

# BMI The London Independent Hospital

## Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

### Ratings

#### Overall rating for this location

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Good



# Summary of findings

## Letter from the Chief Inspector of Hospitals

BMI The London Independent is an acute private sector hospital located in Stepney Green, East London. The hospital is a purpose built 5 storey single building which opened in 1986. The hospital provides services to patients aged 16 years or over. Services are provided by UK registered health care professionals and support teams across a range of specialties including Cardiology; Cardio-Thoracic surgery; Dermatology; ENT; Endoscopy; General Medicine; General Surgery [including upper GI, lower GI and breast]; Maxillo-facial; Ophthalmology; Orthopaedics; Pain Management; Physiotherapy; Plastic Surgery; Podiatry; Renal Medicine [including Dialysis]; Renal Surgery [including live donor transplant]; Spinal; Urology and Vascular.

We inspected the core inpatient services of inpatient medicine, surgery, critical care as well as outpatients and diagnostic imaging.

We rated this hospital as good overall. We rated it good for effective, caring, responsive and well-led. We rated safe as requires improvement. We rated medicine, critical care and outpatients and diagnostic imaging as good. We rated surgery as requires improvement.

Our key findings were as follows:

We found evidence of outstanding practice:

- The endoscopy suite had been recently refurbished and was purpose built with excellent patient and treatment facilities.

We found evidence of the following good practice:

- There was evidence of suitable investigation, learning and dissemination of learning from incidents.
- Hospital infection prevention and control practices were followed and these were regularly monitored by the infection control lead, to reduce the risk of spreading of infections.
- Appropriate equipment was available for patient procedures and tests. Equipment was well maintained and tested annually or in accordance with manufacturers' guidelines.
- The provider had begun a refurbishment programme of the whole hospital which was recognised as requiring updating in parts.
- Medicines were suitably prescribed, stored and administered.
- We observed suitable infection prevention and control procedures in use, and audit results showed 100% compliance with hand hygiene and bare below the elbow principles.
- There were sufficient nursing and medical staffing levels to enable safe care.
- Staff had undertaken appropriate mandatory training for their role, were up-to-date with training and were well supported to undertake training.
- We saw evidence-based practice in place, compliance with recommendations from the National Institute for Health and Care Excellence (NICE) and other national guidelines according to speciality.
- Patients received care from competent staff who had received the necessary training to undertake their respective roles.
- Staff had good access to patient information and liaised with internal as well as external agencies to plan and deliver patient care.
- Patients received suitable nutrition and hydration, and additional support was available for those with specific dietary requirements.
- Patient outcomes, including mortality, unplanned returns to theatre and unplanned readmissions to hospital, were good.
- Pain was well managed and we observed staff asking patients if they had pain during their routine observations.

# Summary of findings

- Most staff demonstrated a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- We observed staff provided care in a compassionate and respectful manner. Patients were treated with dignity and respect.
- Patient feedback forms about their overall experience and their opinions of the nursing and medical staff demonstrated positive results, with scores frequently above 95% satisfaction.
- Patients felt they were fully involved in planning their care and treatment. Staff ensured they listened to and responded to patients' questions appropriately. Patients commented that they had been well supported.
- Relatives were confident in the care provided throughout the service and told us they were suitably involved in the care of their loved one.
- Access to services for NHS patients and privately funded patients was straight forward and efficient.
- Services were tailored to meet the needs of individual people and there was flexibility in the provision of care.
- Staff demonstrated a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met their needs and promoted equality.
- Support was available for international patients from Kuwait. This included translation support and liaison with the Kuwaiti embassy. The hospital had an international team working closely with ITU in the admission and discharge of patients.
- Services were planned and delivered in a way which met the needs of patients. Patients had timely access to appointments. Clinics were held on weekdays into the evenings and Saturday mornings to suit patients' preferences.
- Risk registers contained items considered as issues by the leadership team and reflected our inspection findings. Key risks were displayed on posters in staff areas to raise awareness.
- Suitable governance processes were in place with a clear clinical and organisational structure. The Medical Advisory Committee (MAC) were involved in a number of key processes, including performance reviews and quality measure.
- There was a positive culture throughout the hospital, and low sickness rates.
- Staff had a good understanding of the organisation's visions and values.
- Staff described a visible and approachable leadership team and told us they felt able to raise concerns or report incidents without fear of repercussions.
- There was evidence of some innovative practice and plans for additional service development, with quality, safety and sustainability at the forefront of the decision making process.

However we found evidence of the following poor practice:

- Compliance with the World Health Organisation (WHO) Five Steps to Safer Surgery checklist was variable.
- Theatres did not have access to an uninterruptible power supply UPS, which was not in line with recommendations for surgical estates, and meant theatres could temporarily lose power in the event of a power cut.
- There were no designated hand wash sinks in patient rooms on wards, which meant staff washed their hands in patient basins. This was not compliant with hand hygiene protocols.
- Most clinical staff received level-one safeguarding training, which is not sufficient to comply with recommendations from NHS England.
- We saw that information, including information on how to complain, was in English only. Although staff had access to interpreters, there was no translated literature and no translated signage.
- There was no visitors' waiting room for ITU or HDU.
- The reception desks in outpatients and in diagnostic imaging did not have lowered areas for accessibility to wheelchair users.
- The changing room in the nuclear medicine area did not have direct access to the consulting rooms. Patients had to wear gowns and walk down the corridor where they could be seen by other patients.
- Importantly the hospital should:

# Summary of findings

- Review and ensure full compliance with the World Health Organisation (WHO) Five Steps to Safer Surgery checklist by all surgical staff.
- Take steps to ensure that theatres have access to an uninterruptible power supply (UPS).
- Provide designated hand wash sinks in patient rooms on wards, to comply with hand hygiene protocols.
- Review and implement safeguarding training sufficient to comply with recommendations from NHS England.
- Although numbers of patients aged 16-18 are low, review safeguarding, paediatric nurse cover and assessment of suitable patient pathways for these patients.
- Provide information, including information on how to complain, in other languages as well as English.
- Provide a visitors' waiting room for ITU or HDU.
- Ensure that reception desks in outpatients and in diagnostic imaging have lowered areas for accessibility to wheelchair users.
- Take appropriate steps to preserve patient dignity in the nuclear medicine area by providing direct access to the consulting rooms from changing areas.
- Take steps to modify the temperature in the OPD sluice room.
- Complete its replacement programme for fire doors.
- Prepare an action plan to address the health and safety audit results for May and June 2016 which recorded that 'power tools and electrical tools in good working order, free from splits, cracks and deformities' was rated poor.
- The above list is not exhaustive and the provider should review all elements of the report in order to continually improve the quality of its services to patients.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

### Rating Summary of each main service

#### Medical care

Good



- There was evidence of suitable investigation, learning and dissemination of learning from incidents. Suitable governance processes were in place and the Medical Advisory Committee (MAC) were involved in a number of key processes, including performance reviews and quality measurement.
- Risk registers contained items considered as issues by the leadership team and reflected our inspection findings. Key risks were displayed on posters in staff areas to raise awareness.
- Safety indicators showed good results and we observed suitable infection prevention and control procedures in use.
- We saw evidence-based practice in place, compliance with recommendations from the National Institute for Health and Care Excellence (NICE) and British Society of Gastroenterology.
- Patients received care from competent staff, including staff in endoscopy who had undergone nationally recognised training.
- Staff had good access to patient information and liaised with internal as well as external agencies to plan and deliver patient care.
- Patient feedback forms about their overall experience and their opinions of the nursing staff demonstrated positive results, with scores frequently above 95% satisfaction.
- Relatives were confident in the care provided throughout the service and told us they were suitably involved in the care of their loved one.
- Access to medicine services for NHS patients and privately funded patients was straight forward and efficient. A points-based system for procedures in endoscopy ensured a smooth running service, with limited delays and no non-clinical cancellations.

# Summary of findings

- There was a positive culture throughout the service, and low sickness rates. Staff described a visible and approachable leadership team and told us they felt able to raise concerns or report incidents without fear of repercussions.

However;

- Most clinical staff received level one safeguarding training, which is not sufficient to comply with recommendations from NHS England.
- There were no designated hand wash sinks in patient rooms on the ward, which meant staff washed their hands in patient basins. This was not compliant with hand hygiene protocols.
- Many doors were not labelled with suitable fire door labels, although a replacement programme was ongoing at the time of our inspection.
- Medical care staff knowledge of Deprivation of Liberty Safeguards (DoLS) was limited and told us, in their opinion, that it was only relevant when patients were being restrained.
- The medicine service was unable to accommodate patients with significant mental health needs, including patients living with dementia, or those with a learning disability.

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## Surgery

**Requires improvement**



- There was evidence of suitable investigation, learning and dissemination of learning from incidents and infections, and safety indicators, such as the numbers of pressure ulcers, patient falls and urinary tract infections, showed good results.
- Patient outcomes, including mortality, unplanned returns to theatre and unplanned readmissions to hospital, were good.
- We saw evidence-based practice in place, including enhanced recovery programmes for certain procedures and compliance with recommendations from the National Institute for Health and Care Excellence (NICE).

# Summary of findings

- Patient feedback about the care they received was positive and questionnaire results supported this feedback. Staff maintained privacy and dignity, and provided emotional support to patients.
- Access to surgical services for NHS patients and privately funded patients was efficient, with 91-97% compliance within the 18 week referral to treatment time target for NHS patients between April 2015 and March 2016.
- The flexibility of the surgical service meant it could absorb patients who needed to return to theatre unexpectedly as well as those with longer length of stays than expected. There were no procedures cancelled for nonclinical reasons between April 2015 and March 2016.
- Risk registers contained items mostly recognised by the leadership team and reflected our inspection findings. Key risks were displayed on posters in staff areas to raise awareness.
- Suitable governance processes were in place and the Medical Advisory Committee (MAC) was involved in a number of key processes, including performance reviews and quality measurement.
- There was evidence of some innovative practice and plans for additional service development, with quality, safety and sustainability at the forefront of the decision making process.

However:

- Compliance with the Five Steps to Safer Surgery WHO checklist was variable.
- Between April 2015 and March 2016 there were 22 surgical site infections, including higher rates per 100 procedures than the average in NHS hospitals for hip and knee primary arthroplasties.
- Theatres did not have access to an uninterruptible power supply (UPS), which was not in line with recommendations for surgical estates, and meant theatres could temporarily lose power in the event of a power cut.

# Summary of findings

- Risks documented on the risk register were not always fully mitigated. For example, not all operating staff were formally informed about the lack of UPS, which could cause delays in appropriate action being taken in the event of power loss.

## Critical care

Good 

- We found significant areas of good practice through our review of clinical audits, staff training, patient notes and minutes of intensive therapy unit (ITU) governance meetings.
- Leadership in the unit had a clear structure, and leaders were respected by staff. This contributed to a cohesive team that demonstrated an innovative approach to treatment and care.
- The unit contributed to national audits compiled by the Intensive Care National Audit and Research Centre (ICNARC) and provided patient-centred, evidence-based care.
- The critical care unit (CCU) team had access to multidisciplinary specialists who contributed to decision-making and ward rounds to ensure safe care for patients.
- Both ITU and the high dependence unit (HDU) appeared clean, hygienic and well maintained and staff demonstrated good infection control practices.
- The CCU was responsive to the international patient client group they regularly admitted to the unit and there were robust arrangements in place to meet the individual needs of these patients.
- Patients were protected from avoidable harm and there were processes and systems in place, which prioritised patient safety.
- Incident reporting was embedded in the culture of the unit and there was evidence that learning from investigations had taken place with a system in place to ensure all staff were aware of updates to practice. This contributed to an environment in which safety was prioritised and patients received individualised care.

# Summary of findings

- Staffing levels were reviewed continually using an established nursing acuity tool and there were enough staff to provide care and treatment in accordance with Royal College of Nursing (RCN) guidance. The use of agency staff at the time of our inspection had significantly decreased in comparison to the start of 2015.
- All staff we spoke with told us they were supported and valued by the senior team and they felt proud to work in the unit.

However:

- Staff did not always accurately record the daily checks for medicine management.
- There was one oxygen port (air and suction) per bed space in the high dependency unit (HDU). This was not in line with the building regulations for critical care (HBN 04-02) which suggests three to four oxygen outlets per bed space. We took into account the fact that the regulations came into force after the building of HDU however; we asked the provider to consider the requirements set out within the building regulations for critical care (HBN 04-02) in terms of risk and patient safety.

## Outpatients and diagnostic imaging

Good



- Medicines were stored securely and well managed.
- Staff had a good understanding of how to report incidents and learning from incidents was shared at departmental level.
- Staff undertook appropriate mandatory training for their role and support was available for non-mandatory training.
- Patients were protected from the risk of abuse and avoidable harm.
- Hospital infection prevention and control practices were followed and these were regularly monitored by an infection control lead, to reduce the risk of spread of infections.
- Equipment was well maintained and tested annually or in accordance with manufacturers' guidelines.
- Staffing levels and the skill mix of staff was appropriate for both the outpatients

## Summary of findings

department and diagnostic imaging services. Work pressures were manageable as there has been ongoing recruitment with posts being filled. Bank staff are used when the department gets busy and some bank staff were made permanent. Trained staff in basic life support were available to respond appropriately in an emergency situation.

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# Summary of findings

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Good 

# BMI The London Independent Hospital

## Services we looked at

Medical care; Surgery; Critical care; Outpatients and diagnostic imaging;

# Summary of this inspection

## Background to BMI The London Independent Hospital

BMI The London Independent is an acute private sector hospital located in Stepney Green, East London. The hospital is a purpose built 5 storey single building which opened in 1986. The hospital provides services to patients aged 16 years or over. Services are provided by UK registered health care professionals and support teams across a range of specialties including Cardiology; Cardio-Thoracic surgery; Dermatology; ENT; Endoscopy; General Medicine; General Surgery [including upper GI, lower GI and breast]; Maxillo-facial; Ophthalmology; Orthopaedics; Pain Management; Physiotherapy; Plastic Surgery; Podiatry; Renal Medicine [including Dialysis]; Renal Surgery [including live donor transplant]; Spinal; Urology and Vascular. Services to NHS patients either through block contracts or NHS Choose and Book currently accounts for approximately 61% of the services provided by this hospital.

In-patient facilities are located on the Third Floor and comprise 34 ward beds, a 3 bed Level 2 High Dependency Unit and a 6 bed Intensive Therapy Unit. The Day Care Unit is located on the Second Floor and has 21 beds and there are 9 trolleys in the Endoscopy Unit situated on the Ground Floor, therefore total capacity is 73 beds / trolleys. In addition to in-patient services there are 17 general Consulting Rooms, 4 Physiotherapy out-patient rooms, Pre-Admission Assessment service and Cardiac Catheterisation/Cardiology Unit.

There are 3 main Operating Theatres [two with Laminar Flow]; a designated Endoscopy Suite; Imaging Department with fluoroscopy, plain film, mammography, ultrasound, nuclear medicine, CT and MRI. The hospital also has an in-house Pharmacy Department.

## Our inspection team

Our inspection team was led by:

Inspection Lead: Robert Throw, Inspection Manager, Care Quality Commission.

The team included CQC inspectors and a combination of specialists including a consultant critical care, a surgery nurse, general medicine nurse, outpatient nurse and CQC pharmacist.

## Why we carried out this inspection

We carried out this inspection as part of CQC's comprehensive inspection programme.

## How we carried out this inspection

We carried out the announced part of the inspection on 19 and 20 July 2016. We also carried out an unannounced visit on 25 July 2016.

We spoke with patients and members of staff, including managers, nursing staff (registered and unregistered), medical staff, pharmacy staff, allied healthcare professionals, and support staff. We observed how patients were being cared for and reviewed patients' clinical records.

Prior to the inspection we reviewed a range of information we had received from the hospital. We also distributed comment cards for patients to complete and return to us. We also asked the local clinical commissioning group to share what they knew about the hospital.

# Summary of this inspection

## Information about BMI The London Independent Hospital

### Core services:

- Cosmetic Surgery
- Critical care (level 2\* and level 3)
- Diagnostic imaging\*
- Dialysis
- Endoscopy\*
- Living Donor Kidney Transplant
- Medical care (includes older people's care)\*
- Outpatients
- Surgery (excludes cosmetic surgery)

### Services provided by outside contractors:

- Catering • Decontamination Services • Grounds Maintenance • Histology -Unilabs • Pathology -The Doctors' Laboratory Ltd • Resident Medical Officers (RMO) • Resuscitation and Moving/Handling Training .

Digital imaging facilities

- CT
- Digital Mammography
- Fluoroscopy
- MRI
- Nuclear Medicine
- Plain Film Imaging
- Ultrasound.

Outpatient department specialties and approximate breakdown (%) for each one:

- Cardiology 3.1%
- Cardiothoracic Surgery 0.4%
- Dermatology 4.4%
- EarNose and Throat (ENT) 6.3%
- Gastroenterology 3.8%
- Gen Medicine 1.8%
- Gen Surgery 10.1%

- Gynaecology 10%
- Haematology 0.1%
- Maxillo-Facial 3.8%
- Ophthalmology 1.7%
- Orthopaedics 25.4%
- Pain Management 13.3%
- Plastic Surgery 0.8%
- Podiatry 2.7%
- Rheumatology 1.4%
- Spinal 6.2%
- Urology 4.4%
- Vascular 0.3%.

### Services accredited by a national body:

'Living Donor Kidney Transplant –Accreditation NHS Blood and Transplant (NHSBT)'

### Staffing information

#### Medical Staff

#### Doctors and dentists employed or practising under rules or privileges >6 months : 331

No consultants have been permanently suspended or temporarily suspended for clinical reasons. 77 consultants have been temporarily suspended due to late provision of documentation but all practising privileges have been restored.

5 consultants did not renew their practising privileges in the previous 12 months.

**RMOs: 6**

#### Nursing staff:

In-patients: 41.6

Theatres: 22

Outpatients: 2.8

Total: 68.6

# Summary of this inspection

ODP and Healthcare Assistants

In-patients: 27

Theatres: 14.2

Outpatients 2.8

Other hospital staff: 104

## What people who use the service say

NHS Choices rating 3 out of 5 stars based on 30 ratings for this hospital.

