between August 2018 and January 2020.

The latest Never Event related to incorrect side anaesthetic block. The consent form for the proposed procedure stated:

'bilateral medial hamstring releases and distal femoral anterior 8 plate insertion plus left split tibialis anterior transfer+/-hindfoot release.'

Reviewing the details of this incident indicated that the patient was also consented for:

'examination of teeth under general anaesthetic, and removal of at least one baby tooth... dental scaling and any other treatment.'

This was not indicated on the operating list or in the original patient consent form, and the theatre team were unaware of this additional procedure until the [redacted] attended theatre and produced a separate consent form.

According to the information available, the [redacted] reviewed the patient in the admissions lounge and confirmed laterality with the patient's mother. He then marked the patient limb, without having site of the consent form which had been agreed three weeks previously. The [redacted] proceeded to mark the right leg whilst the consent form had indicated the left side.

The anaesthetic team proceeded to undertake the regional anaesthetic block, and the stop moment was conducted with the team by observing the site marking, rather than verifying both the site marking and the consent form together. The patient was then transferred into theatre ready for surgery.

During the patient identification check process, the scrub practitioner noted that earlier the discussion with the surgeon had identified that the planned surgery was on the opposite side. The patient was [redacted]

Recommendations:

- The details presented as the intended procedure is, in both these instances, unclear and has the potential for error. The procedure should be clearly identified.
- Where there is more than one procedure this should be indicated separately, and the proposed intervention clearly written in each case.
- In the event that information is not displayed on the operating theatre list in this way, the team should be able to challenge and for the information to be changed.
- It is recommended that a full review of the process for providing an appropriate theatre list is undertaken to outline and determine all the details required to meet this standard.
- It is recommended that reference is made to the Thematic Review Report provided by AfPP in January 2021. There are thirty-two recommendations made by the Alder Hey RCA panel to specifically address the issues identified as part of the analysis for each Never Event. The recommendations and themes identified are highly relevant as part of this report and as part of providing a sustainable solution for appropriate policies, practice change and compliance.

Excerpt from the RCA Report relating to recurring issues and themes (TOR 1/2):

Several similarities were reported across incidents which give an overall impression of disorganisation and lack of structure and clarity for staff. These issues do not necessarily fall within one category but cross lines between leadership, organisation, training, policies and guidelines and, compliance with such policies. Some relate to human factors.

For the purpose of the report and by way of highlighting the types and degree of problems, some, but not all, examples have been given within each category although they could be relevant to other categories as well.

The main strengths of leadership are the ability to set a clear vision to guide and motivate others through the tasks at hand by effective communication, negotiation, organisation, situational awareness and building morale. All these lead to clarity of purpose and help to determine organisational culture.

Organisation of the work environment enables efficiency, clarity of roles and purpose, good time management, minimises risk, enhances safety and reduces stress.

Training is a vital tool when implementing new policies, introducing new or updated equipment, and engaging new or temporary employees. The training process moulds the thinking of employees and enhances the skills, capabilities, and knowledge of employees for doing a particular job.

Agreed policies and procedures provide a framework in which decisions can be made by standardising practice, thereby improving services and achieving greater understanding. They are designed to provide guidance, consistency, accountability, efficiency, and clarity by influencing and determining all major decisions, actions and activities which take place within the boundaries set by them. They set the foundation for the delivery of safe and cost-effective quality care. (AfPP-Mona Guckian Fisher-Thematic Review-January 2021).

Discussion on relevant overall findings during the visit 28-29 April 2021.

The theatres provided a bright, scrupulously clean and welcoming environment, and staff were friendly and welcoming. Whilst undoubtedly a real positive, from more in-depth observation and discussion with staff, there are underlying issues identified and cited within the report that have the potential to escalate and change aspects of this outward appearance unless addressed.

This type of environment, where people feel happy and comfortable in their roles, can easily lend itself to situations where individuals are wary of upsetting the balance by raising concerns, and consequently it becomes easy to allow standards to slip, accepting non-compliance and reluctance to change and improve. Such examples are provided from observations made during the theatre audit in the report below.