# Summary of this inspection

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

We rated safety at this hospital as requires improvement overall because:

- Compliance with the World Health Organisation (WHO) Five Steps to Safer Surgery checklist was variable.
- Theatres did not have access to an uninterruptible power supply UPS, which was not in line with recommendations for surgical estates, and meant theatres could temporarily lose power in the event of a power cut.
- There were no designated hand wash sinks in patient rooms on wards, which meant staff washed their hands in patient basins. This was not compliant with hand hygiene protocols.
- Most clinical staff received level one safeguarding training, which is not sufficient to comply with recommendations from NHS England.
- However:
- There was evidence of suitable investigation, learning and dissemination of learning from incidents.
- Hospital infection prevention and control practices were followed and these were regularly monitored by the infection control lead, to reduce the risk of spreading of infections.
- Appropriate equipment was available for patient procedures and tests. Equipment was well maintained and tested annually or in accordance with manufacturers' guidelines.
- Medicines were suitably prescribed, stored and administered.
- We observed suitable infection prevention and control procedures in use, and audit results showed 100% compliance with hand hygiene and bare below the elbow principles.
- There were sufficient nursing and medical staffing levels to enable safe care.
- Staff had undertaken appropriate mandatory training for their role, were up-to-date with training and were well supported to undertake training.

Requires improvement



### Are services effective?

We rated effective at this hospital as good overall because:

- We saw evidence-based practice in place, compliance with recommendations from the National Institute for Health and Care Excellence (NICE) and other national guidelines according to speciality.
- Patients received care from competent staff who had received the necessary training to undertake their respective roles.

Good



# Summary of this inspection

- Staff had good access to patient information and liaised with internal as well as external agencies to plan and deliver patient care.
- Patients received suitable nutrition and hydration, and additional support was available for those with specific dietary requirements.
- Patient outcomes, including mortality, unplanned returns to theatre and unplanned readmissions to hospital, were good.
- Pain was well managed and we observed staff asking patients if they had pain during their routine observations.
- Most staff demonstrated a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards.

## Are services caring?

We rated caring at this hospital as good overall because:

- We observed staff provided care in a compassionate and respectful manner. Patients were treated with dignity and respect.
- Patient feedback forms about their overall experience and their opinions of the nursing and medical staff demonstrated positive results, with scores frequently above 95% satisfaction.
- Patients felt they were fully involved in planning their care and treatment. Staff ensured they listened to and responded to patients' questions appropriately. Patients commented that they had been well supported.
- Relatives were confident in the care provided throughout the service and told us they were suitably involved in the care of their loved one.

Good



## Are services responsive?

We rated responsive at this hospital as good overall because:

- Access to services for NHS patients and privately funded patients was straight forward and efficient.
- Services were tailored to meet the needs of individual people and there was flexibility in the provision of care.
- Staff demonstrated a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met their needs and promoted equality.
- Support was available for international patients from Kuwait. This included translation support and liaison with the Kuwaiti embassy. The hospital had an international team working closely with ITU in the admission and discharge of patients.

Good



# Summary of this inspection

- Services were planned and delivered in a way which met the needs of patients. Patients had timely access to appointments. Clinics were held on weekdays into the evenings and Saturday mornings to suit patients' preferences.

However:

- We saw that information, including information on how to complain, was in English only. Although staff had access to interpreters, there was no translated literature and no translated signage.
- There was no visitors' waiting room for ITU or HDU.
- The reception desks in outpatients and in diagnostic imaging did not have lowered areas for accessibility to wheelchair users.
- We were informed and saw that the changing room in the nuclear medicine area did not have direct access to the consulting rooms, patients had to wear gowns and walk down the corridor where they could be seen by other patients.

## Are services well-led?

We rated well led as good overall because:

- Risk registers contained items considered as issues by the leadership team and reflected our inspection findings. Key risks were displayed on posters in staff areas to raise awareness.
- Suitable governance processes were in place with a clear clinical and organisational structure. The Medical Advisory Committee (MAC) were involved in a number of key processes, including performance reviews and quality measure.
- There was a positive culture throughout the hospital, and low sickness rates.
- Staff had a good understanding of the organisation's visions and values.
- Staff described a visible and approachable leadership team and told us they felt able to raise concerns or report incidents without fear of repercussions.
- There was evidence of some innovative practice and plans for additional service development, with quality, safety and sustainability at the forefront of the decision making process.

Good



# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Critical care	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

### Notes

# Medical care

Safe	Good 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Good 

## Information about the service

Medical patients are admitted to be reviewed under cardiologists, for pain management or renal dialysis. The most common medical procedures completed between April 2015 and March 2016 were: diagnostic colonoscopy (1162 procedures completed), renal dialysis (660) and diagnostic oesophago-gastro-duodenoscopy (OGD) (336). Many patients attended the hospital for cardiac catheterisation, with 232 procedures completed in this period.

Inpatients are accommodated in the 34-bedded ward which is split into two sides, known as 3A (which accommodates mainly surgical patients) and 3B (which accommodates a mix of surgical and medical patients). There is one endoscopy suite, with a seven bedded bay and two side rooms. A cardiac catheterisation laboratory is also available.

Many medical patients also have surgical pathways, therefore much of the data available for the medicine service is combined with that of the surgical service. Between April 2015 and March 2016 there were 3151 inpatient admissions for the medical and surgical services combined, and 7434 day case patients seen.

We visited the medical service at BMI The London Independent for two announced inspection days and one unannounced inspection day. During our inspection we inspected the inpatient ward, dialysis service and endoscopy suite, and spoke with seventeen members of staff including doctors, nurses, allied health professionals and ancillary staff. We also spoke with the leadership team, ten patients and two relatives. We reviewed information provided by the hospital, nine patient records and checked many items of clinical and non-clinical equipment.

## Summary of findings

Overall, we rated this service as good. We gave this rating because;

- There was evidence of suitable investigation, learning and dissemination of learning from incidents. Suitable governance processes were in place and the Medical Advisory Committee (MAC) were involved in a number of key processes, including performance reviews and quality measurement.
- Risk registers contained items considered as issues by the leadership team and reflected our inspection findings. Key risks were displayed on posters in staff areas to raise awareness.
- Safety indicators showed good results and we observed suitable infection prevention and control procedures in use.
- We saw evidence-based practice in place, compliance with recommendations from the National Institute for Health and Care Excellence (NICE) and British Society of Gastroenterology.
- Patients received care from competent staff, including staff in endoscopy who had undergone nationally recognised training.
- Staff had good access to patient information and liaised with internal as well as external agencies to plan and deliver patient care.

# Medical care

- Patient feedback forms about their overall experience and their opinions of the nursing staff demonstrated positive results, with scores frequently above 95% satisfaction.
- Relatives were confident in the care provided throughout the service and told us they were suitably involved in the care of their loved one.
- Access to medicine services for NHS patients and privately funded patients was straight forward and efficient. A points-based system for procedures in endoscopy ensured a smooth running service, with limited delays and no non-clinical cancellations.
- There was a positive culture throughout the service, and low sickness rates. Staff described a visible and approachable leadership team and told us they felt able to raise concerns or report incidents without fear of repercussions.

However;

- Most clinical staff received level one safeguarding vulnerable adults and children training, which is not sufficient to comply with recommendations from NHS England.
- There were no designated hand wash sinks in patient rooms on the ward, which meant staff washed their hands in patient basins. This was not compliant with hand hygiene protocols.
- Many doors were not labelled with suitable fire door labels, although a replacement programme was ongoing at the time of our inspection.
- Staff knowledge of Deprivation of Liberty Safeguards (DoLS) was limited and told us, in their opinion, that it was only relevant when patients were being restrained.
- The medicine service was unable to accommodate patients with significant mental health needs, including patients living with dementia, or those with a learning disability.

We rated this service as good for safe because:

- There was evidence of suitable investigation, learning and dissemination of learning from incidents.

- Safety indicators, including the numbers of pressure ulcers, patient falls and urinary tract infections, showed good results.
- Medicines were suitably prescribed, stored and administered throughout the medical service.
- We observed suitable infection prevention and control procedures in use, and audit results showed 100% compliance with hand hygiene and bare below the elbow principles.
- The clinical areas of the medical service and equipment used were noted to be visibly clean and well maintained.

We rated this service as good for effective because:

- We saw evidence-based practice in place, compliance with recommendations from the National Institute for Health and Care Excellence (NICE) and British Society of Gastroenterology.
- Patients received care from competent staff, including staff in endoscopy who had undergone nationally recognised training.
- Staff had good access to patient information and liaised with internal as well as external agencies to plan and deliver patient care.
- Patients received suitable nutrition and hydration, and additional support was available for those with specific dietary requirements.

We rated this service good for caring because:

- Patient feedback forms about their overall experience and their opinions of the nursing staff demonstrated positive results, with scores frequently above 95% satisfaction.
- We saw several cards from patients and their families on display at the nursing stations on the wards, which praised the friendly and approachable staff.
- Patients told us staff introduced themselves when they first met, and that they were friendly and kind.
- Relatives were confident in the care provided throughout the service and told us they were suitably involved in the care of their loved one.

# Medical care

We rated this service as good for responsive because;

- Access to medicine services for NHS patients and privately funded patients was straight forward and efficient.
- There were suitable facilities for patients receiving care under the medicine service, as well as their relatives.
- Patients undergoing procedures in endoscopy received comprehensive information booklets prior to their admission, so they knew what to expect from their procedure.
- A points-based system for procedures in endoscopy ensured a smooth running service, with limited delays and no non-clinical cancellations.
- Patients' language needs were well met throughout the service, including the use of translators and communication booklets.

We rated this service as good for well led because;

- Risk registers contained items considered as issues by the leadership team and reflected our inspection findings. Key risks were displayed on posters in staff areas to raise awareness.
- Suitable governance processes were in place and the Medical Advisory Committee (MAC) were involved in a number of key processes, including performance reviews and quality measure.
- Staff in endoscopy told us the leadership team were open to new ideas and receptive to feedback from staff.
- Real time feedback from consultants using the endoscopy suite was obtained in debrief sessions immediately after the endoscopy list, to identify areas of poor performance or staff training needs.
- Staff described a visible and approachable leadership team and told us they felt able to raise concerns or report incidents without fear of repercussions.

## Are medical care services safe?

Good 

We rated this service as good for safe because:

- There was evidence of suitable investigation, learning and dissemination of learning from incidents.
- Safety indicators, including the numbers of pressure ulcers, patient falls and urinary tract infections, showed good results.
- Medicines were suitably prescribed, stored and administered throughout the medical service.
- We observed suitable infection prevention and control procedures in use, and audit results showed 100% compliance with hand hygiene and bare below the elbow principles.
- The clinical areas of the medical service and equipment used were noted to be visibly clean and well maintained.

However;

- Most clinical staff received level one safeguarding vulnerable adults and children training, which is not sufficient to comply with recommendations from NHS England.
- There were no designated hand wash sinks in patient rooms on the ward, which meant staff washed their hands in patient basins. This was not compliant with hand hygiene protocols.
- Many doors were not labelled with suitable fire door labels, although a replacement programme was ongoing at the time of our inspection.

### Incidents:

- Incidents were reported on paper-based forms which staff passed on to the ward manager, as appropriate. Incidents were followed up by the manager, who communicated their findings to the quality and risk team. This team then inputted the incident data onto a computer-based system and further reviewed the incident if appropriate.

# Medical care

- Staff at all levels were able to describe the types of situations which would trigger the completion of an incident form and provided examples such as patient falls and medicine errors.
- Senior staff told us any significant incidents were raised at the “10 @ 10” meeting held with the senior management team and other area managers daily, and this facilitated immediate awareness of key issues throughout the hospital. We observed two such meetings and observed this being done.
- Numbers and themes of incidents were displayed in staff rest areas on noticeboards. We saw evidence that lessons learnt from these incidents was also communicated in this way. Staff told us key themes and learning points were communicated to them during staff meetings and update emails.
- We saw evidence that different services within the hospital worked together to learn from incidents and to change practice.
- There were no formal morbidity and mortality meetings held in the hospital due to the low number of patient deaths. Patient deaths were discussed at hospital-wide clinical governance meetings and debrief meetings were also held with staff involved in the patient’s care if appropriate.
- Between April 2015 and March 2016, there were 349 clinical incidents reported across surgery and medical inpatients. There were an additional 48 non-clinical incidents reported.
- Between April 2015 and March 2016, there were two serious incidents which were reported to the STEIS. There were no never events relating to medicine patients. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Although each Never Event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a Never Event.

## Duty of Candour:

- Many staff were unaware of the term ‘duty of candour’, however were able to identify duty of candour principles

appropriately. For example telling a patient when a mistake was made and apologising for this. We saw documented evidence in patient notes that duty of candour principles were upheld.

## Safety Thermometer:

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients receiving NHS funded care, such as new pressure ulcers, catheter and urinary tract infections, falls with harm to patients over 70 and venous thromboembolism (VTE) incidence. A single day ‘snapshot’ of patient harms was submitted to the database on a monthly basis.
- Between June 2015 and June 2016, there were no new pressures ulcers, catheter and urinary tract infections, falls with harm to patients over 70 or VTEs reported to the safety thermometer.
- Specific safety indicators which were linked to the safety thermometer included all patients and were displayed at the entrance to the inpatient ward. These included the number of patient falls, pressure ulcers, UTIs and infections between June 2015 and June 2016.
- The safety indicators displayed by the hospital showed there were three patient falls in the reporting period (one in June 2015, one in July 2015 and one in May 2016).
- There were no pressure ulcers or UTIs in the reporting period.

## Mandatory Training:

- All staff were required to complete several mandatory training modules including information governance, basic life support and health and safety. Other topics such as aseptic non-touch technique, infection prevention and control and blood transfusion were also covered for those clinical staff requiring these specific skills. Training was completed by e-learning modules or classroom-based teaching.
- At the time of our inspection, 93.6% of mandatory training had been completed by inpatient ward staff. Senior staff explained that the shortfall was due to a member of staff on maternity leave at the time.

## Medical care

- Mandatory training was up to date for 98.7% of endoscopy staff and senior staff told us dates were booked for staff to complete the outstanding modules.
- 95% of ward staff had completed intermediate life support and 85% had completed advanced life support training.

### Safeguarding:

- Safeguarding training was provided as part of the organisation's mandatory training. All staff were required to undertake safeguarding vulnerable adults and children training level 1. Managers responsible for the ward were required to complete safeguarding level 2 training for vulnerable adults and children. The safeguarding lead had completed level 3 training. NHS England recommendations suggest that all clinical staff should have a minimum of level 2 safeguarding training and level 3 training when treating children up to age 18, therefore the training provision did not meet this recommendation.
- Staff were aware of how to raise safeguarding concerns and told us they would make referrals to the local safeguarding authority with support of the safeguarding lead within the hospital. They told us this happened infrequently due to the cohort of patients most frequently served by the hospital.

### Cleanliness, infection control and hygiene:

- Housekeepers were allocated for the inpatient ward, the dialysis room, and the endoscopy unit. The housekeepers worked according to cleaning schedules and checklists. For example, we saw each patient room on the wards had a cleaning schedule which included a comprehensive list of cleaning jobs, such as mirrors and air vents. Staff told us a housekeeping supervisor reviewed each area on a weekly basis and worked with ward staff to ensure cleaning standards were suitable.
- We inspected the patient ward rooms, the dialysis room and endoscopy suite, and saw that they were visibly clean. Results from the 'patient-led assessments of the care environment' (PLACE) showed that the hospital scored better than the England average for cleanliness (99% compared to 98%).

- We inspected four commodes on the inpatient ward and other equipment, such as hoists and blood pressure machines. We saw that equipment was visibly clean and green "I am clean" stickers were used to identify this to staff.
- Infection prevention and control support was provided by the lead nurse, who completed daily rounds on the ward to review isolation procedures in place and identify any patients with new infection control concerns. Infection prevention and control link nurses were identified on the inpatient ward and in endoscopy.
- Patients requiring barrier nursing were identified by isolation signs on the door to their room. We saw these signs in use during our inspection and noted that doors to these rooms were kept closed, in line with the isolation requirements.
- Patients were swabbed for MRSA. Patient rooms were deep cleaned when patients with MRSA had been accommodated within them.
- The hospital infection prevention and control lead acknowledged a high incidence of carbapenem-resistant enterobacteriaceae (CRE) in some patient groups, and so patients admitted from high risk areas were assumed to be infected until a swab confirmed otherwise. When patients from high risk areas were electively admitted, a CRE screening was done at the preoperative assessment. CRE is a type of bacteria which is resistant to many types of antibiotics and is therefore difficult to treat.
- Patients who required care under isolation conditions (such as those colonised with MRSA or CRE) were placed last on the endoscopy list to allow a deep clean of the endoscopy suite before the next patient underwent their procedure.
- Water supplies to the ward were flushed and tested for pseudomonas and legionella at regular intervals. The most recent water test occurred in June 2016 and all but one sink were clear of infection. The sink identified as growing pseudomonas had a filter fitted and was being reviewed by the infection prevention and control team.
- We saw an audit schedule for monitoring infections on the wards. For example, central venous catheters were audited quarterly and peripheral intra-venous lines were audited three times per year.

# Medical care

- Basic personal protective equipment (PPE), such as gloves and aprons, was available at the entrance to each patient room on the wards. We observed staff wearing and disposing of PPE correctly, for example when completing personal care tasks and when moving between different patients.
- Alcohol gel was available at the entrance to the ward and endoscopy unit. We also noted gel dispensers were available at several locations throughout the ward.
- There were no staff handwashing sinks within the patient rooms, or in the ward corridors. This meant staff had to wash their hands in patient sinks, which was not in line with hand hygiene protocols. This was identified on the risk register as being a concern and senior staff, including the infection prevention and control lead, told us plans were in place to begin introducing staff sinks in patient rooms.
- We observed staff cleaning their hands with alcohol gel or soap and water, before and after patient contact. However, we observed occasions where staff came into contact with patient equipment on the inpatient ward without cleaning their hands appropriately.
- We observed that staff were bare below the elbows in clinical areas, which was in line with infection prevention and control guidance.
- On the inpatient ward, the hand hygiene audit result from September 2015 showed 100% of staff were bare below the elbow and 100% completed hand hygiene at appropriate times in line with the 'World Health Organisation 5 Moments of Hand Hygiene'.
- Yellow sharps bins were available in each patient room and in the treatment rooms. We saw that these bins were suitably labelled and none were overfilled.
- Equipment matrixes were held for equipment throughout the medical service, including dialysis machines and patient hoists. We inspected many items of equipment throughout the ward and saw that the equipment had been safety tested recently. Dates were recorded on each item to highlight when the next test was due.
- Machines used for renal dialysis were calibrated and checked prior to each use. These checks were documented alongside the machine's serial number to provide an audit trail of checks.

## Medicines:

- Prescriptions were written on paper based charts and were filed within the patient nursing record folders. Prescription charts we reviewed were legible and fully completed.
- Medicines on the inpatient ward were stored in locked cupboards within treatment rooms. Treatment rooms had air conditioning and had their temperature monitored on a daily basis. We observed no gaps in the temperature checking document on ward 3A.
- Medicines cupboards were neatly organised and medicines we checked were seen to be within their expiry date.
- Some medicines were stored in lockable fridges, according to the individual instructions for each medicine. Fridge temperatures were checked daily, however we noted two temperatures out of the desired range were documented on consecutive days and no actions to address this issue were recorded on the form.
- Controlled drugs (CDs) were stored in a wall mounted, lockable cupboard within the ward treatment room. The keys for this cupboard were held by the nurse in charge. The CD stock book was stored in a nearby drawer. Staff told us the corporate policy identified that this book should be stored within the CD cupboard, however they told us the cupboard was too small for this to happen.
- We checked three items in the 3A CD cupboard against the CD stock book and found that the documented values matched what was found in the cupboard.

## Environment and equipment:

- We saw that many doors throughout the ward were not labelled with suitable fire door labels. Senior staff acknowledged this issue and identified that this was recorded on the risk register. A replacement programme for doors within the hospital had begun and some doors on the ward had already been replaced.
- There was one resuscitation trolley available on the inpatient ward. We observed that the contents of the trolley were checked on a daily basis, and the correct items were located on the trolley.

# Medical care

- Medicines management audits were completed by the hospital on a monthly basis and showed that medicines were generally stored correctly on the inpatient ward. This reflected our inspection findings.
- We observed staff administering medicines, including oral and intravenous medicines, as well as CDs. Staff followed correct procedures and the BMI policy for medicines administration, including suitable checks of patient identification and for patient allergies.
- A medicines administration audit completed by the hospital on the inpatient ward in February 2016 showed there were 19.3% of medicines doses missed. Missed doses were correctly documented by staff in 90.9% of cases and were due to medicines omitted for clinical reasons or patient refusal. There were no medicines doses missed in error.
- Requests for patients' tablets to take away (TTAs) were sent to pharmacy on the day of patient discharge. Hospital audit data from February 2016 showed that 83% of TTAs were dispensed in less than one hour. Of these TTAs, 88% were dispensed in less than 30 minutes. Of the 17% of TTAs dispensed in more than one hour, 80% of these were non-urgent or had queries which need to be resolved by medical staff.

## Records:

- All patient records within the medical service were paper-based. Reviews by the consultant and registered medical officer (RMO) were recorded in a file of medical notes, stored on the ward during the patient's admission. Nursing notes, observations and care pathways were stored in a separate folder within the patients' rooms. Consultants usually retained notes for their own individual patients following their admission to the hospital.
- Records we reviewed were generally well completed in legible writing, with times and dates, and staff signatures for each entry.
- We identified some audit forms which contained patients' personal information, such as their full name, date of birth and address, which were stored unsecured in folders at the nursing station on the ward. Although staff told us there were "always staff around", we were concerned that this information could potentially be accessed inappropriately.

## Assessing and responding to patient risk:

- In line with NICE guidance, the 'National Early Warning Score' (NEWS) was used in recovery and on the inpatient ward to identify patients at risk of deterioration and trigger escalation to the ward registered medical officer (RMO) or the critical care RMO.
- Patient records we reviewed showed patient observations were completed at appropriate intervals and patient care was escalated correctly. Ward staff were required to undergo competency assessment for acute illness management, which included a written and practical assessment.
- When patients received renal dialysis, staff completed a full set of observations on a half hour or hourly basis, depending upon patient need. A blood glucose measurement was also taken before and after receiving dialysis. Patient with any observation readings which were highlighted as abnormal were referred to the RMO for review.
- "Think sepsis" posters were displayed in clinical and staff break areas. These posters highlighted what clinical signs should indicate to staff that a patient may be septic (for example fever or increased heart rate) and what steps should be taken in this instance. Staff were able to describe what clinical signs might indicate sepsis and what they should do in response to this.
- Patients who deteriorated and needed additional care provided by another hospital (for example due to a specific type of support not being provided) were transferred by a 999 emergency ambulance.
- Falls risk assessments were completed by staff if a patient was thought to be at risk and a referral to the physiotherapy team was made if necessary.
- Records showed that patients were assessed for VTE risk on admission, 24 hours after admission and again after seven days. VTE risk assessment was audited by the hospital on a quarterly basis and showed an improving trend; 84% in the period April to June 2015, 87% in July to September 2015, 90% in October to December 2015 and 99% in January to March 2016. The target was 100%.
- All patients undergoing procedures in endoscopy had a VTE assessment completed as part of their pre-procedure assessment.

## Nurse Staffing:

## Medical care

- An acuity tool was used to plan the staffing required on the inpatient ward, according to patients numbers and needs. Senior staff told us they aimed to sustain a ratio of 2:1 of registered nursing staff to health care assistants. Registered nurses were usually responsible for 6-8 patients each, depending upon patient needs.
- Staffing levels were displayed at the ward entrance, and showed that planned and actual levels of staffing matched throughout our inspection.
- There were 15 whole time equivalent (WTE) registered nurses and 7 WTE health care assistants across the inpatient ward. This included one registered nurse vacancy and one member of staff on maternity leave at the time of our inspection.
- Staffing in endoscopy recovery was based on two registered nurses caring for patients as they came out of the endoscopy suite, with a maximum of nine patients at any time. Staff told us it would be very rare for the recovery area to be full and described how sedated and non-sedated patients were alternated to ensure staffing remained at a suitable level.
- There was one vacancy for an endoscopy registered nurse at the time of our inspection.
- We saw evidence of some bank and agency staff usage to ensure safe levels of staffing at all times. The inpatient ward was compliant with best practice guidance which recommended no more than 20% agency nursing staff working in an area at any one time.
- Four members of permanent bank staff were responsible for delivering the dialysis service. A lead nurse coordinated shifts and determined how many staff were required, according to the number of patients expected for dialysis. Patients receiving dialysis were cared for on a one to one basis.
- Nursing staff handovers took place at 8am and 8pm, and key patient information was passed on to the staff coming on shift.

### Medical Staffing:

- Consultants who worked at the hospital were required to maintain current practicing privileges in line with the BMI practicing privileges policy to be eligible to work on

site. At the time of our inspection there were 331 consultants with practising privileges at the hospital, which was a mix of medical consultants, surgeons and anaesthetists.

- 12.4% of consultants with practising privileges had not completed an episode of care at the hospital between April 2015 and March 2016.
- Consultants were clinically responsible for the patients admitted under their care, and were required to review their patients once per day as a minimum. This was achieved with support from the resident medical officer (RMO) who completed basic reviews as needed.
- There was no formal rota for patients to access expertise from consultants in other specialties and staff told us referrals were made informally between consultants on the inpatient wards. If a patient was admitted for dialysis but began to complain of chest pain overnight, the RMO would be required to deal with the situation and/or call upon consultant assistance to review the patient.
- RMOs were provided to the hospital by an external organisation. There was one RMO deployed to cover the inpatient ward for seven days to complete ward tasks such as assessing patients, inserting cannulas and writing drug charts.

### Major incident awareness and training:

- Senior hospital staff told us there was no expectation or plan for the hospital to be involved in a local major incident response, for example in the event of a terrorist attack. They explained that they could become involved in relocating patients from a local hospital or taking on additional patients at a later, after the initial response was made.

### Are medical care services effective?

Good 

We rated this service as good for effective because:

- We saw evidence-based practice in place, compliance with recommendations from the National Institute for Health and Care Excellence (NICE) and British Society of Gastroenterology.

# Medical care

- Patients received care from competent staff, including staff in endoscopy who had undergone nationally recognised training.
- Staff had good access to patient information and liaised with internal as well as external agencies to plan and deliver patient care.
- Patients received suitable nutrition and hydration, and additional support was available for those with specific dietary requirements.

However;

- Staff knowledge of Deprivation of Liberty Safeguards (DoLS) was limited and told us that, in their opinion, it was only relevant when patients were being restrained.

## Evidence-based care and treatment:

- Clinical audit programmes were in place and included audit of a range of performance indicators throughout the year. For example, medicines management, cleaning and VTE assessment audits. We saw evidence of actions in response to audit findings for most audits we reviewed, although this was not apparent for the pain audits we saw.
- We reviewed BMI policies and procedures relevant to the medical service and noted that they reflected current best practice recommendations from organisations such as the National Institute for Health and Care Excellence (NICE) and the International Society for Peritoneal Dialysis.
- We observed that a number of practices across the medical service were in line with recommendations from NICE. For example, staff demonstrated that patients received dialysis care in line with NICE CG125 (Chronic kidney disease: peritoneal dialysis) guidelines, such as discussing treatment choices with consideration to patient lifestyle.
- Evidence based care bundles were used to guide patient care, for example for indwelling urinary catheters.
- Nursing staff on the inpatient ward assessed and recorded patient visual infusion phlebitis (VIP) score in line with the 'Infusion Nursing Standards of Practice' (2011). When patients had cannulas inserted in endoscopy so they could receive sedation, VIP assessments were also used.

- Staff used the 'Waterlow Pressure Ulcer Prevention Score' to assess the patients' risk of developing a pressure sore on admission and on subsequent days. This had been completed in the patient records we reviewed.
- The endoscopy unit had been recently refurbished. Since it reopened, the hospital had been submitting endoscopy data to the Joint Advisory Group (JAG) and recently applied for unit accreditation. Senior staff told us they expected their application to be successful, as the design of the unit met all required standards and there were minimal waiting lists.
- Staff working in endoscopy completed procedures in accordance with recommendations from the British Society of Gastroenterology.

## Nutrition and hydration:

- Patients were able to select meals from a menu, which included options for patients with specific nutritional needs. For example those who required a soft textured diet and those with allergies.
- Nutritional support was available via a telephone referral to a dietitian from an external organisation, who reviewed patients in person or offered telephone advice when needed. Because of this external support we did not see evidence of use of a MUST (malnutrition universal screening) tool in use.
- Fortified drinks were available within the hospital for patients with poor nutritional intake or those with specific needs, such as additional protein.
- Patients were provided with water jugs and glasses, and we saw these were left within patient reach. Hot drinks were also offered to patients frequently.
- Fluid balance charts were maintained for patients where hydration was a concern or where a specific fluid balance was identified by the doctor. We saw these were correctly completed and calculated during our inspection.

## Pain relief:

- Patients were asked to score their pain each time their routine observations were completed. Patients

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reporting discomfort were offered analgesia if they had additional medicines which had been prescribed or were referred for a pain management review by the doctor if pain was difficult to control.

- Pain management audits were completed on a monthly basis and stored in folders on the inpatient ward. Audit findings detailed numbers of patients receiving analgesia but not what this meant or if any actions for improvement were identified.
- Patient feedback forms also provided feedback on pain management and we saw these mainly contained positive responses.
- Ward staff were unaware if any learning had been identified from either of the pain management audits.

## Patient outcomes:

- The colonoscopy completion rate in endoscopy between October 2015 and April 2016 was 95.4%, which was better than the 90% standard identified by the Joint Advisory Group on GI Endoscopy (JAG).
- JAG standards advise that the rate of successful oesophago-gastro-duodenoscopy (OGD) intubation should be audited by the provider. Between October 2015 and April 2016, the endoscopy unit achieved a 99.4% successful intubation rate.
- Polyps were detected in 30.6% of colonoscopy patients between October 2015 and April 2016. JAG standards state a 90% target for polyp retrieval and the endoscopy unit achieved 96.1% retrieval in this period.
- There was one unplanned admission from endoscopy between April 2015 and March 2016, due to bleeding post polyp excision.
- There were five inpatient deaths between April 2015 and March 2016, which equated to less than 0.31% of all inpatient admissions and represents a low mortality rate in comparison with other independent acute hospitals CQC holds this type of data for. Data regarding these deaths was submitted to 'National Confidential Enquiry into Patient Outcome and Death' (NCEPOD) for inclusion in upcoming reports.
- Between April 2015 and March 2016, there were seven cases where inpatients had unplanned readmissions to hospital within 29 days of discharge, including both

surgical and medical inpatients. The rate of unplanned readmissions was not high when compared to other independent acute hospitals which submitted performance data to CQC.

## Competent staff:

### Nursing:

- All new staff were required to be inducted to their area of work on their first day. This was completed by the ward manager. We saw evidence of completed induction documents.
- New starters worked as supernumerary members of staff when commencing work, to allow them time to get to know the ways of working and to fully orientate them to the ward.
- Staff working on the ward were required to complete set competencies prior to working independently. Basic competencies were completed when commencing their post and more complex competencies were completed within three months. We saw evidence of competency completion for staff across the service.
- Staff within endoscopy received nationally recognised endoscopy training through the JAG Endoscopy Training System (JETS). Staff also had training records containing clear evidence that they had been specifically trained to use each piece of equipment documented.
- Appraisals for ward staff were completed by the ward manager and documentation shown to us during our inspection demonstrated that 81.8% of appraisals had been completed within the last year. The remaining appraisals had been booked to be completed within the following month. The target for appraisal completion was 100%.
- Appraisals for staff in endoscopy were all up to date, with 100% of staff having completed an appraisal in the previous 12 months. All endoscopy staff also had an individualised training programme in place for the following 12 months.

### Medical:

- All consultants were required to maintain current practising privileges in line with the BMI practising privileges policy. This policy ensured consultants took responsibility for maintaining their own clinical

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competence and had adequate professional insurance to practice. To maintain their practising privileges, consultants were also required to show evidence of annual appraisal.

- RMOs were provided by an external organisation that completed relevant employment checks, such as DBS and General Medical Council registration. CVs were sent to the hospital for approval before new RMOs were sent to work there, and the hospital reviewed documentation to ensure relevant training and registration was up to date. Mandatory training for RMOs was organised and overseen by the agency, not the hospital.
- New consultants and RMOs were inducted to the hospital by the Director of Clinical Services and the relevant departmental managers.

### Multidisciplinary working:

- A weekly multidisciplinary team (MDT) meeting was held within the hospital weekly. Staff told us that patient specific meetings had also been organised for long-term or complex patients, particularly when discharge planning.
- We observed staff on the ward communicating about planning patient care, patient progress and difficulties. Staff also communicated via patients' clinical notes.
- Staff were clear that each individual patient's admitting consultant was responsible for the patient's care throughout the course of their admission. They were clear that escalation of concerns should be to the RMO in the first instance but that concerns could also be communicated directly to the consultant.
- Patients could also be escalated for review by the critical care RMO if needed. Staff told us the inpatient ward RMO and critical care RMOs discussed individual patient cases where there were concerns of deterioration, and that this was done in conjunction with both the admitting consultant and the critical care consultants.
- Staff within the hospital liaised with external agencies, such as GPs and care providers to obtain information about patients and to plan their ongoing needs. For example, we saw a nurse telephoning a district nursing team to discuss a patient's ongoing needs.

### Seven day services:

- Patients could access imaging during department opening hours, however an on-call radiologist was available out of hours, when the imaging department was closed. This meant patients requiring urgent investigations could access this service, for example after a fall on the ward.
- Physiotherapy services were available seven days per week to assist with patient rehabilitation and mobility. An on-call physiotherapy service was available out of hours to treat patients with specific respiratory difficulties and those requiring additional mobility support.
- The pharmacy department was open Monday to Friday and for half a day on Saturdays. An on-call pharmacy service was available for advice and emergency dispensing when the pharmacy service was officially closed.

### Access to information:

- Patient information was compiled in medical notes or in the care plan documentation. These records followed the patient through their admission. Staff told us missing notes were rarely an issue.
- Upon the patients' discharge from hospital a discharge summary, containing information about the patient's admission details, was sent to the patient's GP to ensure continuity of care in the community. A copy of the discharge summary was also given to the patient for their reference.
- Where patients were funded by private health insurance, copies of relevant documentation were also sent to the insurers, along with any invoices.
- Policies were available on the hospital-wide computer system; however paper copies were also available in some areas. For example, some printed policies were available on the inpatient ward.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS):

- Staff told us it was important to obtain consent from patients for all interventions, including taking their observations and repositioning them. Staff told us they

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would respect patients' wishes if they refused an intervention, however they said they would explain why the procedure was necessary and the reasons it would be beneficial.

- Staff told us they rarely cared for patients with mental capacity issues, as these patients would be treated in other hospitals if mental capacity was a concern.
- Staff were aware that patients should always be assumed as having capacity unless proven otherwise and told us capacity assessments would be completed by the RMO if there was any doubt about a patient's capacity.
- Some staff were aware of deprivation of liberty safeguards (DoLS), whereas others were unfamiliar with the term. Staff spoke about DoLS in terms of patients requiring restraint, however were unfamiliar with other factors which could constitute as deprivation of liberty. Staff told us restraint was "never used" within the hospital and so DoLS was not a concern.

### Are medical care services caring?

Good 

We rated this service good for caring because:

- Patient feedback forms about their overall experience and their opinions of the nursing staff demonstrated positive results, with scores frequently above 95% satisfaction.
- We saw several cards from patients and their families on display at the nursing stations on the wards, which praised the friendly and approachable staff.
- Patients told us staff introduced themselves when they first met, and that they were friendly and kind.
- Relatives were confident in the care provided throughout the service and told us they were suitably involved in the care of their loved one.