Organisational Culture

It is recognised that each single practice and organisation has its own kind of culture. Operating theatres are notoriously cited as difficult areas to work, and which adapt a specific departmental culture understood only by those who work within it. Defining culture is difficult and we have no clear understanding of what it means. Culture affects us in a variety of different ways and is experienced through the group of people that we work regularly with, in this instance in the operating theatre.

In the NHS organisational culture is defined as:

- the way things that are done within the workplace
- the way things are done within the team, and which is heavily influenced by shared unwritten rules and the reflection of what has worked well in the past www.institute.nhs.uk/improvementguides

Safety culture relates to staff attitudes and, the way that staff think and behave within the workplace. These include safeguards in place, team working, communication and attitudes to all aspects of patient and colleague safety.

One commonly used safeguard is a checklist, which is more than a simple intervention. At a basic level, the checklist functions as a reminder, which ensures basic care processes are complied with, assuming the checklist in place is used correctly. At a broader level, checklists and their usage have implications for team working, team cohesion, and safety culture.

Checklists require people to change their work routines, such as seen at the 'time out' phase of the World Health Organisation (WHO) Surgical Safety Checklist (SSC), which requires the entire operating theatre team to gather and pause for a few seconds before proceeding with a procedure. It must be recognised that checklists are not a panacea that will fix every safety problem but serve a purpose in bringing about team interaction. If significant, wider problems exist within an organisation, the likely outcome is that a checklist will not have a positive benefit, and indeed, it may be reduced to a tick box exercise.

Five steps to safer surgery (TOR 4):

The WHO surgical safety checklist and the NPSA Five Steps to Safer Surgery provide perioperative teams the opportunity to improve the safety of surgery by recognising factors that contribute to poor patient outcomes. The aim of this process is to bring all team members from the different perioperative professions together to ensure that patients are cared for in a safe environment, by a team who are informed about all the expected and unexpected steps of the planned procedure.

This core set of safety checks is crucial for identifying and improving performance at safety critical times within the patients' intraoperative care pathway; and thereby reduce the number of errors and complications resulting from surgical procedures by improving team communication and by verifying and checking essential care interventions. It is vital to have this in place to initiate meaningful and purposeful conversation between relevant members of the clinical team to improve the safety of surgery.

During the review it was evident that the WHO check list is in place, and evidence of some very good practice but this is not consistently seen throughout all the operating theatres, and there should be some concern due to the variability of application.

The WHO check list was completed more than once while the surgeon was scrubbing, or working on the computer, and they were not, therefore engaged in the process.

The standard in place identifies that surgical safety checks incorporating the five steps to safer surgery (team briefing, sign in, time, sign out, team debriefing), are performed for all patients undergoing surgical intervention. The checklist is used as a tool for improving communication and patient safety, and not a means of ticking a box for compliance monitoring.

Observations of improvements on practice (TOR 3):

There is evidence of support and attempts to improve systems for perioperative teams to ensure effective communication and compliance, as can be seen from the introduction of the green sticker labels as an additional check following the most recent Never Event in theatre.

Whilst overall, the intention of introducing this additional check was obvious, it is understood that introducing further controls within a system, that should in theory and practice at the outset be a simple exercise, can often lead to further error. This was evident in the way that the newly used green sticker was being utilised by staff in theatre.

The new paperwork identified as the solution has a red box in position that requires a green label to be placed on top to indicate that completion of the second check has been achieved. Many staff were not aware of why this new additional check had been introduced or, at the very least, were very vague in terms of attempting to explain the rationale around its requirement. Unsurprisingly, in some instances, the patient's paperwork was pre-populated with the green sticker which defeated the entire purpose of introducing this additional check.

Recommendations:

- The full team needs to be involved with the five steps process to ensure consistency. Identified as a need within the training needs analysis.
- The department requires further work to educate, re-inform and embed this process in practice. It is acknowledged that only a snapshot review of this process was undertaken.

- Further sustained and ongoing audit is recommended.
- The new green label process requires review and further exploration to address the shortcomings in understanding and compliance from staff, and to consider whether it is, in fact, worth continuance as the intended solution, or whether an alternative approach would be better and easier to manage.