However;

- Patients funded through private healthcare insurance were unsure if their insurance covered all costs associated with their admission or if they were required to contribute.

### Compassionate care:

- Patient satisfaction of nursing care on the wards showed an improving trend since January 2016, with all scores at or above 95% from April to June 2016.
- We saw several cards from patients and their families on display at the nursing stations on the wards, which praised the friendly and approachable staff.
- Patient feedback about the care they received on the wards and in endoscopy was very positive and one patient told us the ward staff "have got caring down to a fine art". Patients told us staff were friendly and kind, and that they felt comfortable voicing any concerns they had.
- Relatives told us they were confident in the care received by their loved one and one relative said the patients were in "safe hands".
- We observed staff speaking respectfully and politely to patients and their visitors throughout our inspection, including calling patients by their preferred name when requested.
- Patients told us that staff took care to preserve their privacy and dignity at all times. One patient commented that staff "even protected [their] modesty during a shower". Results from the 'patient-led assessments of the care environment' (PLACE) showed that the hospital scored better than the England average for the maintenance of privacy, dignity and wellbeing (91% compared to 87%).
- We observed that patient call bells were usually answered within 10 rings and patients told us ward staff came quickly when they needed them. Senior staff told us the length of time taken to answer call bells was not audited.

### Understanding and involvement of patients and those close to them:

- Patients told us staff were patient and sensitively explained information to them in a thoughtful and empathetic manner. We observed staff checking patients understood their explanations and offered opportunities for patients to ask questions.
- We observed staff offer information leaflets to patients and advise that they could help explain anything that was unclear.

## Medical care

- Patients and their relatives told us most staff introduced themselves when they first met and that they knew who was looking after them.
- Relatives told us they were suitably involved in the care of their loved one, and that they knew what the patients' care plan entailed. Relatives told us consultants always greeted them during ward rounds and asked if they had any questions.
- Self-funding patients and their relatives told us costs associated with the patient's procedure or admission had been clearly explained to them before they booked their admission. However, patients funded by private healthcare insurance were not sure if every part of their admission was covered by their insurance or if they were required to contribute to any costs.

### Emotional support:

- Ward staff told us providing emotional support to patients was part of their daily role. They acknowledged the need to be encouraging and empathetic to patients' individual needs.
- Staff told us patients were often nervous before their endoscopy procedure and it was important to make them feel at ease. Patients told us staff were reassuring and sensitive prior to their endoscopy procedure.

### Are medical care services responsive?

Good 

We rated this service as good for responsive because;

- Access to medicine services for NHS patients and privately funded patients was straight forward and efficient.
- There were suitable facilities for patients receiving care under the medicine service, as well as their relatives.
- Patients undergoing procedures in endoscopy received comprehensive information booklets prior to their admission, so they knew what to expect from their procedure.
- A points-based system for procedures in endoscopy ensured a smooth running service, with limited delays and no non-clinical cancellations.

- Patients' language needs were well met throughout the medical service, including the use of translators and communication booklets.

However;

- The medicine service was unable to accommodate patients with significant mental health needs, including patients living with dementia, or those with a learning disability. Patients living with these conditions were referred to other hospitals offering this service when assessing referrals.

### Service planning and delivery to meet the needs of local people:

- Patient admissions in the hospital were semi- elective, which meant that the flow of patients into the ward was usually predictable. Staff told us the inpatient ward could accommodate patients with a slightly longer than expected length of stay without the need to delay or cancel other admissions.
- Inpatients were accommodated in individual rooms on the inpatient ward. Each room had en suite bathroom facilities. Patient rooms had their own air conditioning control which meant patients were able to set the temperature for their own comfort
- There were three rooms with in-room monitoring and telemetry capabilities in all rooms on 3B.
- Dialysis patients usually received treatment in a side room on the ward, however at the time of our inspection this room was not in use and the dialysis service had been moved to other patient rooms near to the ward. The change of location was clearly signed and patients were directed to the new location by hospital reception staff on arrival at the hospital.
- Waiting room facilities were available at the ward entrance, with seating for eight people and newspapers and magazines available. Staff told us these facilities were sufficient to meet the needs of visitors as there were few occasions when they were asked to wait outside patient rooms.
- Facilities for medical patients were appropriate for the services that were planned and delivered by the hospital.

### Meeting people's individual needs:

## Medical care

- The hospital accepted referrals for young people aged 16-18 years old. Prior to any admission or treatment, a specialist children's nurse assessed each individual to determine whether it would be appropriate for them to follow an adult care pathway. Between April 2015 and March 2016, there were two young people admitted as inpatients and eight cared for as day case patients.
  - There were four designated bariatric patient rooms on the inpatient wards, which had widened doorways to facilitate easier access. These rooms could accommodate bariatric beds and chairs if required. En suite bathroom facilities for these rooms had not been specially adapted and facilities in them were the same as other bathrooms on the ward.
  - Staff told us patients with mental health issues, including those living with dementia, and a learning disability were not admitted to the hospital due to the complex nature of caring for these patients. They told us patients with these types of healthcare needs would receive treatment at locations where suitable support could be provided.
  - Staff told us patients wishing to be cared for by a nurse of the same sex as them would be accommodated wherever possible, although this could be challenging at times, depending on who was rostered to work.
  - Information leaflets were available at the ward entrance, including topics such as breast health and cardiac care. We saw staff providing patients with leaflets appropriate to their own individual needs. All leaflets we saw were written in English, however staff told us they could access leaflets in other languages on the computer system.
  - Comprehensive information packs were given to patients prior to their procedures in endoscopy, which meant they had access to detailed and relevant information about what their procedure entails and what to expect afterwards.
  - Arabic translators were available within the hospital and translators in other languages could be booked if needed. We saw evidence translators were used during ward rounds to help consultants communicate with patients and their families.
  - We observed staff on the ward using an Arabic communication booklet, which had pictures and translated words and expressions to assist staff in caring for Arabic speaking patients and their families.
  - A multi-faith room was available for patients and visitors to use for quiet reflection and prayer.
- Access and flow:**
- NHS patients could access medical care services at the hospital via the 'choose and book' system, where services had been commissioned by local clinical commissioning groups (CCGs). There were four main local CCGs which commissioned services at the hospital. Patients receiving CCG commissioned care at the hospital usually attended the hospital for the duration of their care episode; from initial consultant review and inpatient admission, through to their post discharge outpatient review.
  - Patients who were self-funding their care or with private health insurance accessed medical care services at the hospital via GP referrals direct to specific consultants.
  - Patients having procedures within the endoscopy suite were required to have a pre-procedure assessment completed. Patients assessed as being 'low risk' by endoscopy staff could have this assessment completed via a telephone consultation with a trained member of endoscopy staff, whereas higher risk patients had to attend for a consultation.
  - In line with JAG recommendations, a procedure points system was in place in endoscopy to facilitate planning in the department. Each procedure was allocated a number of points according to how long each procedure took, and a maximum number of points for each endoscopy suite was identified. This meant lists ran to time and staff told us there were very few lists that ran late. Senior staff reported that there had been no non-clinical cancellations of patient procedures in endoscopy.
  - Endoscopy staff told us the points system for planning procedures in endoscopy meant there was flexibility to accommodate urgent patients onto the list at short notice, as time for this was planned in the unit schedule.

## Medical care

- The day case dialysis patients usually attended three days per week, for periods of four to five hours at a time. There was some flexibility regarding timing of dialysis visits although only one patient could receive treatment at a time.

### Learning from complaints and concerns:

- Staff told us complaints were managed at ward level whenever possible and that senior staff did “satisfaction ward rounds” to check everyone on the ward was happy with the service they were receiving.
- Patients were supported to make formal complaints to the hospital if they wished. Formal complaints triggered investigations and a formal complaint response was sent to the complainant from the Executive Director.
- The numbers of complaints received by the ward and within the hospital were displayed on the staff noticeboards. The themes of the complaints received were also outlined, although this was done on a hospital wide basis rather than at ward level. Staff told us the ward managers highlighted any issues or learning relating to complaints during staff meetings.
- There were 21 complaints from inpatients (medical and surgical) between April 2015 and March 2016. We saw examples of complaint responses which responded appropriately to complaints made, and included apologies where appropriate.

### Are medical care services well-led?

Good 

We rated this service as good for well led because;

- Risk registers contained items considered as issues by the leadership team and reflected our inspection findings. Key risks were displayed on posters in staff areas to raise awareness.
- Suitable governance processes were in place and the Medical Advisory Committee (MAC) were involved in a number of key processes, including performance reviews and quality measure.
- Staff in endoscopy told us the leadership team were open to new ideas and receptive to feedback from staff.

- Real time feedback from consultants using the endoscopy suite was obtained in debrief sessions immediately after the endoscopy list, to identify areas of good performance and areas which required improvement.
- Staff described a visible and approachable leadership team and told us they felt able to raise concerns or report incidents without fear of repercussions.

However;

- Senior staff did not acknowledge the shortfall in safeguarding training.
- Staff on the inpatient ward told us they were not engaged in service development or quality measures, and that they have little ownership of the service they provided.
- A specific strategy for developing the medicine service further was not evident.

### Vision and strategy for this service:

- The overarching aim of the service was to provide a safe and satisfactory experience for all patients accessing medical care within the hospital. Senior staff identified that there were also financial targets for the service, but that quality, safety and patient experience remained the most important outcomes.
- The vision of the service was displayed on posters on noticeboards within staff areas on the inpatient ward and staff told us they were focusing on safety and ensuring a good patient experience.
- There were no specific action plans in place to develop the inpatient medicine service.

### Governance, risk management and quality measure:

- A “10 @ 10” meeting was held in the Executive Director’s office daily from Monday to Friday, which included the senior management team and managers from all areas of the hospital. This provided senior staff the opportunity to raise any immediate issues or highlight any significant incidents which had occurred. Topics such as staffing levels and new infections were also covered.

# Medical care

- Managers from the inpatient ward and endoscopy attended hospital-wide governance meetings on a monthly basis. This enabled them to identify key themes and learning from incidents or other issues throughout the hospital.
- Information from hospital governance meetings was disseminated to staff during their unit meeting and via posters displayed in staff areas. Senior staff told us they also disseminated urgent information during morning or evening handovers on the wards and during pre-procedure meetings in endoscopy.
- Risk registers were held centrally within the hospital, however senior staff in each area could access the documents for reviews and updates. We reviewed risk registers for the inpatient wards and endoscopy unit, and found that the register reflected the issues senior staff described as areas of concern as well as the risks we identified during our inspection.
- Consultant practising privileges were placed on hold for any consultant whose indemnity insurance expired before new documentation was provided to the hospital. The senior management team told us this was a new “zero tolerance” approach. Practising privileges were suspended for 12 consultants between April 2015 and March 2016 for this reason.
- Quality monitoring took place for NHS funded patients, via feedback to the commissioning body through incident, patient outcome and complaint data.
- The leadership team in endoscopy held debriefs with consultants using the suite for procedures. This allowed the nurse in charge to obtain immediate feedback about the performance of the unit, and implement changes and deliver additional training to staff if needed.
- Safeguarding vulnerable adults and children training provided for staff within the service was not adequate to protect these patient groups from harm. Senior staff did not acknowledge the shortfall in safeguarding training.

## Leadership of service:

- Nursing leadership was provided at ward level and in the endoscopy unit by senior sisters and overseen by the ward manager. Overall nursing leadership was provided by the Director for Clinical Services.

- Medical leadership was provided by the medical advisory committee (MAC), which provided expert advice to the senior management team regarding specific medical issues. For example, where complaints regarding patient management were made, the MAC would review patient notes and determine whether care was appropriate.
- Representatives for various specialities, such as orthopaedics and anaesthesia, volunteered to participate in MAC meetings and discussions.
- Staff working in managerial posts had significant clinical experience in a range of organisations, including NHS hospitals and other independent health organisations.
- Staff throughout the medical service told us the leadership team were visible in the clinical areas. They told us their line managers were available within their clinical area daily and were present at regular intervals to check everything was okay and to provide support if needed.
- Staff told us the senior management team were also very visible and had a strong presence throughout the hospital. We observed the senior management team engaging with staff throughout the medical inpatient service.

## Culture within service:

- Ward staff told us the leadership team were approachable and that they felt “safe” to raise any concerns. They described a no blame culture relating to incidents and mistakes.
- Senior ward staff told us they emailed their staff thanking them for their hard work and contribution to ward improvements. We saw evidence of these emails and ward staff told us it made them feel appreciated.
- On the inpatient ward between April 2015 and March 2016, staff sickness rates for health care assistants and registered nurses were lower than in other independent acute hospital we hold this type of data for.
- There was a higher than expected turnover of nursing staff and health care assistants (28.2% and 46.7% respectively) on the inpatient ward during this period. This was attributed to new management of the unit and performance management of some staff.

## Public and staff engagement:

## Medical care

- All patients who received care through the service were asked to complete feedback forms to identify their level of satisfaction with the service they received. These forms were analysed by the quality and risk team, as well as the manager for the inpatient ward.
- Noticeboards included “you said, we did” posters which highlighted steps taken by the hospital in response to feedback from patients and their families. For example, some patient feedback suggested they were dissatisfied with the amount of information provided on discharge from the ward. In response to this, the hospital introduced discharge information packs.
- Student nurses on placement on the wards were asked to complete satisfaction questionnaires at the end of their clinical placements. Feedback forms we reviewed from December 2015 showed 100% satisfaction from students who provided feedback. Comments on the forms praised the inclusive and supportive ward staff.
- Staff told us the endoscopy leadership team was open to new ideas and receptive to any feedback provided by staff. They told us feedback was taken on board and they felt that had “a voice” within the department.
- However, some staff in other areas of the service told us their views were not sought and that they were not engaged in planning service developments or clinical priorities. Staff on the inpatient ward described how some staff had roles as link nurses however audit activity, such as hand hygiene audits, was completed by senior staff and so they had little ownership of the service they provided.

# Surgery

Safe	Requires improvement 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Requires improvement 

## Information about the service

Surgery is the primary activity within the hospital and a range of specialties are available, such as orthopaedics, general surgery, gynaecology, cardiothoracic and ear, nose and throat surgery. Patients are accommodated in the day surgery unit or the 34-bedded inpatient ward. The inpatient ward is split into two sides, known as 3A (which accommodates mainly surgical patients) and 3B (which accommodates a mix of surgical and medical patients). There are three multispecialty theatres available, including two with laminar flow. Between April 2015 and March 2016 there were 9302 visits to theatre, including day cases and outpatient procedures. Some surgical patients also had medical pathways, therefore much of the inpatient data is combined with that of the medicine service.

We visited the surgical service at BMI The London Independent for two announced inspection days and one unannounced inspection day. During our inspection we inspected the preoperative assessment clinic, theatres, recovery and the inpatient ward, and spoke with 18 members of staff including doctors, nurses, allied health professionals and ancillary staff. We also spoke with the surgical leadership team, nine patients and three relatives. We reviewed information provided by the hospital, eight patient records and checked many items of clinical and nonclinical equipment.

## Summary of findings

Overall, we rated this service as requires improvement. We gave this rating because:

- Compliance with the World Health Organisation (WHO) Five Steps to Safer Surgery checklist was variable. We observed that checks were sometimes complete without a physical list in front of the surgical team. This is not in line with WHO recommendations. Some aspects from the checklist were missed out.
- Most clinical staff received level one safeguarding vulnerable adults and children training, which is not sufficient to comply with recommendations from NHS England.
- Some key safety issues, such as poor WHO checklist completion and lack of adequate safeguarding training, were not identified as concerns by the leadership team.
- Between April 2015 and March 2016 there were 22 surgical site infections, including higher rates per 100 procedures than the average in NHS hospitals for hip and knee primary arthroplasties.
- Theatres did not have access to an uninterruptible power supply (UPS), which was not in line with recommendations for surgical estates, and meant theatres could temporarily lose power in the event of a power cut.

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- Risks documented on the risk register were not always fully mitigated. For example, not all operating staff were formally informed about the lack of UPS, which could cause delays in appropriate action being taken in the event of power loss.

However;

- There was evidence of suitable investigation, learning and dissemination of learning from incidents and infections, and safety indicators, such as the numbers of pressure ulcers, patient falls and urinary tract infections, showed good results.
- Patient outcomes, including mortality, unplanned returns to theatre and unplanned readmissions to hospital, were good.
- We saw evidence-based practice in place, including enhanced recovery programmes for certain procedures and compliance with recommendations from the National Institute for Health and Care Excellence (NICE).
- Patient feedback about the care they received was positive and questionnaire results supported this feedback. Staff maintained privacy and dignity, and provided emotional support to patients.
- Access to surgical services for NHS patients and privately funded patients was efficient, with 91-97% compliance within the 18 week referral to treatment time target for NHS patients between April 2015 and March 2016.
- Suitable governance processes were in place and the Medical Advisory Committee (MAC) was involved in a number of key processes, including performance reviews and quality measurement.

We rated this service as requires improvement for safe because:

- Compliance with the World Health Organisation (WHO) Five Steps to Safer Surgery checklist was variable. We observed that checks were sometimes complete without a physical list in front of the surgical team. This is not line with WHO recommendations. Some aspects from the checklist were missed out.

- We observed recovery staff filling in the WHO Five Steps to Safer Surgery checklist form retrospectively for the theatre activity which had taken place, although this staff member had not been present in theatre during the procedure.
- Hand hygiene audit results from April 2016 showed 80% of staff were bare below the elbow and 50% completed hand hygiene at appropriate times in line with the 'World Health Organisation 5 Moments of Hand Hygiene'.
- Between April 2015 and March 2016 there were 22 surgical site infections, including higher rates per 100 procedures than the average in NHS hospitals for hip and knee primary arthroplasties.
- Theatres did not have access to an uninterruptible power supply (UPS), which was not in line with recommendations for surgical estates and meant theatres temporarily lose power in the event of a power cut.
- There were no designated hand wash sinks in patient rooms on the ward, which meant staff washed their hands in patient basins. This was not compliant with hand hygiene protocols.
- Most clinical staff received level one safeguarding vulnerable adults and children training, which is not sufficient to comply with recommendations from NHS England.

We rated this service as good for effective because:

- Patient outcomes, including mortality, unplanned returns to theatre and unplanned readmissions to hospital, were good.
- We saw evidence-based practice in place, including enhanced recovery programmes for certain procedures and compliance with recommendations from the National Institute for Health and Care Excellence (NICE).
- Staff working within the surgical service were competent and there was clear support and opportunity for further development, particularly within theatres.

# Surgery

- Patient feedback was that pain was well managed and we observed staff asking patients if they had pain during their routine observations.
- Staff had good access to patient information and liaised with internal as well as external agencies to plan and deliver patient care.

We rated this service good for caring because:

- Patient feedback forms about their overall experience and their opinions of the nursing staff demonstrated positive results, with scores frequently above 95% satisfaction.
- We saw several cards from patients and their families on display at the nursing stations on the wards, which praised the friendly and approachable staff.
- Patients told us staff introduced themselves when they first met, and that they were friendly and kind.
- Relatives were confident in the care provided throughout the surgical service and told us they were suitably involved in the care of their loved one.
- We observed staff maintained privacy and dignity, including during wound examinations and when in theatre.
- We also observed staff providing emotional support to patients in the anaesthetic rooms and when waking from their anaesthetic in recovery.

We rated this service as good for responsive because;

- Access to surgical services for NHS patients and privately funded patients was straight forward and efficient. Information provided by the hospital indicated 91-97% compliance within the 18 week referral to treatment time target for NHS patients between April 2015 and March 2016.
- The flexibility of the surgical service meant it could absorb patients who needed to return to theatre unexpectedly and those with longer length of stays than expected, without the need to cancel other procedures or admissions.
- There were no procedures cancelled for nonclinical reasons between April 2015 and March 2016.

- Patients' cultural and language needs were well met throughout the surgical service, including the use of translators and same sex nursing if requested.

We rated this service as requires improvement for well led because;

- Risks documented on the risk register were not always fully mitigated, for example not all operating staff were formally informed about the lack of UPS, which could cause delays in appropriate action being taken in the event of power loss.
- Some key safety issues, such as variable WHO checklist completion and lack of adequate safeguarding training, were not identified as concerns by the leadership team.
- Staff on the inpatient ward told us they were not engaged in service development or quality measures, and that they have little ownership of the service they provided.

# Surgery

## Are surgery services safe?

Requires improvement 

We rated this service as requires improvement for safe because:

- Compliance with the World Health Organisation (WHO) Five Steps to Safer Surgery checklist was variable. We observed that checks were sometimes complete without a physical list in front of the surgical team. This is not in line with WHO recommendations. Some aspects from the checklist were missed out.
- We observed recovery staff filling in the WHO Five Steps to Safer Surgery checklist form retrospectively for the theatre activity which had taken place, although this staff member had not been present in theatre during the procedure.
- Hand hygiene audit results from April 2016 showed 80% of staff were bare below the elbow and 50% completed hand hygiene at appropriate times in line with the 'World Health Organisation 5 Moments of Hand Hygiene'.
- Between April 2015 and March 2016 there were 22 surgical site infections, including higher rates per 100 procedures than the average in NHS hospitals for hip and knee primary arthroplasties.
- Theatres did not have access to an uninterruptible power supply (UPS), which was not in line with recommendations for surgical estates and meant theatres temporarily lose power in the event of a power cut.
- There were no designated hand wash sinks in patient rooms on the ward, which meant staff washed their hands in patient basins. This was not compliant with hand hygiene protocols.
- Most clinical staff received level one safeguarding vulnerable adults and children training, which is not sufficient to comply with recommendations from NHS England.

However:

- There was evidence of suitable investigation, learning and dissemination of learning from incidents, including infections which occurred.
- Safety indicators, including the numbers of pressure ulcers, patient falls and urinary tract infections, showed good results.
- The clinical areas of the surgical service and equipment used were noted to be visibly clean and well maintained.
- Medicines were suitably prescribed, stored and administered throughout the surgical service.

### Incidents:

- Incidents were reported on paper-based forms which staff passed on to the theatre or ward manager, as appropriate. Incidents were followed up by the relevant manager, who communicated their findings to the quality and risk team. This team then inputted the incident data onto a computer-based system and further reviewed the incident if appropriate.
- Staff at all levels were able to describe the types of situations which would trigger the completion of an incident form and provided examples, such as patient falls and medicine errors.
- Senior staff told us any significant incidents were raised at the "10 @ 10" meeting held with the senior management team and other area managers daily, and this facilitated immediate awareness of key issues throughout the hospital. We observed two such meetings and observed this being done.
- Numbers and themes of incidents were displayed on staff noticeboards throughout the surgical service. We saw evidence that lessons learnt from these incidents was also communicated in this way. Staff told us key themes and learning points were communicated to them during staff meetings and update emails.
- We saw evidence that different services within the hospital worked together to learn from incidents and to change practice. For example, a patient who underwent a hip operation went for a postoperative x-ray but incorrectly had a knee x-ray. The imaging department

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worked with the ward to change practice, including transport of the patients' notes and a nurse or health care assistant escort, to ensure this would not happen again.

- There were no formal morbidity and mortality meetings held in the hospital due to the low number of patient deaths. Patient deaths were discussed at hospital-wide clinical governance meetings and debrief meetings were also held with staff involved in the patient's care if appropriate.
- Between April 2015 and March 2016, there were 349 clinical incidents reported across surgery and inpatients. There were an additional 48 non-clinical incidents reported.
- Between April 2015 and March 2016, there were two serious incidents which were reported to the STEIS, including one never event that occurred in theatres. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Although each Never Event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a Never Event.
- The never event was a wrong site nerve block for post-operative pain control and occurred in October 2015. The never event was fully investigated and actions were put in place to ensure the mistake did not happen again. Awareness was also raised amongst staff through new "stock before you block" posters which were displayed through the theatres department.

## Duty of Candour:

- Many staff were unaware of the term 'duty of candour', however were able to identify duty of candour principles appropriately. For example telling a patient when a mistake was made and apologising for this. We saw documented evidence in patient notes that duty of candour principles were upheld.

## Safety Thermometer:

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients receiving NHS funded care, such as

new pressure ulcers, catheter and urinary tract infections (CUTI and UTIs), falls with harm to patients over 70 and venous thromboembolism (VTE) incidence. A single day 'snapshot' of patient harms was submitted to the database on a monthly basis.

- Between June 2015 and June 2016, there were no new pressure ulcers, catheter and urinary tract infections, falls with harm to patients over 70 or VTEs reported to the safety thermometer.
- Specific safety indicators which were linked to the safety thermometer included all patients and were displayed at the entrance to the inpatient ward. These included the number of patient falls, pressure ulcers, UTIs and infections between June 2015 and June 2016.
- The safety indicators displayed by the hospital showed there were three patient falls in the reporting period (one in June 2015, one in July 2015 and one in May 2016).
- There were no pressure ulcers or UTIs in the reporting period.

## Mandatory Training:

- All staff were required to complete several mandatory training modules including information governance, basic life support and health and safety. Other topics such as aseptic non-touch technique, infection prevention and control and blood transfusion were also covered for those clinical staff requiring these specific skills. Training was completed by e-learning modules or classroom-based teaching.
- At the time of our inspection, 93.6% of mandatory training had been completed by inpatient ward staff. Senior staff explained that the shortfall was due to a member of staff on maternity leave at the time. In theatres, 91.2% of mandatory training had been completed. We saw evidence that theatres staff were booked on or had time planned to complete the remaining mandatory training topics.
- 95% of ward staff had completed intermediate life support and 85% had completed advanced life support training.

## Safeguarding:

- Safeguarding training was provided as part of the organisation's mandatory training. All staff were

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required by the hospital to undertake safeguarding vulnerable adults and children training level 1. Managers responsible for the inpatient ward and theatres were required to complete safeguarding level 2 training for vulnerable adults and children. The safeguarding lead had completed level 3 training. NHS England recommendations suggest that all clinical staff should have a minimum of level 2 safeguarding training and level 3 for children up to the age of 18, therefore the training provision did not meet this recommendation.

- Staff were aware of how to raise safeguarding concerns and told us they would make referrals to the local safeguarding authority with support of the safeguarding lead within the hospital. They told us this happened infrequently due to the cohort of patients most frequently served by the hospital.
- We did not see evidence of a policy in relation to female genital mutilation (FGM), although staff information on FGM was available in the ward safeguarding folder.

## Cleanliness, infection control and hygiene:

- Housekeepers were allocated for each area of the surgical service. The housekeepers worked according to cleaning schedules and checklists. For example, we saw each patient room on the wards had a cleaning schedule which included a comprehensive list of cleaning jobs, such as mirrors and air vents. Staff told us a housekeeping supervisor reviewed each area on a weekly basis and worked with ward staff to ensure cleaning standards were suitable.
- We inspected the pre-operative assessment rooms, patient ward rooms, theatres and recovery, and saw that they were visibly clean.
- We inspected four commodes on the inpatient ward and other equipment, such as hoists and blood pressure machines. We saw that equipment was visibly clean and green "I am clean" stickers were used to identify this to staff.
- Infection prevention and control support was provided by the lead nurse, who completed daily rounds on the ward to review isolation procedures in place and identify any patients with new infection control concerns. Infection prevention and control link nurses were identified on the inpatient ward and in theatres.

- Patients requiring barrier nursing were identified by isolation signs on the door to their room. We saw these signs in use during our inspection and noted that doors to these rooms were kept closed, in line with the isolation requirements.
- All patients were swabbed for MRSA and carbapenem-resistant enterobacteriaceae (CRE) - the latter if the patient was from a high risk area. Any patient with hospital acquired infection would have their procedure last on the operation list, to allow for a deep clean of the theatre overnight. Patient rooms were also deep cleaned when patients with MRSA or CRE had been accommodated within them.
- The hospital infection prevention and control lead acknowledged a high incidence of carbapenem-resistant enterobacteriaceae (CRE) in some patient groups, and so patients admitted from high risk areas were assumed to be infected until a swab confirmed otherwise. When patients from high risk areas were electively admitted, a CRE screening was done at the preoperative assessment. CRE is a type of bacteria which is resistant to many types of antibiotics and is therefore difficult to treat.
- There were 22 surgical site infections between April 2015 and March 2016:
  - The rate of surgical site infection per 100 surgeries performed for primary hip and primary knee arthroplasties (two infections for each type) were worse than average performance in NHS hospitals.
  - There were 14 orthopaedic and trauma infections, two upper gastrointestinal and colorectal infection, and two cardiothoracic infections. There was no benchmarking data available for these infections.
  - There were no infections reported for spinal, gynaecology, urological, cranial or vascular surgeries.
- We saw evidence that investigations were completed when infections occurred and investigations showed no themes or trends, such as the same surgeon or theatre used, were identified for the reported infections.
- Learning points from infection investigations were communicated to staff on noticeboards. For example, lessons learnt from an MRSA bacteraemia in June 2016 were displayed on the staff noticeboard on 3A during our inspection. We also saw that the MRSA screening

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policy was updated in response to this and the updated policy was available on the noticeboard with a sign indicating “please read”; however there was no signature list to indicate which members of staff had reviewed this.

- Water supplies to the ward and theatres were flushed and tested for pseudomonas and legionella at regular intervals. The most recent water test occurred in June 2016 and all but one sink were clear of infection. The sink identified as growing pseudomonas had a filter fitted and was being reviewed by the infection prevention and control team.
- We saw an audit schedule for monitoring infections on the wards. For example, central venous catheters were audited quarterly and peripheral intra-venous lines were audited three times per year.
- Staff working in theatres were required to wear scrub uniforms, including a theatre cap. Staff told us they were able to leave theatres in their scrubs but were required to change their scrubs when returning if they had been out of the department for an extended period of time, however staff were unclear what the timeframe for this was. We were concerned that patients could be placed at risk of infection if staff returned to theatre in scrubs which had been worn out of the department, particularly those worn by theatre porters who moved between theatres and the rest of the hospital frequently. This was not compliant with NICE CG74 (surgical site infections; prevention and treatment).
- We saw that procedures regarding patient preparation for surgery, including appropriate theatre attire and antibiotic prophylaxis, were compliant with NICE CG74 (surgical site infections; prevention and treatment). Intraoperative and postoperative phases were also compliant.
- Surgical equipment decontamination was completed off-site at a BMI facility. Equipment was visually checked on receipt in the hospital and also when received in theatre, prior to an anaesthetic being given to the patient.
- Basic personal protective equipment (PPE), such as gloves and aprons, was available at the entrance to

each patient room on the wards. We observed staff wearing and disposing of PPE correctly, for example when changing patient dressings and when moving between different patients.

- Alcohol gel was available at the entrance to the ward and theatres. We also noted gel dispensers were available at regular intervals throughout the ward.
- There were no staff handwashing sinks within the patient rooms, or in the ward corridors. This meant staff had to wash their hands in patient sinks, which was not in line with hand hygiene protocols. This was identified on the risk register as being a concern and senior staff, including the infection prevention and control lead, told us plans were in place to begin introducing staff sinks in patient rooms.
- We observed staff cleaning their hands with alcohol gel or soap and water, before and after patient contact. However, we observed occasions where staff picked up items from the theatres floor or came into contact with patient equipment on the inpatient ward without cleaning their hand appropriately.
- We observed that staff were bare below the elbows in clinical areas, which was in line with infection prevention and control guidance.
- In theatres, the hand hygiene audit result from April 2016 showed 80% of staff were bare below the elbow and 50% completed hand hygiene at appropriate times in line with the ‘World Health Organisation 5 Moments of Hand Hygiene’.
- On the inpatient ward, the hand hygiene audit result from September 2015 showed 100% of staff were bare below the elbow and 100% completed hand hygiene at appropriate times in line with the ‘World Health Organisation 5 Moments of Hand Hygiene’. It was documented that staff who failed to clean their hands were reminded of when hand hygiene was needed.
- In the day surgery unit, the hand hygiene audit result from April 2016 showed 100% of staff were bare below the elbow and 100% completed hand hygiene at appropriate times in line with the ‘World Health Organisation 5 Moments of Hand Hygiene’.

## Environment and equipment:

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- We saw that many doors throughout the ward were not labelled with suitable fire door labels. Senior staff acknowledged this issue and identified that this was recorded on the risk register. A replacement programme for doors within the hospital had begun and some doors on the ward had already been replaced.
  - Resuscitation trolleys were available on the inpatient ward, in theatres and in recovery. There was also a difficult airway trolley available within theatres. We observed that the contents of the trolleys were checked on a daily basis, however we identified some out of date equipment (for example a laryngeal mask airway was out of date on the difficult airway trolley in theatres).
  - Access to theatres was through an electronic card controlled door. A theatres receptionist was located adjacent to the entrance and staff told us visitors to theatres would be stopped from entering if they were not allowed to be in the department. However, on more than one occasion we entered the theatres department when the door was open and no member of staff was at the reception desk, which meant we could access the department without challenge.
  - Anaesthetic rooms were standardised which meant equipment was located in the same place within each room, enabling staff to locate equipment quickly and efficiently.
  - Two theatres had laminar flow, which was best practice for ventilation within operating theatres, however the air handling units for this system were 29 years old and described by senior staff as “on [its] last legs”. This issue was acknowledged on the unit risk register and plans were in place for the equipment to be updated in September 2016.
  - Theatres did not have access to an uninterruptible power supply UPS, which meant they would temporarily lose power in the event of a power cut, before generators would begin to provide power to equipment, including patient ventilators. Senior staff told us this was documented on the risk register and plans were in place to address this in September 2016. However, surgeons and anaesthetists working in the theatres were not routinely made aware of this during their induction to the hospital or prior to performing surgery, which could place patients at risk.
  - Yellow sharps bins were available in anaesthetic rooms, theatres and recovery. On the wards, sharps bins were also available in each patient room and in the treatment rooms. We saw that these bins were suitably labelled and none were overfilled.
  - Equipment matrixes were held for equipment throughout the surgical service. We reviewed the theatre equipment matrix which showed what items should be located in the department, the serial number of each item and its required service date.
  - We inspected many items of equipment throughout the ward and theatres, and saw that the equipment had been safety tested recently. Dates were recorded on each item to highlight when the next test was due.
- Medicines:**
- Prescriptions were written on paper based charts and were transferred with the patient throughout their admission. Prescription charts we reviewed were legible and fully completed. We observed that prophylactic antibiotics were prescribed and administered before patients were anaesthetised in theatre. Postoperative pain relief was prescribed by the operating surgeon following the operation, and included medicines which were to be administered either once only, could be given regularly, or ‘as required’ (PRN).
  - Medicines on the inpatient ward were stored in locked cupboards within treatment rooms. Treatment rooms had air conditioning and had their temperature monitored on a daily basis. We observed no gaps in the temperature checking document on ward 3A.
  - Medicines cupboards were neatly organised and medicines we checked were seen to be within their expiry date.
  - Some medicines were stored in lockable fridges, according to the individual instructions for each medicine. Fridge temperatures were checked daily, however we noted two temperatures out of the desired range were documented on consecutive days and no actions to address this issue were recorded on the form.
  - Controlled drugs (CDs) were stored in a wall mounted, lockable cupboard within the ward treatment room. The keys for this cupboard were held by the nurse in charge.

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The CD stock book was stored in a nearby drawer. Staff told us the corporate policy identified that this book should be stored within the CD cupboard, however they told us the cupboard was too small for this to happen.

- We checked three items in the ward 3A CD cupboard against the CD stock book and found that the documented values matched what was found in the cupboard.
- Medicines management audits were completed by the hospital on a monthly basis and showed that medicines were generally stored correctly on the inpatient ward. This reflected our inspection findings.
- We observed staff administering medicines, including oral and intravenous medicines, as well as CDs. Staff followed correct procedures and the BMI policy for medicines administration, including suitable checks of patient identification and for patient allergies.
- A medicines administration audit completed by the hospital on the inpatient ward in February 2016 showed there were 19.3% of medicines doses missed. Missed doses were correctly documented by staff in 90.9% of cases and were due to medicines omitted for clinical reasons or patient refusal. There were no medicines doses missed in error.
- Requests for patients' tablets to take away (TTAs) were sent to pharmacy on the day of patient discharge. Hospital audit data from February 2016 showed that 83% of TTAs were dispensed in less than one hour. Of these TTAs, 88% were dispensed in less than 30 minutes. Of the TTAs dispensed after one hour, 80% of these were non-urgent or had queries which need to be resolved by medical staff.