Staff Comments and Perceptions:

The experiences and perceptions of staff need to be considered to determine the process that will support teamworking and improvement within the department.

It was observed that there was an obvious divide between the 'upstairs-downstairs' levels of theatres. Team members described a clique mentality in some areas of the department.

There were descriptions of colleagues who were 'set in their ways' and 'not receptive' to different ways of working. The perception of staff outlined a high degree of favouritism and staff did not feel or experience treatment that was equal or fair.

There were comments which supported what was observed in practice by the auditors, in that some staff described complacency with standards of practice, in particular with counts, the debriefing process and incident reporting. One member of staff discussed an incident of wrong side procedure. They felt [redacted] had dismissed the error as being of no importance and there was an attitude that it did not matter. This was not reported as an adverse occurrence, and apparently the consultant had no concern with proceeding outside of the consented procedure.

Observations of learning/improvement:

The hospital management team informed the consultants that a post incident debrief was held with the team involved. This was chaired by the Divisional Director and the Director of Nursing and Chief of Operative Care were also in attendance. Evidence of this was shown to the AfPP consultants, which listed the learning as:

- Staff missing from huddle.
- Operating list different to the consent form.
- Patient 'check in' thought to be possible source of distraction and potential for confirmation bias.
- Time out not performed.
- Distraction with staff leaving the theatre to obtain equipment.

The actions put in place because of the incident and debrief were shared with the consultants, as follows:

- Update sign in process to remove the 'check in step' from the hospital's current practice, as it does not fit with the five steps.
- Consent form audit implemented.
- Review/Re-write LocSSIPs, revamp/relaunch.
- Review the LocSSIPs audit process – reduce the number of procedures we audit but improve quality of the audit.
- Review the leadership within the SDC theatre.
- After the pilot in orthopaedics use day case as the next area for the STAT programme.

There was no evidence to support that these actions had taken place and were embedded into practice.

Anecdotally, [redacted] was told by another member of staff to 'do the right thing next time and stop wasting people's time', allegedly because they had been asked to complete a statement.

Other incidents were discussed, and it was apparent that when issues were raised there was no consistency either in practice or policy with how these should be managed. One such incident related to an ophthalmic procedure where an 'eyelash' had inadvertently been dropped, and they were told it was not worth escalating or looking for this, as they would not find it.

Staff also discussed difficulties with medical staff, and how the five steps are managed, particularly the huddle. When it should take place and who is ultimately responsible for ensuring the huddle takes place and the effectiveness of said process.

Some staff described an environment which supported a 'blame culture' and anecdotally told us that some incident forms disappeared.

One staff member discussed an incident investigation from some time ago (unsure on timing) that had resulted in themselves, and another team member being treated unfairly. According to the member of staff, the outcome of this investigation had not been discussed with them and is still awaited. [redacted] It is imperative that timely feedback and engagement is provided where staff investigations are underway or concluded.

All theatre staff should be provided with this update regularly and would benefit from this being a fixed agenda item for staff meetings.

There was discussion with the auditor regarding a recent incident where removal of a plaster cast resulted in damage to a child's skin. It was alleged that the individual undertaking this task was not trained and competent, and that furthermore the report had since been lost. Some staff described the 'Alder Hey carpet' and felt that senior staff chose what they wanted to report.

The incident form relating to this event was given to the AfPP consultants on the day of the audit. Following the incident, it was discussed with the staff member involved and appropriate management steps were taken. The hospital were unable to share feedback on this incident as it was reported anonymously.

Some of the [redacted] staff told us that they liked their work but felt undervalued.

The hospital provides a training programme for the assistant practitioner role, which is commendable. However, those interested in this training programme had been told that there would be no more secondments; that registered training was their only way to progress, and that subsequently two members of staff were seconded to ODP training.

We heard positive comments from a [redacted] who is very happy at work. Another [redacted] expressed that there was no development for them within theatre. Many members of staff we spoke to expressed positive sentiments, stating they loved working in theatres at Alder Hey.