## Records:

- All patient records within the surgical service were paper-based. Details from the preoperative assessment, consent forms, surgical notes and ongoing plans were recorded in a file of medical notes, stored on the ward during the patient's admission. Nursing notes, observations and surgical care pathways were stored in a separate folder within the patients' rooms. Consultants usually retained notes for their own individual patients following their admission to the hospital.

- Records we reviewed were generally well completed in legible writing, with times and dates, and staff signatures for each entry.
- We identified some audit forms which contained patients' personal information, such as their full name, date of birth and address, which were stored unsecured in folders at the nursing station on the ward. Although staff told us there were "always staff around", we were concerned that this information could potentially be accessed inappropriately.

## Assessing and responding to patient risk:

- The World Health Organisation (WHO) Five Steps to Safer Surgery checklist was in use within theatres and hospital audit results indicated 98-100% compliance between July and September 2016. However we observed that compliance with this checklist was variable. We observed that the checklist was not always completed with a physical list in front of the surgical team, which is not in line with WHO recommendations, and that some aspects from the checklist were missed out. For example, we observed the patient's airway and risk of blood loss were not covered during the pre-anaesthesia aspect. We also saw that the surgical site was not always physically marked on the patient.
- We observed recovery staff filling in the WHO Five Steps to Safer Surgery checklist form retrospectively for the theatre activity which had taken place, although this staff member had not been present in theatre during the procedure. This was not appropriate practice.
- Equipment, including consumables such as swabs, used during surgical procedures were documented on theatre whiteboards to ensure the same number were present at the start and end of each procedure. We saw these whiteboards in use during our inspection.
- In line with NICE guidance, the 'National Early Warning Score' (NEWS) was used in recovery and on the inpatient ward to identify patients at risk of deterioration and trigger escalation to the ward registered medical officer (RMO) or the critical care RMO.
- Patient records we reviewed showed patient observations were completed at appropriate intervals and patient care was escalated correctly. Ward staff were required to undergo competency assessment for acute illness management, which included a written and practical assessment.

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- “Think sepsis” posters were displayed in clinical and staff break areas. These posters highlighted what clinical signs should indicate to staff that a patient may be septic (for example fever or increased heart rate) and what steps should be taken in this instance. Staff were able to describe what clinical signs might indicate sepsis and what they should do in response to this.
- Patients who deteriorated and needed additional care would be transferred to a different BMI hospital if appropriate. If patients became particularly unwell and needed care from a different provider, a 999 emergency ambulance would be called.
- Staff used the ‘Waterlow Pressure Ulcer Prevention Score’ to assess the patients’ risk of developing a pressure sore on admission and on subsequent days. This had been completed in the patient records we reviewed. We also observed staff using pressure relieving gel pads in theatres to reduce the risk of pressure ulcer occurrence.
- Records showed that patients were assessed for VTE risk on admission, 24 hours after admission and again after seven days. Mechanical VTE prophylaxis was used for all patients in theatre undergoing a general anaesthetic. VTE risk assessment was audited by the hospital on a quarterly basis and showed an improving trend; 84% in the period April to June 2015, 87% in July to September 2015, 90% in October to December 2016 and 99% in January to March 2016.
- Non invasive core temperature monitoring was used for all patients expected to undergo a procedure lasting 30 minutes or more. For cardiac procedures, invasive temperature monitoring was used.
- The BMI care of the child policy states that 16-18 year olds should be seen by an adult nurse to approve they are suitable for the adult pathway. Because we did not see any patients in this age group being treated we were unable to confirm if this policy was being followed.

## Nurse Staffing:

- An acuity tool was used to plan the staffing required on the inpatient ward, according to patients numbers and needs. Staffing within theatres was arranged according to the planned lists for the following week.
- Staffing levels were displayed at the ward entrance, and showed that planned and actual levels of staffing

matched throughout our inspection. Senior staff told us they aimed to sustain a ratio of 2:1 of registered nursing staff to health care assistants. Registered nurses were usually responsible for 6-8 patients each, depending upon patient needs.

- We observed that staffing within theatres was compliant with recommendations from the Association for Perioperative Practice (AfPP).
- There were 15 whole time equivalent (WTE) registered nurses and 7 WTE health care assistants across the inpatient ward. This included one registered nurse vacancy and one member of staff on maternity leave at the time of our inspection.
- There were three WTE nurses who worked in the preoperative assessment clinic.
- There were 10WTE operating department practitioners and health care assistants, and 22 WTE registered nurses working within the theatres department. There was one scrub practitioner vacancy at the time of our inspection.
- We saw evidence of some bank and agency staff usage to ensure safe levels of staffing at all times. The inpatient ward and theatres were compliant with best practice guidance which recommended no more than 20% agency nursing staff working in an area at any one time.

## Medical Staffing:

- Consultants and anaesthetists who operated at the hospital were required to maintain current practicing privileges in line with the BMI practicing privileges policy to be eligible to work on site. At the time of our inspection, there were 331 consultants with practicing privileges at the hospital. Senior staff told us many of these were anaesthetic staff and that it was important to have a large staff base of anaesthetists to allow flexibility.
- 12.4% of consultants with practising privileges had not completed an episode of care at the hospital between April 2015 and March 2016.
- Surgeons operated with a theatre team provided by the hospital and an assistant, who was either a surgical trainee from their primary hospital or a member of hospital theatre staff.

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- Surgeons were clinically responsible for the patients admitted under their care, and were required to review their patients once per day as a minimum. This was achieved with support from the registered medical officer (RMO) who completed basic reviews as needed.
- There was no formal rota for patients to access expertise from consultants in other specialties and staff told us referrals were made informally between consultants on the inpatient wards. For example, if a patient who had a knee replacement complained of chest pain overnight, there was no contact point for a cardiologist to review the patient.
- Surgeons usually organised their own anaesthetic support for private patients, whereas a higher proportion of anaesthetists were organised by the theatres team for NHS patients.
- Anaesthetists were responsible for supporting the anaesthesia of their patients returning to theatre after their initial procedure for 24 hours with private patients and 30 days for NHS patients. If the anaesthetist was not able to provide this support (for example due to other commitments), it was expected that they identified a suitable colleague to cover this.
- RMOs were provided to the hospital by an external organisation. There was one RMO deployed to cover the inpatient ward for seven days to complete ward tasks such as assessing patients, inserting cannulas and writing drug charts. The RMO sometimes reviewed patients in recovery but were not involved in theatres activity.
- Patient outcomes, including mortality, unplanned returns to theatre and unplanned readmissions to hospital, were good.
- We saw evidence-based practice in place, including enhanced recovery programmes for certain procedures and compliance with recommendations from the National Institute for Health and Care Excellence (NICE).
- Staff working within the surgical service were competent and there was clear support and opportunity for further development, particularly within theatres.
- Patient feedback was that pain was well managed and we observed staff asking patients if they had pain during their routine observations.
- Staff had good access to patient information and liaised with internal as well as external agencies to plan and deliver patient care.

However;

- Staff knowledge of Deprivation of Liberty Safeguards (DoLS) was limited and told us it was only relevant when patients were being restrained.

## Evidence-based care and treatment:

- Clinical audit programmes were in place and included audit of a range of performance indicators throughout the year. For example, medicines management, cleaning and VTE assessment audits. We saw evidence of actions in response to audit findings for most audits we reviewed, although this was not apparent for the pain audits we saw.
- The hospital offered a living donor kidney transplant service, for which it was accredited by the NHS Blood and Transplant Special Health Authority. These procedures were completed in accordance with the Living Kidney Donor Guidelines, from the British Transplantation Society.
- Surgical care plans were used to guide patient care after their procedure and were based on evidence-based interventions.
- BMI policies and procedures relevant to the surgical service, such as the Major Haemorrhage policy, were seen to reflect current recommendations from organisations such as the National Institute for Health and Care Excellence (NICE).

## Major incident awareness and training:

- Senior hospital staff told us there was no expectation or plan for the hospital to be involved in a local major incident response, for example in the event of a terrorist attack. They explained that they could become involved in relocating patients from a local hospital or taking on additional surgeries at a later date, after the initial response was made.

## Are surgery services effective?

Good 

We rated this service as good for effective because:

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- Staff told us evidence-based enhanced recovery programmes were used following certain procedures in line with relevant best practice guidance, for example following hip replacement surgery. We saw evidence of postoperative care leaflets which were based on best practice guidance.
- We observed that a number of practices across the surgical service were in line with recommendations from NICE. For example, we saw that investigations requested for patients preoperatively were compliant with recommendations made within NICE NG45 (Routine preoperative tests for elective surgery). Additionally, practice relating to antibiotic prophylaxis prior to surgical procedures was in line with recommendations from NICE QS49 (Surgical site infection).
- The 'American Society of Anaesthesiologists' (ASA) physical status classification was used to establish the physical status of patients prior to undergoing anaesthesia and followed best practice guidance.
- Nursing staff on the inpatient ward assessed and recorded patient visual infusion phlebitis (VIP) score in line with the 'Infusion Nursing Standards of Practice' (2011).

## Nutrition and hydration:

- Patients were able to select meals from a menu, which included options for patients with specific nutritional needs. For example those who required a soft textured diet and those with allergies.
- Nutritional support was available via a telephone referral to a dietician from an external organisation, who reviewed patients in person or offered telephone advice when needed.
- Fortified drinks were available within the hospital for patients with poor nutritional intake or those with specific needs, such as additional protein.
- Patients were provided with water jugs and glasses, and we saw these were left within patient reach. Hot drinks were also offered to patients frequently.
- Fluid balance charts were maintained for patients where hydration was a concern or where a specific fluid balance was identified by the doctor. We saw these were correctly completed and calculated during our inspection.

## Pain relief:

- Patients were asked to score their pain each time their routine observations were completed. Patients reporting discomfort were offered analgesia if they had additional medicines which had been prescribed or were referred for a pain management review by the doctor if pain was difficult to control.
- Staff told us the expertise of anaesthetic staff was often used to guide pain management for complex postoperative patients, however this depended upon the surgeon caring for the patient.
- Patients received pain relief via oral or intravenous medicines, or through patient controlled analgesia (PCA) devices. Additionally, some patients had pain relief via epidurals or nerve blocks.
- Pain management audits were completed on a monthly basis and stored in folders on the inpatient ward. A section of the folder was designated for recovery pain audits, however no results were available. Audit findings detailed numbers of patients receiving analgesia but not what this meant or if any actions for improvement were identified.
- Patient feedback forms also provided feedback on pain management and we saw these mainly contained positive responses.
- Ward staff were unaware if any learning had been identified from either of the pain management audits.

## Patient outcomes:

- There were five inpatient deaths between April 2015 and March 2016, which equated to less than 0.31% of all inpatient admissions and represents a low mortality rate. Data regarding these deaths was submitted to 'National Confidential Enquiry into Patient Outcome and Death' (NCEPOD) for inclusion in upcoming reports.
- Between April 2015 and March 2016, there were six cases where patients had unplanned returns to theatre.
- Between April 2015 and March 2016, there were three unplanned transfers of inpatients to other hospitals, either within the BMI hospital group or to an NHS provider if BMI was unable to provide the necessary treatments. The rate of unplanned transfers was not high when compared to other independent acute hospitals which submitted performance data to CQC.

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- Between April 2015 and March 2016, there were seven cases where patients had unplanned readmissions to hospital within 29 days of discharge. The rate of unplanned readmissions was not high when compared to other independent acute hospitals which submitted performance data to CQC.
- Data for all joint replacements was submitted to the National Joint Registry (NJR) and the choice of orthopaedic prosthesis was guided by data from NJR reports.
- There was insufficient patient reported outcome measures (PROMs) data for primary knee replacement (for NHS funded patients) to calculate a result which could be compared with other centres. This was because of low numbers of eligible procedures. However, out of 12 modelled patient records, 100% reported improvement on the Oxford Knee Score. Additionally, out of eight modelled patient records, the EQ-5D Index indicated 87.5% of patients reported improvement. The EQ-VAS (Visual Analogue Scale component of the EQ-5D) showed 66.7% were reported as improved out of six modelled patient records, and 33.3% were worse.
- There was insufficient patient reported outcome measures (PROMs) data for primary hip replacement (for NHS funded patients) to calculate a result which could be compared with other centres. This was because of low numbers of eligible procedures. However, out of nine modelled patient records, 100% reported improvement on the Oxford Hip Score. Additionally, out of seven modelled patient records, the EQ-5D Index indicated 85.7% of patients reported improvement. The EQ-VAS showed 100% were reported as improved out of six modelled patient records.
- There was insufficient patient reported outcome measures (PROMs) data for groin hernia treatment (for NHS funded patients) to calculate a result which could be compared with other centres. This was because of low numbers of eligible procedures. However, out of 16 modelled patient records, the EQ-5D Index indicated 31.3% of patients reported improvement and 25% reported worse symptoms. The EQ-VAS showed 52.9% were reported as improved out of 17 modelled patient records and 41.2% were worse.

## Competent staff:

### Nursing:

- All new staff were required to be inducted in their area of work on their first day. This was completed by the ward or theatre manager, depending upon where they would be working. We saw evidence of completed induction documents.
- New starters worked as supernumerary members of staff when commencing work, to allow them time to get to know the ways of working and to fully orientate them to the ward.
- Staff working throughout the surgical service were required to complete set competencies prior to working independently in the pre-operative assessment clinic, on the wards or in theatres. Basic competencies were completed when commencing their post and more complex competencies were completed within three months. We saw evidence of competency completion for staff across the service.
- Appraisals for ward staff were completed by the ward manager and documentation shown to us during our inspection demonstrated that 81.8% of appraisals had been completed within the last year. The remaining appraisals had been booked to be completed within the following month.
- Individual folders were held for each member of staff working within theatres, including details of their most recent appraisal, personal development plan and copies of their completed competency documents.
- We saw a clear focus on staff development within theatres and records showed all members of staff in the department had been appraised and attended a course for development purposes within the previous 12 months. Theatres staff worked across all surgical specialities to gain competence in a range of areas. Staff spoke positively of their learning opportunities and told us staff development was a key focus for the leadership team.

### Medical:

- All consultant surgeons and anaesthetists were required to maintain current practising privileges in line with the BMI practising privileges policy. This policy ensured consultants took responsibility for maintaining their

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own clinical competence and had adequate professional insurance to practice. To maintain their practicing privileges, consultants were also required to show evidence of annual appraisal.

- Surgeons operated with an operating assistant, who was sometimes a surgical trainee from the consultants' other place of work. The theatre manager was responsible for ensuring assistants had relevant paperwork to demonstrate occupational health clearance and GMC registration.
- RMOs were provided by an external organisation that completed relevant employment checks, such as DBS and General Medical Council registration. CVs were sent to the hospital for approval before new RMOs were sent to work there, and the hospital reviewed documentation to ensure relevant training and registration was up to date. Mandatory training was organised and overseen by the agency, not the hospital.
- New consultants and RMOs were inducted to the hospital by the Director of Clinical Services and the relevant departmental managers.

## Multidisciplinary working:

- There were no regular, formal multidisciplinary team (MDT) meetings held within the surgical service, however staff told us MDT meetings had been organised for long-term or complex patients, particularly when discharge planning.
- We observed staff on the ward communicating about planning patient care, patient progress and difficulties. We observed nursing staff administering pain relief medicines at a specific time so that it was effective by the time the patient's physiotherapist arrived. Staff also communicated via patients' clinical notes.
- Staff were clear that each individual patient's admitting consultant was responsible for the patient's care throughout the course of their admission. They were clear that escalation of concerns should be to the RMO in the first instance but that concerns could also be communicated directly to the consultant.
- Patients could also be escalated for review by the critical care RMO if needed. Staff told us the inpatient ward RMO and critical care RMOs discussed individual

patient cases where there were concerns of deterioration, and that this was done in conjunction with both the admitting consultant and the critical care consultants.

- Staff within the hospital liaised with external agencies, such as GPs and care providers to obtain information about patients and to plan their ongoing needs. For example, we saw a hospital therapist speaking to a community therapy team to plan ongoing rehabilitation for an orthopaedic patient.

## Seven day services:

- There were three theatres available from Monday to Friday from 7am to 8:30pm and 7am to 5pm on Saturdays. All theatres were set up for multiple specialities including emergency surgery, although one theatre could accommodate cardiothoracic surgery. An on-call theatre team were available out of hours in case a patient needed to be transferred back to theatre urgently. An on-call cardiovascular perfusionist was available to assist with cardiothoracic procedures at short notice, out of hours.
- Surgical patients could access imaging during department opening hours, however an on-call radiologist was available out of hours, when the imaging department was closed. This meant patients requiring urgent investigations could access this service, for example after a fall on the ward.
- Physiotherapy services were available seven days per week to assist with patient rehabilitation and mobility. An on-call physiotherapy service was available out of hours to treat patients with specific respiratory difficulties and those requiring additional mobility support.
- The pharmacy department was open Monday to Friday and for half a day on Saturdays. An on-call pharmacy service was available for advice and emergency dispensing when the pharmacy service was officially closed.

## Access to information:

- Patient information was compiled in medical notes or in the care plan documentation. These records followed

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the patient through their admission; from initial consultant and pre-assessment to follow up outpatient appointments. Staff told us missing notes were rarely an issue.