Most of the staff who spoke to us reported that, as an overall experience, the department is very segregated and that the specialty teams do not mix or talk to each other. According to staff, this is additionally evident during break times.

Some staff explained that they do not know the senior team and described a disconnect between the 'floor and senior staff'. There appeared to be a lack of visibility in clinical areas by the senior team and, with rare exception, this was evidenced during the audit.

There was some positive feedback received about the support received from their [redacted]. On the day of the audit, the [redacted] was seen to be engaged and clinically active within the team.

However, overall staff described feeling unsupported and unfairly treated due to levels of favouritism, specifically in the allocation of weekend emergency work. There is also a perception that medical staff are allowed to do things their own way, such as not engaging appropriately in the SSC process.

In a discussion around patient care, we discussed issues around noise and distraction within the theatres that could have a detrimental effect on patient safety and wellbeing. Issues had been reported but the team felt that nothing had been done to address the situation.

We were told that, in general, staff in theatres are resistant to change and that work practices are adapted to please the medical staff.

A member of staff discussed issues of bullying. They explained the discrepancies between two teams [redacted] where there were misunderstandings and altercations, and where HR and theatre management supported one team, without any provision to hear the voice of the

other theatre team. This resulted in long term sickness absence and distress, which continues to affect staff involved. It is recommended that this is followed up and discussed where appropriate.

AfPP were informed that this relates to an historical incident which occurred [redacted] It is important to note that these issues have been investigated [redacted] in line with the correct internal HR processes and a conclusion has been reached. However, the staff concerned remain dissatisfied with the outcome from these proceedings.

Recommendations:

- A review of the reporting mechanism for incident as there was no consistency either in practice or policy with how these should be managed.
- Identify and review of the procedure in place for the counting of needles, instruments, and swabs, and how this is managed and documented within the various disciplines in theatre.
- Training in respect of the five steps to support all practitioners with the management of this process.
- Leadership development to ensure decisive and supportive responses to team members to reinforce agreed procedures and processes. To support them if issues need raising and, how to have difficult conversations.
- It is recommended that the overall system for reporting incidents by staff is reviewed and that staff receive instruction and encouragement on incident reporting. It is imperative that all reported incidents and concerns are dealt with and that the staff involved are provided with an update and feedback on outcomes from their report/concern.
- Suggest that incident reporting and feedback, become a fixed agenda item for team meetings.
- Some internal training to provide more defined descriptions and information around roles and responsibilities within the teams, particularly the roles of senior management to manage expectations of those working within the department. This could form part of the induction programme for new members of the Alder Hey team.
- A review of rota administration to ensure parity across the teams when allocating overtime and emergency work.
- A review of noise and distraction within the theatre environment.

Departmental Leadership:

Leadership in the department was not visible and the concerns expressed by staff about this during our informal discussions were validated by the observational experience of the auditors. There was a feeling of 'comfortable' leadership i.e., using a limited set of behaviours to deliver a steady level of performance without a sense of risk. The outcome is that working practices have become custom and practice rather than innovative and progressive.

Effective clinical leaders are linked to facilitating and maintaining healthier workplaces-by driving cultural change among all health professionals in the workplace. To achieve these positive outcomes, clinical leaders need to be seen as credible, that is, be recognised by colleagues as having clinical competence-and have the skills and capacity to effectively support and communicate with members of multidisciplinary clinical teams.

Leadership skills are developed by experience, reflection, and guidance. There is a requirement for individuals in this position to have the capacity for objective assessment combined with insight, appropriate attitude and solutions in the face of difficult challenges, which are to be expected as the norm within this kind of complex multidisciplinary working environment.

Recommendations:

- Introduce a programme of leadership training and supportive education for those in leadership roles or aspiring to a leadership role. The training should address:
  *Visibility
  *Communication
  *Conflict resolution

Teamworking:

It is important for the team to develop and be supported towards a level of psychological safety in the workplace. This creates a belief among team members that it is safe to take risks in communications without fear of negative consequences. It needs to be recognised that status and power differences often discourage individuals from speaking up and sharing information freely. In terms of the number and nature of never events within the department and based on the experience shared by some members of staff, this is important to consider in the complex environment of the operating theatre, where all team members must speak up with critical information or concerns.

It is of equal importance that where issues or concerns are raised that these are listened to, explored, and addressed in a timely manner.

Care in the operating theatre is delivered by interprofessional teams. The complexity, pace, and uncertainty of patient care typified by surgical practice requires active contributions from the whole team. The focus needs to be collaborative, recognising and enhancing team identity and insisting on the best possible performance of the whole team.

Teamworking reduces error and provides a safer working environment. It is recognised that error is a normal human attribute and must be detected by constant vigilance. It must also be managed by every member of the team. It is known that surgical errors are rarely the result of a single mistake by an individual, and systems factors have been shown to contribute to more than 80% of cases. Safe care depends on both teamwork and systems.

Recommendations:

- Develop a programme of whole team training to develop and improve team behaviours as well as safety.
- Develop a programme of human factors training that looks at situational awareness and organisational memory and moving forward from dysfunctionality. It would identify how the accumulation of minor failures may provoke major failures and affect patient outcomes.
- Develop a programme of audit that supports improvements and collaboration.

Environment:

In general, posters and information displayed for staff was neatly presented and laminated. However, in some areas, paper posters were on display which is not conducive to good infection prevention protocols.

The doors were left open between the anaesthetic room and the corridor in a number of theatres. Some anaesthetic rooms and theatres had bags and personal belongings, which we were told were the property of the medical staff.

Recommendations:

- Suggest the use of the OneTogether audit tool, which is open access via the OneTogether website. This will assist with general infection prevention requirements with the environment.

Observations and Examples of Theatre Practice:

An Anaesthetic room induction was observed to be very safe and streamlined with all checks undertaken. There was good communication within the multidisciplinary team.

The patient checking was seen to be comprehensive as the patient and mother were both involved and engaged. There was a very caring and relaxed atmosphere provided for the patient and mum by the staff, with the mother being very well supported.

Great care was observed to be taken around the security of the endotracheal tube and included consideration for pressure area care around the placement of the endotracheal tube.

Disposal of Waste:

The standard in place provides that all clinical and nonclinical waste generated within the perioperative setting is managed safely, and in accordance with national guidance and statutory requirements, and that there is a written policy outlining how this process is managed.

Orange and black bags were observed to be used within the clinical areas. In discussion, staff gave different responses to how waste was managed, but overall, the general expectation was that everybody knew what the differential in waste should be and, provided adherence to this. The auditors did not feel that the responses in terms of disposal of clinical waste, were adequate to provide assurance that clinical waste would be disposed of appropriately.

The disposal of waste was observed within the theatres and some waste was not appropriately disposed of. For example, paper in an orange bag which quite clearly would have been more appropriate in domestic waste. In one anaesthetic room the auditor observed green anaesthetic swabs and gloves, which had been used clinically, disposed of in a black domestic waste bag. There did not appear to be a standard operating procedure (SOP) or policy which addresses this issue. If such a procedure exists, it is clear, that staff are not aware of its existence.

A patient urinary catheterisation was observed, using scrupulous safe aseptic technique.

Recommendations:

- Review and audit clinical waste requirements within the department.

Theatre Etiquette:

There was no jewellery worn by any member of staff observed and compliance with that standard was observed to be excellent within the department.

It was observed that the skin cleaning preparation solution and swab were kept on the sterile trolley throughout the case.

Information, including signatures and names of staff involved in procedures, was missing from the book which records the procedures.

Some preference cards for surgeons had not been updated, some were dated 2002.

Perusal of the consent policy in place identified that it did not reflect the latest GMC consent guidance. This was being addressed by the head of nursing. The auditors asked whether the senior team had developed a process for staff to employ when the registrar is not available, to assist the surgeon during surgery. No risk assessment or contingency plan was seen. We were told that the policy was being reviewed and would emphasise that instruction and training needs to follow.