- Upon patients' discharge from hospital a discharge summary, containing information about the patient's admission and operation details, was sent to the patient's GP to ensure continuity of care in the community. A copy of the discharge summary was also given to the patient for their reference.
- Where patients were funded by private health insurance, copies of relevant documentation were also sent to the insurers, along with any invoices.
- Policies were available on the hospital-wide computer system; however paper copies were also available in some areas. For example, in theatres there was a storage cupboard containing up to date printed versions of all key policies and signature documents to indicate who had read the policy.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS):

- We saw appropriate consent forms were used to document the information provided to patients regarding their surgical procedure and their signature to demonstrate their consent. These forms were reviewed prior to patients being anaesthetised and were stored in the patients' medical records.
- Forms clearly showed where translators were used to obtain consent from patients and staff told us independent translators would always be used for formal consent processes, rather than patients' family members.
- Staff told us it was important to obtain consent from patients for all interventions, including taking their observations and changing dressings. Staff told us they would respect patients' wishes if they refused an intervention, however they said they would explain why the procedure was necessary and the reasons it would be beneficial.
- Staff told us they rarely cared for patients with mental capacity issues, as these patients would be picked up during the preoperative assessment processes and admitted elsewhere if mental capacity was a concern.

- Staff were aware that patients should always be assumed as having capacity unless proven otherwise and told us capacity assessments would be completed by the RMO if there was any doubt about a patient's capacity.
- Some staff were aware of deprivation of liberty safeguards (DoLS), whereas others were unfamiliar with the term. Staff spoke about DoLS in terms of patients requiring restraint, however were unfamiliar with other factors which could constitute as deprivation of liberty. Staff told us restraint was "never used" within the hospital and so DoLS was not a concern.

## Are surgery services caring?

Good 

We rated this service good for caring because:

- Patient feedback forms about their overall experience and their opinions of the nursing staff demonstrated positive results, with scores frequently above 95% satisfaction.
- We saw several cards from patients and their families on display at the nursing stations on the wards, which praised the friendly and approachable staff.
- Patients told us staff introduced themselves when they first met, and that they were friendly and kind.
- Relatives were confident in the care provided throughout the surgical service and told us they were suitably involved in the care of their loved one.
- We observed staff maintained privacy and dignity, including during wound examinations and when in theatre.
- We also observed staff providing emotional support to patients in the anaesthetic rooms and when waking from their anaesthetic in recovery.

However;

- Two patients described situations where they felt staff did not provide them with sufficient support after their procedure.

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- Patients funded through private healthcare insurance were unsure if their insurance covered all costs associated with their procedure and admission or if they were required to contribute.

## Compassionate care:

- Patient experience feedback was displayed on posters in the theatres corridor. Results showed patient satisfaction was consistently high between January and May 2016, with scores ranging from 96.9-100%.
- Patient satisfaction of nursing care on the wards showed an improving trend since January 2016, with all scores at or above 95% from April to June 2016.
- We saw several cards from patients and their families on display at the nursing stations on the wards, which praised the friendly and approachable staff.
- Patient feedback about the care they received on the wards was very positive and one patient told us the ward staff “have got caring down to a fine art”. Patients told us staff were friendly and kind, and that they felt comfortable voicing any concerns they had.
- Relatives told us they were confident in the care received by their loved one and one relative said the patients were in “safe hands”.
- Patients told us staff respected their cultural and religious needs, for example one patient told us they wanted to continue wearing their headscarf as long as possible before their operation and afterwards. The patient told us the hospital took every care to comply as far as possible with their wishes.
- We observed staff speaking respectfully and politely to patients and their visitors throughout our inspection, including calling patients by their preferred name when requested.
- Staff took care to preserve patient privacy and dignity throughout the surgical service, including while patients were in theatre. Staff ensured that patients were suitably covered whenever possible, including during examinations.
- We observed that patient call bells were usually answered within 10 rings and patients told us ward staff came quickly when they needed them. Senior staff told us the length of time taken to answer call bells was not audited.

## Understanding and involvement of patients and those close to them:

- Patients told us staff were patient and sensitively explained procedures to patients in a thoughtful and empathetic manner. We observed staff checking patients understood their explanations and offered opportunities for patients and their relatives to ask questions.
- We observed staff offer information leaflets to patients and advise that they could help explain anything that was unclear.
- Patients and their relatives told us most staff introduced themselves when they first met and that they knew who was looking after them.
- Relatives told us they were suitably involved in the care of their loved one, and that they were kept informed when patients were undergoing procedures. One relative told us they waited in the patient’s room during the patient’s procedure and that staff regularly checked they were okay, as well as offering hot drinks.
- Self-funding patients and their relatives told us costs associated with the patient’s procedure and admission had been clearly explained to them before they booked their surgery. However, patients funded by private healthcare insurance were not sure if every part of their admission was covered by their insurance or if they were required to contribute to any costs.

## Emotional support:

- We observed staff providing emotional support in theatres, prior to patients receiving anaesthetic. Staff chatted to patients as they were anaesthetised and told us it was an important time to make patients feel at ease.
- Recovery staff spoke gently to patients coming round from anaesthetics, providing reassurance about the patients’ procedure and how they were doing postoperatively.
- Ward staff told us providing emotional support to patients was part of their daily role. They acknowledged the need to be encouraging, empathetic and sensitive to patients’ individual needs. One nurse described a

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patient who was particularly nervous about walking after their operation and how the nurse worked alongside the physiotherapist to ensure the patient felt safe and supported during the therapy sessions.

- Most patients reported feeling emotionally supported by staff, however two patients described circumstances where they felt staff did not provide them with sufficient support after their operation. For example, one patient requested help with bathing and staff assisted the patient to the bathroom and then “just left [them] to it without offering any other help”.

## Are surgery services responsive?

Good 

We rated this service as good for responsive because;

- Access to surgical services for NHS patients and privately funded patients was straight forward and efficient. Information provided by the hospital indicated 91-97% compliance within the 18 week referral to treatment time target for NHS patients between April 2015 and March 2016.
- The flexibility of the surgical service meant it could absorb patients who needed to return to theatre unexpectedly and those with longer length of stays than expected, without the need to cancel other procedures or admissions.
- There were no procedures cancelled for nonclinical reasons between April 2015 and March 2016.
- Patients’ cultural and language needs were well met throughout the surgical service, including the use of translators and same sex nursing if requested.

However;

- Pre-operative assessment appointments had limited availability outside of normal working hours which made access difficult for people who work full time.
- The surgical service was unable to accommodate patients with significant mental health needs, including patients living with dementia, or those with a learning disability.

## Service planning and delivery to meet the needs of local people:

- Surgical procedures completed at the hospital were elective, which meant that the flow of patients into the service and patient length of stay was usually predictable.
- Staff told us the inpatient ward could accommodate patients with a slightly longer than expected length of stay without the need to delay or cancel other admissions.
- If patients had to return to theatre unexpectedly, staff told us this could be absorbed within the theatre capacity without the need to cancel other surgeries. Hospital data indicated there were no procedures cancelled for nonclinical reasons between April 2015 and March 2016.
- Services were delivered according to what individual consultants wished to provide for both NHS and privately funded patients. However, when specific surgical services were commissioned at the hospital, the hospital worked with their consultant-base to ensure the terms of the commissioning contract could be met.
- Surgical inpatients were accommodated in individual rooms on the inpatient ward. Each room had en suite bathroom facilities. Patient rooms had their own air conditioning control which meant patients were able to set the temperature for their own comfort.
- Day surgery patients were accommodated in one of three six-bedded bays or in a three-bedded bay. This was divided into male and female patient bays, so that mixed sex accommodation breaches did not occur.
- Waiting room facilities were available at the ward entrance, with seating for eight people and newspapers and magazines available. Staff told us these facilities were sufficient to meet the needs of visitors as there were few occasions when they were asked to wait outside patient rooms.
- Facilities for surgical patients were appropriate for the services that were planned and delivered by the hospital.

## Meeting people’s individual needs:

- The hospital accepted referrals for young people aged 16-18 years old. Prior to any admission or treatment, a

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specialist children's nurse assessed each individual to determine whether it would be appropriate for them to follow an adult care pathway. Between April 2015 and March 2016, there were two young people admitted as inpatients and eight cared for as day case patients.

- Patients with specific mobility difficulties or those undergoing certain procedures, such as a knee replacement, were screened by a physiotherapist during their preoperative assessment. This allowed the therapist to identify any specific needs the patient had prior to their admission.
- Bariatric equipment, including theatre trolleys, was available if needed. Additionally, there were four designated bariatric patient rooms on the inpatient wards, which had widened doorways to facilitate easier access. These rooms could accommodate bariatric beds and chairs if required. En suite bathroom facilities for these rooms had not been specially adapted and facilities in them were the same as other bathrooms on the ward.
- Staff told us patients with mental health issues, including those living with dementia, and a learning disability were not admitted to the hospital due to the complex nature of caring for these patients. They told us patients with these types of healthcare needs would receive treatment at locations where suitable support could be provided.
- Staff told us patients wishing to be cared for by a nurse of the same sex as them would be accommodated wherever possible, although this could be challenging at times, depending on who was rostered to work.
- Information leaflets were available at the ward entrance, including topics such as breast health and cardiac care. We saw staff providing patients with leaflets appropriate to their own individual needs. All leaflets we saw were written in English, however staff told us they could access leaflets in other languages on the computer system.
- Arabic translators were available within the hospital and translators in other languages could be booked if needed. We saw evidence translators were used during ward rounds to help consultants communicate with patients and their families.

- We observed staff on the ward using an Arabic communication booklet, which had pictures and translated words and expressions to assist staff in caring for Arabic speaking patients and their families.
- A multi-faith room was available for patients and visitors to use for quiet reflection and prayer.

## Access and flow:

- NHS patients could access surgical services at the hospital via the 'choose and book' system, where services had been commissioned by local clinical commissioning groups (CCGs). There were four main local CCGs which commissioned services at the hospital. Patients receiving CCG commissioned care at the hospital usually attended the hospital for the duration of their care episode; from initial consultant review and preoperative assessment, through to their postoperative outpatient review.
- Surgical services could also be accessed by NHS patients where specific contracts had been agreed with other local providers. For example, a local hospital could sub-commission procedures to BMI The London Independent Hospital. Patients who accessed services at the hospital usually only attended for their procedure. Other outpatient visits were completed in the NHS service.
- Patients who were self-funding their care or with private health insurance accessed surgical services at the hospital via GP referrals direct to specific consultants.
- NHS and private patients were booked into theatre slots with the relevant surgeon as soon as a convenient time was available. Staff told us theatre lists were sometimes split into NHS and private patient lists so that equal access was achieved. It was the decision of individual consultants to prioritise patients over one another.
- A rolling rota was used to allocate theatre slots to surgeons using the hospital. This was an ongoing rota, which allowed surgeons and patients flexibility for booking procedures as they could book a long time in advance if they wished.
- Surgical procedures had to be booked a minimum of five days in advance to ensure suitable theatres staff and equipment were available. This rule also ensured that results from pre-operative investigations, such as blood

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tests and MRSA swabs, were back before the patient was admitted for their procedure. Consultants told us this met patient needs as most procedures were booked at least two or three weeks in advance.

- Surgical bookings were made at a convenient time for the patient and surgeon involved. A designated team within the hospital was responsible for ensuring NHS patients accessing elective consultant-led care and treatment at the hospital did not wait more than 18 weeks from referral to treatment. Hospital data indicated that waiting times were dependent on consultant and patient availability rather than access to theatres or ward beds, which could be made available within one week. Hospital data showed between 91-97% compliance within the 18 week referral to treatment time target for NHS patients between April 2015 and March 2016.
- Once a date for surgery had been agreed with the surgeon, patients were required to have a pre-operative assessment completed. Patients having minimally invasive procedures with no significant past medical history were assessed via telephone consultations with a pre-operative assessment nurse. All other patients were assessed in person by the nurses.
- Appointments with the preoperative assessment nurses were available from 8am to 4pm Monday to Friday. These appointments were held within the outpatients department of the hospital. Two patients told us attending a preoperative assessment had been difficult for them due to working full time and there being no preoperative assessment clinic in the evenings.
- Preoperative assessment nurses told us the assessments could not take place more than six weeks prior to a procedure, in case a patient's health status changed.
- Theatre utilisation was monitored by the theatre manager and averaged 70% between January and June 2016.
- There was a three bedded recovery bay where patients remained postoperatively for an average of twenty minutes before being transferred back to the ward. If patients remained drowsy, had high levels of pain or high oxygen requirements, they remained within the recovery area for longer periods of time.

- Patients had a designated room on the inpatient ward which was reserved for them from the time they were admitted. This meant there were no delays in discharging patients from the recovery area back to the ward.

## Learning from complaints and concerns:

- Staff told us complaints were managed at ward level whenever possible and that senior staff did "satisfaction ward rounds" to check everyone on the ward was happy with the service they were receiving.
- Patients were supported to make formal complaints to the hospital if they wished. Formal complaints triggered investigations and a formal complaint response was sent to the complainant from the Executive Director.
- The numbers of complaints received by the ward and within the hospital were displayed on the staff noticeboards. The themes of the complaints received were also outlined, although this was done on a hospital wide basis rather than at ward level. Staff told us the ward managers highlighted any issues or learning relating to complaints during staff meetings.
- There were 21 complaints about the inpatient service (Surgical and medical combined) and four complaints about theatres between April 2015 and March 2016. We saw examples of complaint responses which responded appropriately to complaints made, and included apologies where appropriate.

## Are surgery services well-led?

Requires improvement 

We rated this service as requires improvement for well led because;

- Risks documented on the risk register were not always fully mitigated, for example not all operating staff were formally informed about the lack of UPS, which could cause delays in appropriate action being taken in the event of power loss.
- Some safety issues, such as poor WHO checklist completion and lack of adequate safeguarding training, were not identified as an issue by the leadership team.

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- Staff on the inpatient ward told us they were not engaged in service development or quality measures, and that they have little ownership of the service they provided.

However;

- Suitable governance processes were in place and the Medical Advisory Committee (MAC) were involved in a number of key processes, including performance reviews and quality measure.
- Staff described a visible and approachable leadership team and told us they felt able to raise concerns or report incidents without fear of repercussions.

## Vision and strategy for this service:

- The overarching aim of the service was to provide a safe and satisfactory experience for all patients accessing surgical care within the hospital. Within this overall vision, theatres and the inpatient ward identified areas to develop individually, as well as together, to achieve this vision. Senior staff identified that there were also financial targets for the service, but that quality, safety and patient experience remained the most important outcomes.
- The vision of the service was displayed on posters in the theatres corridor and on noticeboards within staff areas on the inpatient ward.
- Staff knew the priorities of the service and were able to articulate how they would individually contribute to achieving the vision. For example, one staff member identified the number of surgical site infections as an area for improvement and told us it was the responsibility of everyone involved in patient care to ensure they followed infection prevention and control guidance, with aim of reducing the incidence of infections.
- Staff could also explain how investment in the service would contribute to achieving the vision of the service, for example through investments in the air handling units and power supply in theatres.

## Governance, risk management and quality measure:

- A “10 @ 10” meeting was held in the Executive Director’s office daily from Monday to Friday, which included the senior management team and managers from all areas of the hospital. This provided senior staff the

opportunity to raise any immediate issues or highlight any significant incidents which had occurred. Topics such as staffing levels and new infections were also covered.

- Managers from the inpatient ward and theatres attended hospital-wide governance meetings on a monthly basis. This enabled them to identify key themes and learning from incidents or other issues throughout the hospital.
- Information from hospital governance meetings was disseminated to theatres and ward staff during their unit meeting and via posters displayed in staff areas. Senior staff told us they also disseminated urgent information during morning or evening handovers on the wards, and during preoperative briefings in theatres.
- Risk registers were held centrally within the hospital, however senior staff in each area could access the documents for reviews and updates. We reviewed risk registers for theatres and the inpatient wards, and found that the register reflected the issues senior staff described as areas of concern as well as the risks we identified during our inspection.
- Not all risks recorded on the risk register had been fully mitigated. For example, the lack of UPS in theatres was documented and plans were in place to address the problem, however not all operating staff were aware of the issue, which could cause delays in appropriate action being taken in the event of power loss.
- In staff areas, posters displaying the five key risks for that clinical area were displayed. Staff were aware of the risks associated with their area of work and could describe steps in place to mitigate or resolve the risk.
- Surgery outcomes were reviewed by the Medical Advisory Committee (MAC), alongside the senior management team, and if there were concerns about the performance of a specific consultant, a review of their practicing privileges took place. No consultants had their practicing privileges revoked between April 2015 and March 2016, although senior management staff told us a consultant was performance managed into retirement during this time.
- Consultant practicing privileges were placed on hold for any consultant whose indemnity insurance expired before new documentation was provided to the

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hospital. The senior management team told us this was a new “zero tolerance” approach. Practising privileges were suspended for 12 consultants between April 2015 and March 2016 for this reason.

- Quality monitoring took place for NHS funded patients, via feedback to the commissioning body through incident, patient outcome and complaint data.
- Audit results for the completion of the WHO Five Steps to Safer Surgery checklist showed 98% compliance in July 2016, 99% in August 2016 and 100% in September 2016. However our observations indicated that the checklist was not being completed correctly in theatres. Management staff did not acknowledge correct completion of the WHO Five Steps to Safer Surgery checklist as a concern regarding the surgical service.
- The theatre leadership team were in the process of developing a formal process for surgeons to feedback regarding the service they received by the theatres department in the hospital. At the time of our inspection, most feedback was received on an informal, ad hoc basis after each theatre list. Staff told us some surgeons also used the ‘debrief’ forms to record feedback.
- Safeguarding vulnerable adults and children training provided for staff within the service was not adequate to protect these patient groups from harm. Senior staff did not acknowledge the shortfall in safeguarding training.

## Leadership of service:

- Nursing leadership was provided at ward level by senior sisters and overseen by the ward manager. Overall nursing leadership was provided by the Director for Clinical Services.
- Leadership within theatres was provided by the theatre manager and deputy theatre manager.
- Medical leadership was provided by the medical advisory committee (MAC), which provided expert advice to the senior management team regarding specific medical issues. For example, where complaints regarding patient management were made, the MAC would review patient notes and determine whether care was appropriate.