Recommendations:

- A back-to-basics review of theatre etiquette to support leaders ensure that the correct standards of dress etc., are adhered to in theatres and the best practice requirements to support why.

- Develop a best practice guide to support the understanding of the sterile field. This would form part of the theatre etiquette training.
- Training around consent and the importance of consent is highly recommended.
- Develop a good governance guide for theatres, which would support risk assessments and contingency plans should they be needed.

Accountability:

There were issues of concern identified during the review and, also as part of the focus group discussions. These included the importance of preparing for the following days theatre list ensuring that instruments and equipment are available. It was identified that often, the question on equipment requirements is presented by staff during the theatre huddle. The medical staff have alluded to this as a frequent problem and explained that, when asked what instruments are required, staff run off to sort it out disrupting the huddle and delaying the start of the procedure. This highlights a lack of individual accountability within the department.

It has become apparent from the audit and subsequent discussion with staff, that there is a lack of standard operational procedures in place which break down the criteria, set out in local policy, and which can provide a simple set of instructions for staff to follow. It is a reality that invariably where there are numerous pages of policy, staff will not refer to these on a regular basis and, in any event, they do not provide the level of workable detail needed. Where clear, direct, and simple instructions are extrapolated from an overarching hospital policy and presented as a standard operational procedure (SOP), this system can be beneficial for staff and those in charge of managing quality within the theatres.

Recommendations:

- Development of a standard operating procedures to support equipment/instrument requirements for surgery – particularly, taking into account next day needs.

Observation of Patient Journey:

The complete journey of a [redacted] patient for [redacted] surgery, was observed from their admission from home directly to theatre.

The admission area was allocated as per Covid management requirements. All checks were observed to be undertaken in the admissions lounge; anaesthetic gel (emla cream) was applied to both hands. The patient was taken to the waiting room with their mother. The surgeon and anaesthetist both visited the patient and mother and comprehensively checked the necessary details. The anaesthetist explained to the child what they would see in the anaesthetic room on arrival there.

When observing the [redacted] patient in the anaesthetic room, the anaesthetist removed the Emla cream and inserted the cannula into the child's hand which was supported under the mother's arm and behind her back. The blue tray, which contained the syringes and drugs for induction, was utilised from the floor by the anaesthetist until the patient was asleep. The child was then transferred from the mother's knee to the trolley. At this point the tray, which had been situated on the floor, was placed on the trolley together with the patient. This is clearly an infection control risk.

In the operating theatre we noted hazards, a trailing light cable from a headlamp and secondly from the diathermy. Theatre was noisy with alarms going off making it difficult to hear. It was not possible to determine any of the introductions or checks during the five-step process. It is acknowledged that this was also hindered by additional Covid precautions, masks and visors.

Electrical plugs are on a mobile ceiling mounted boom and could have been repositioned to provide safety in theatre. One member of staff was noted to absently lift the cable to walk underneath. Halfway through the procedure, the ODP rectified the situation by moving and readjusting the boom.

Observation showed that the consultant surgeon was in theatre to support the registrar but was not engaged in any of the five-steps process. It should be noted that the prepping of the patient was inadequate with only a [redacted] drape being used. A second available drape was kept on the trolley and not utilised to create a sterile barrier. A student nurse was scrubbed for the case and was supported by an ODP. A member of the team was observed to be standing too close to the sterile trolley whilst drying her hands after scrubbing. There appeared to be no consideration of the significant risk of contamination.

Swabs were counted [redacted] and left in the middle of the trolley, not placed in a bowl or managed in a tidy manner. The count was not transferred to the white board. After surgery had begun, the [redacted] added the numbers to the white board without any consultation with the scrub team. She had not been engaged in the initial count, and this does not meet general standards and recommendations.

The [redacted] did not come into theatre during the procedure and was observed to remain in the anaesthetic room throughout. There was a consultant anaesthetist and registrar with the patient. The Royal College of Anaesthetists and AfPP state that it is a national requirement that any patient having a general anaesthetic, for an ODP to be present with the patient, there are very specific guidelines about the role of the ODP or anaesthetic nurse within theatres. This requirement should form part of the theatre policies and guidelines.

The scrub table was messy and disorganised, suction and diathermy were intertwined and difficult to separate. The disposal system wasn't used to count out swabs following use. All the swabs were on the table at the end of the case and, were rolled up together in a piece of

paper for disposal. When counting the instruments with the student nurse, it was observed that [redacted] appeared to be amused that this count was taking place at the end of the procedure. The instruments were counted at the end of the procedure and the surgeon was not informed that the count was correct. This does not reflect good practice and does not meet AfPP's standards and recommendations for safe practice. It was observed that this was a formal part of a student's education, which does not support good practice and was essentially endorsing that the practice undertaken was acceptable.

In the interest of best practice, it is important that the teams are aware that an audible count for swabs, instruments and needles is the standard required, to confirm to the surgeon, and then to ascertain his/her understanding that this communication has been received.

The timeout was observed to take place with one staff member cleaning theatre at the same time.

One surgeon was disgruntled that there was an unannounced visit in his theatre. He wanted to know who had authorised the visit and why. He explained that he should have been told and that he did not hear the auditor when introduced. The auditor explained the purpose of the visit. It was noted that the surgeon himself had not engaged in the introductions prior to start of surgery. The auditors had raised the issue of informing surgeons prior to entering theatre and, have been assured that this would not be problematic.

The patient was accompanied to the recovery room by the full team and handover from the anaesthetist recovery staff was comprehensive. The patient was well cared for in the recovery room, full monitoring was in place throughout the patient's stay in recovery.

The recovery room cleaning procedure after patient discharge was observed to be very thorough. Overall, excellent recovery care was observed being given to all patients whilst the auditor was present.

Recommendations:

- In the context of best practice our recommendation would be to ensure that noise and distraction during the checking in process and within the theatre environment, would support patient safety and better communications for the patient and parent.
- Best practice would suggest that risk assessments should be carried out regularly to identify trailing cables or lights etc., that may require repositioning prior to commencement of surgery.
- Back to basics training to include swab and instrument counts and their importance.
- Review and update the policy for visitors to theatre. AfPP do have a poster to support this.

Theatre Practice:

The environment was visibly clean, and the auditors felt that a great deal of pride was invested in maintaining the theatre environment cleaning standards.

The 'time out' was fully interactive, led by the healthcare assistant (HCA), [redacted]. Silent focus was observed by the entire team and all elements of the checklist were verbalised.

Good practice with 'time out' was also observed in other theatres, with full introduction of the team, and where silent focus and all the required elements were verbalised and confirmed. Full interaction was observed with all staff and they were given the opportunity to raise concerns or ask questions.

The 'Sign Out' process was instigated by the HCA; however, the process was halted as members of the team were not present or present but not engaged.

The auditor observed an instrument count, when all instruments were verbalised from the checklist by the circulator who did not visualise all the instruments during check. This does not meet the requirements of good practice.

During the observation within Day Case, there was evidence to show that the newly introduced process for using green labels was not fully embedded into practice. There was an understanding of why it had been introduced i.e., to prevent further incidents but there was no background understanding of what had prompted the change.

It was noted in one theatre, that the 'sign in' section of the checklist was not completed or signed and there was no green sticker on the checklist for safe handover.

The standard procedure for checking instruments is not consistently applied. Some good practice was observed with practitioners undertaking a visual and verbal check using the instrument checklist. Some theatres did not check instruments. Thorough checks were not always observed i.e., removing instruments without checking against the designated checklist.

During the count there was loud music playing with no compliance to silent focus during the safety critical stages.

There was interruption during the instrument count, following which the [redacted] continued midway through the checklist, which does not meet the requirements of good practice.

Due to the fact that small swabs were not separated and, the red tags not removed on 12x12 swabs to count, it was established that the management of swabs and the swab count was wholly inadequate.

The counting process for swabs, needles and instruments was observed in some theatre as adhering to best practice recommendations. The auditor observed visual and verbal confirmation of the count by the scrub and circulating practitioner. The count was recorded on the white board. This represented a high standard and one that should be replicated across all cases.

During one procedure, the auditor noted that a blade was passed to the surgeon by hand and not using a receiver, which is the recommended practice.

There was also inconsistency in maintaining the correct update on the white board where additional needles were provided during the procedure. Neither the [redacted] managed this in line with recommended practice.

Sharps were not always safely managed, in one theatre, the auditor observed two scalpel blades left on the trolley with sharp ends pointing out.

Recommendations:

- Develop a structured process for implementing and managing changes to process and/or policy.
- Back to basics training around the swab and instrument counts plus, handling and passing of instruments during a case.
- Reviewing policy around the management of sharps – AfPP have a poster to support this area of practice.

Education:

The matron discussed a new initiative to provide human factor team training. The Safe Team Alderhay Theatres (STAT). This had been successfully delivered, before lockdown, and there are plans in place to re-establish this programme. This is strongly encouraged to improve team integrity, understanding and commitment. It is essential that this is supported from the highest level at the Trust, in terms of structured attendance time, which does not conflict with other work expectations, and that all levels of the multi-disciplinary team are fully engaged.

Recommendations:

- Develop a programme of delivery of the STAT programme which includes the whole team within theatres. This should not be segregated, and disciplines should be mixed to ensure cross functional learning.

Equipment Procurement:

There does not appear to be a structured approach to the introduction of new equipment within theatres. There is no cross functional engagement in the procurement process. This can result in training needs not being established prior to using the equipment.

Recommendations:

- Involvement of the clinical team and theatre management in the selection and procurement of equipment to ensure management and training needs are identified and fulfilled.

Audits:

There is an audit process in place although the reported results from audit are questionable in terms of their validity and compliance with observed practice. There was no evidence to show that the outcomes from any previous audits had been implemented.

The National Safety Standards for Invasive Procedures (Nat SSIPs) www.england.nhs.uk audit for January, February and March all indicated a hundred percent compliance. The audit looks at a surgical hand wash, implant verification, prevention of retained objects foreign objects, and surgical site marking. Safety check audit shows compliance of a hundred percent in all areas for April 2021. The hand hygiene audit shows 100% compliance for March 2021. This could not be verified in practice by the auditors during the two-day visit.

The Nat SSIPs policy document observed on the information board was a 2012 version and was later confirmed by the head of nursing as the incorrect version. The correct version was printed and replaced. There was no AfPP referencing on the new document and, it was noted that the Perioperative Care Collaborative (PCC) and not AfPP, should have been referenced as providing the recommendations for the surgical first assistant (SFA) reference within the policy.

The risk register summary of 6 April 2021 identifies four risks that appeared immaterial. There is no evidence of any risks identified, or raised as a consequence of serious incidents, and Never Events within theatre. The local standards based on the national standard are not clear or user-friendly and are not appropriately referenced, nor do they provide appropriate and clear guidance.

Recommendations:

- A review of local policy in line with national policy is required to enable staff to be clear in terms of the professional roles and responsibilities.
- In terms of managing the audit process and determining quality, we would advocate periodic and systematic assessments of the operating theatres organisational culture, attitude, and compliance with clinical and process standards, using a well-validated instrument, such as the AfPP Audit Tool. This will allow a time-based evaluation on whether the operating theatres are moving in a certain direction, and whether any implemented interventions are working to cause a positive shift in practice and behaviour.

Conclusion:

There were many areas of good practice observed during the two-day review and these have been mentioned within the body of the report. However, it is recommended that an initial review of all theatre practice is undertaken using the AfPP audit tool. This will benefit the department to set a baseline and develop a plan to improve practice and educate practitioners according to the required national standards of perioperative practice.

It is important that some whole team training is considered to get all disciplines across all specialities to undertake some formal and structured training. It should set the ground rules for leadership requirements, speaking up and speaking out effectively, building morale and taking a back-to-basics approach to why the five steps and other fundamental requirements of perioperative care are important to patient safety.

It is recommended that an ongoing audit is conducted and embedded in practice as set out in the AfPP audit tool.

[redacted]

[redacted]