- Representatives for various specialities, such as orthopaedics and anaesthesia, volunteered to participate in MAC meetings and discussions.
- Staff working in managerial posts had significant clinical experience in a range of organisations, including NHS hospitals and other independent health organisations.
- Staff throughout the surgical service told us the leadership team were visible in the clinical areas. They told us their line managers were available within their clinical area daily and were present at regular intervals to check everything was okay and to provide support if needed.
- Staff told us the senior management team were also very visible and had a strong presence throughout the hospital. We observed the senior management team engaging with staff throughout the surgical service.

## Culture within service:

- Ward staff told us the leadership team were approachable and that they felt “safe” to raise any concerns. They described a no blame culture relating to incidents and mistakes.
- Theatre staff told us they felt valued by their immediate management and the senior management within the hospital. They described the leadership teams as encouraging and supportive. They also told us they were respected by consultants who used the hospital theatres, and that the consultants had paid for social events for theatres staff to show their appreciation.
- Senior ward staff told us they emailed their staff thanking them for their hard work and contribution to ward improvements. We saw evidence of these emails and ward staff told us it made them feel appreciated.
- In theatres between April 2015 and March 2016, staff sickness rates for ODPs and health care assistants, and registered nurses were lower than in other independent acute hospitals we hold this type of data for.
- There was a higher than expected turnover of nursing staff in theatres in this period (47.1%), but a lower than expected turnover of ODPs and health care assistants (11.1%). Senior staff explained this was largely due to a new manager in post and a significant change in ways of working, plus some staff members who were performance managed.

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- On the inpatient ward between April 2015 and March 2016, staff sickness rates for health care assistants and registered nurses were lower than in other independent acute hospital we hold this type of data for.
- There was a higher than expected turnover of nursing staff and health care assistants (28.2% and 46.7% respectively) on the inpatient ward during this period. This was attributed to new management of the unit and performance management of some staff.

## Public and staff engagement:

- All patients who received care through the surgical service were asked to complete feedback forms to identify their level of satisfaction with the service they received. These forms were analysed by the quality and risk team, as well as the manager for the inpatient ward.
- Noticeboards included “you said, we did” posters which highlighted steps taken by the hospital in response to feedback from patients and their families. For example, some patient feedback suggested they were dissatisfied with the amount of information provided on discharge from the ward. In response to this, the hospital introduced discharge information packs.
- Student nurses on placement on the wards were asked to complete satisfaction questionnaires at the end of their clinical placements. Feedback forms we reviewed from December 2015 showed 100% satisfaction from students who provided feedback. Comments on the forms praised the inclusive and supportive ward staff.
- Staff told us their views were not sought and that they were not engaged in planning service developments or

clinical priorities. Staff on the inpatient ward described how some staff had roles as link nurses, however audit activity, such as hand hygiene audits, was completed by senior staff and so they had little ownership of the service they provided.

## Innovation, improvement and sustainability:

- Some procedures, which were not common place in other surgical centres, were completed in the hospital, for example meniscal transplants and live kidney transplants. Theatre staff told us they enjoyed assisting in this type of surgery and hoped that this type of work would increase in the hospital.
- Where new techniques or services were suggested by a consultant, a business case including details of anticipated service demand and sustainability, was put forward to the senior management team to evidence that it would be worthwhile training staff for the new service. The MAC would also be involved in advising the senior management team regarding the impact of any new services.
- Staff in theatres told us they were in the process of starting a robotic surgery service, initially for urology patients. They described working in conjunction with a specific group of surgeons to source suitable equipment and begin training staff for this.
- Staff told us the hospital was contributing data to the ‘Private Healthcare Information Network’ to improve reporting of patient outcomes across the independent healthcare sector.

# Critical care

Safe	Requires improvement 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Good 

## Information about the service

We spoke with 11 members of staff and one patient. We looked at four patient records during our inspection.

The critical care unit at BMI The London Independent Hospital is made up of a six bedded intensive therapy unit (ITU) for level three patients and a three bedded high dependency unit (HDU) for level two patients. The HDU is a three bedded bay located adjacent to the inpatient wards 3A and 3B.

The ITU has two individual side rooms, three pods and one open bed unit in the main ward. The HDU is on the same floor as the ITU but not in the same location. The pods are semi permanent structures used to divide the ward area into separate individual spaces resembling rooms.

The HDU is staffed by ITU staff (both medical and nursing). There were no patients in the HDU during our inspection. The ITU manager also manages the HDU.

The unit admits patients mostly from the United Kingdom but also admits patients from Kuwait. An international office at the hospital is responsible for liaising with the Kuwaiti embassy to arrange admissions and discharges to the unit. Between 1 June 2015 and 30 June 2016 there were 28 direct admissions from overseas to ITU.

The unit started submitting data to the Intensive Care National Audit and Research Centre (ICNARC) in January 2016. They are expecting their first data report in September 2016.

There were 1,083 level two critical care bed days available in the hospital from April 2015 to March 2016. Of these, 990 level two critical care bed days were used. For level three bed days 574 of the 2196 available bed days were used during the same period.

# Critical care

## Summary of findings

Overall we rated critical care services at BMI The London Independent Hospital as good because:

- We found significant areas of good practice through our review of clinical audits, staff training, patient notes and minutes of intensive therapy unit (ITU) governance meetings.
- Leadership in the unit had a clear structure, and leaders were respected by staff. This contributed to a cohesive team that demonstrated an innovative approach to treatment and care.
- The unit contributed to national audits compiled by the Intensive Care National Audit and Research Centre (ICNARC) and provided patient-centred, evidence-based care.
- The critical care unit (CCU) team had access to multidisciplinary specialists who contributed to decision-making and ward rounds to ensure safe care for patients.
- Both ITU and the high dependency unit (HDU) appeared clean, hygienic and well maintained and staff demonstrated good infection control practices.
- The CCU was responsive to the international patient client group they regularly admitted to the unit and there were robust arrangements in place to meet the individual needs of these patients.
- Patients were protected from avoidable harm and there were processes and systems in place which prioritised patient safety.
- Incident reporting was embedded in the culture of the unit and there was evidence that learning from investigations had taken place with a system in place to ensure all staff were aware of updates to practice. This contributed to an environment in which safety was prioritised and patients received individualised care.
- Staffing levels were reviewed continually using an established nursing acuity tool and there were enough staff to provide care and treatment in

accordance with Royal College of Nursing (RCN) guidance. The use of agency staff at the time of our inspection had significantly decreased in comparison to the start of 2015.

- All staff we spoke with told us they were supported and valued by the senior team and they felt proud to work in the unit.

However;

- Staff did not always accurately record the daily checks for medicine management.
- The bed in the main ward area of ITU was in a small bay and staff told us that it was not easy to care for a level three patient from this bed space. Staff reported that the bed was very close to the nursing station and made it difficult for them to manoeuvre whilst looking after a patient.
- There were no designated hand wash sinks in the two side rooms on the ward, which meant staff washed their hands in patient basins. This was not compliant with hand hygiene protocols.
- There was one oxygen port (air and suction) per bed space in the high dependency unit (HDU). This was not in line with the building regulations for critical care (HBN 04-02) which suggest three to four oxygen outlets per bed space. We took into account the fact that the regulations came into force after the building of HDU however; we asked the provider to consider the requirements set out within the building regulations for critical care (HBN 04-02) in terms of risk and patient safety.

# Critical care

## Are critical care services safe?

Requires improvement 

We rated safe as requires improvement because:-

- Staff did not always record medicine checks correctly. For example, where fridge temperatures were above the recommended temperature, staff would record this but would not state what action was taken in response to the high temperature.
- There were no designated hand wash sinks in the two side rooms on the ward, which meant staff washed their hands in patient basins. This was not compliant with hand hygiene protocols.
- In HDU there was only one oxygen port per bed space. This was not in line with the latest building regulations for critical care (HBN 04-02) which suggest three to four oxygen outlets per bed space. We took into account the fact that the regulations came into force after the building of HDU however we asked the provider to consider the requirements set out within the building regulations for critical care (HBN 04-02) in terms of risk and patient safety.
- A few staff said they did not always get feedback on incidents after they reported them. However, this was a minority of the staff we spoke with.
- There were conflicting responses by staff when asked about where the medicines for HDU patients would be retrieved from in the case of an emergency. Some staff told us that medicine would be taken from the ITU and others told us that it would be taken from the medicine room next to the HDU (also used by ward 3A and 3B). HDU and ITU were not in the same location which meant that if medicines were taken from ITU there could potentially be a delay in getting medicine to a patient in an emergency situation.
- Prescriptions for potassium were incomplete and did not show the amount of dilution required, the level required to trigger the infusion or the duration of the infusion.
- The service did not have a sepsis lead to oversee sepsis management.

However:

- Nursing and medical staffing levels consistently met the requirements of the Royal College of Nursing and the Faculty of Intensive Care Medicine.
- Incident reporting was embedded in the culture of the critical care unit (CCU) and there was evidence of learning from incidents.
- The care of patients in the unit was led by a consultant intensivist ( a physician whose expertise is providing special care for critically ill patients) in accordance with the Faculty of Intensive Care Medicine (FICM) guidance on medical staffing.
- Staff were knowledgeable about safeguarding and knew how to escalate concerns.
- **Incidents**
- Staff recorded incidents on a paper form and handed them to the critical care manager who sent them to the quality and risk office. The quality and risk manager recorded incidents on an electronic spreadsheet and investigated all incidents in liaison with the critical care manager. A root cause analysis was undertaken for incidents depending on their nature. Incidents considered to be of a serious nature were escalated to the director of clinical services. There were plans to move to electronic reporting in October 2016.
- Learning from incidents was shared with staff during critical care ward meetings, quality and governance meetings and ward sister meetings. A clinical governance bulletin was sent to all heads of departments by the BMI corporate team and this covered learning from incidents in other hospitals. We saw a copy of the clinical governance bulletin on a noticeboard in the unit's nursing office. This meant that all staff had access to it. However, a minority of the staff we spoke with reported that they did not always get feedback on the incidents they reported.
- There were 55 incidents between June 2015 and June 2016 in critical care. The large majority of these were low harm incidents. Data received from the hospital showed that incidents were investigated and action taken in response to the outcome of investigations. For example, there were six patient deaths in the critical care unit (CCU) between 1 June 2015 and 26 July 2016. Five were expected deaths and one was unexpected. A root cause analysis for the unexpected death was undertaken by

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the critical care manager, the director of clinical services, and the critical care clinical lead. Lessons learned and recommendations were documented in the root cause analysis document. The learning from the root cause analysis was that some intensive therapy unit (ITU) documentation did not meet professional requirements and the recommendation was for regular audits of ITU documentation to be undertaken to address errors and inconsistencies. We requested information on the outcome of these audits from the hospital following the inspection. The Director of Clinical Services told us that regular spot audits were undertaken with staff throughout November and December on a one to one basis and that documentation from all staff was reviewed and immediate feedback given to staff. We were also informed that patient notes were inspected and checked so that individual staff factors could be addressed and that subsequent to this ITU notes were included in the hospital's monthly Patient Health Records Audits. The patient health records audit for the hospital showed 98% compliance in July 2016, 100% compliance in August 2016 and 99% compliance in September 2016.

- The majority of the incidents reported in ITU between June 2015 and June 2016 related to errors in prescribing and administering medicines. The ITU pharmacist and the ITU manager worked together to put plans in place to reduce the incidence of drug incidents. This included talking to staff to raise awareness of these incidents and discussing what went wrong in order to avoid it happening again in the future. We have requested information from the hospital about what measures were put in place to reduce prescribing and administering errors and whether these measures reduced these incidents.
- Patient mortality and morbidity were discussed in the ITU governance meetings which took place every three months. Minutes of the ITU governance meeting for February 2016 showed three patient deaths were discussed in that meeting. Minutes of the governance meeting also showed that staff discussed incidents, near misses, complaints and patient satisfaction. Minutes of these meetings were emailed to the ITU manager who would disseminate to staff not in attendance.
- From April 2015, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with understood their responsibilities under the duty of candour. This included being open and honest with patients and relatives in the event something went wrong and using the incident as a learning opportunity.
- We spoke with staff of various grades about the duty of candour and they all had a good understanding of this duty and were able to explain how it applied to their specific roles. We also saw evidence of 'being open' in the incident investigation reports we reviewed.
- The hospital reported one 'never event' between April 2015 and March 2016. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. This had not taken place in the critical care unit.
- ITU reported one incident of methicillin resistant staphylococcus (MRSA), one incident of escherichia coli (E-Coli), and two incidents of clostridium difficile (C. diff) between April 2015 and March 2016. The unit conducted a root cause analysis for the incident of C. diff which occurred in March 2016. They concluded that this patient was exposed to necessary antibiotics which are believed to have led to the C. diff being detected and hence unavoidable. The unit did not conduct a root cause analysis for the second reported incident of C. diff which occurred in September 2015. Information received following the inspection revealed that this was isolated as part of an international patient's admission screening, therefore, not acquired at the hospital. However, a subsequent stool specimen was taken later in the patient's admission and that result had to be reported as hospital acquired although it was acquired prior to admission.

- **Safety thermometer**

## Critical care

- The critical care unit collected safety thermometer data for NHS patients only. The NHS Safety Thermometer scheme is used to collect local data on specific measures related to patient harm and 'harm free' care to indicate performance in key safety areas. The unit reported no falls between June 2015 and June 2016. There was one grade two-pressure ulcer reported in March 2016. This was recorded as an incident.
- There were no reported incidents of venous thrombo-embolism (VTE), a medical condition where blood clots develop in the veins in the intensive therapy unit (ITU) and high dependency unit (HDU) between June 2015 and June 2016. A VTE risk assessment tool was included in the hospital prescription charts that were audited monthly by ITU. Compliance for patients being risk assessed for VTE was 100%. The hospital reported that there were no falls or VTEs in critical care between 1 June 2015 and 30 June 2016.
- We viewed four patient records and they demonstrated that all patients had undergone VTE assessment on admission.
- **Cleanliness, infection control and hygiene**
- The unit did not currently have an infection control lead due to a vacancy, however, the infection control lead for the hospital attended the unit every morning to advise staff on any infection control concerns.
- There was easy access to personal protective equipment (PPE) in all areas we inspected and we saw staff use PPE during their activities as required. Staff adhered to infection control precautions throughout our inspection such as cleaning hands when entering and exiting the unit and bed spaces, and wearing PPE when caring for patients. Signs were displayed on doors to side rooms and pods to indicate the presence of infection if there was any. However, there were no designated hand wash sinks in the two side rooms in ITU. This meant staff washed their hands in patient basins and this was not compliant with hand hygiene protocols.
- The clinical and non-clinical areas we visited during our inspection appeared clean and tidy. We looked at the equipment used on the units and found it to be clean. Alcohol hand gels were readily available at the entrances to the critical care unit as well as in the main unit.
- Hand hygiene audits for the critical care unit (CCU) for April, May, and June 2016 showed 100% compliance. The hand hygiene audit for January 2016 showed 90% compliance. The audits took into account staff actions such as hand washing before and after patient contact and after fluid exposure risk.
- The unit admitted patients from Kuwait and as part of the hospital's infection control policy international patients were nursed in side rooms until the results of swabs came back. This allowed staff to contain any possible infection. Prior to swabs coming back staff nursed patients with PPE and followed appropriate infection control protocols.
- Housekeeping staff cleaned the unit twice a day, once in the morning and again in the afternoon. They also attended upon request. ITU housekeeping and cleanliness was monitored by the nurse in charge on a daily basis. A housekeeping checklist was completed and reviewed weekly by the ITU manager and the Housekeeping Supervisor.
- Decontamination of equipment was carried out on the unit but sometimes an external agency was used.
- There were appropriate clinical waste bins in the unit.
- We observed information cards outside each pod space stating what the infection control protocol was for the patient inside. For example, it would state what protective equipment was required depending on what the infection risk was. Staff were aware of these and we observed them following them.
- There were no designated hand wash sinks in the two side rooms on the ward, which meant staff washed their hands in patient basins. This was not compliant with hand hygiene protocols.
- **Environment and equipment**
- There were three pods, two side rooms and a bed in the main ward area of ITU. The pods which are also referred to as infection control enclosures, are semi-permanent structures used to convert a single ward area into a series of single-occupancy spaces with a door and an integral air handling system to provide a negative airflow where required.
- The rooms in ITU were spacious and airy. There was a total of four ventilators in ITU.

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- There were three beds in the high dependency unit (HDU). There was also a dialysis machine stored in HDU.
- Emergency equipment such as resuscitation trolleys and difficult intubation trolleys were available on the unit. Staff checked resuscitation equipment daily. We saw evidence of daily checks of resuscitation equipment. The person performing the checks was responsible for making sure that all items on the check list were present in trolleys and in working order.
- A charge nurse in ITU was responsible for equipment and any issues regarding equipment. They were allocated time during their shift to deal with equipment issues.
- In HDU there was only one oxygen port per bed space. This was not in line with the latest building regulations for critical care (HBN 04-02) which suggest three to four oxygen outlets per bed space. We took into account the fact that the regulations came into force after the building of HDU at this hospital; however we asked the provider to consider the requirements set out within the building regulations for critical care (HBN 04-02) in terms of risk and patient safety.
- For HDU, there was one resuscitation trolley used between HDU and two other wards (Ward 3A and ward 3B). We asked staff if this posed any issues in an emergency where, for example, the resuscitation trolley being needed in HDU but in use in one of the other ward. We were told that an annual resuscitation services review had been undertaken by an external resuscitation practitioner, and there had been no issues identified in relation to the provision of emergency equipment for the inpatient wards and the HDU. We were told that staff followed the UK Resuscitation Council guidance that stated that defibrillation should be undertaken within three minutes. The hospital told us that the location of the resuscitation trolley on ward 3B meant that it was accessible immediately for HDU and could be taken to all rooms within wards 3A and 3B via two routes to ensure that all emergency equipment could be transferred to where it was needed within the required time frame.
- Staff reported that there were stock control issues on the unit at times. For example, they gave an example where a doctor wanted to perform a tracheostomy and did not have a fenestrated tube in date and had to have one couriered.
- **Medicines**
  - The pharmacy was open six days a week between 9am and 6pm from Monday to Friday, and 9.30am to 12.30pm on Saturdays. There was a 24-hour on-call pharmaceutical advisory service via switchboard. There was a dedicated intensive therapy unit (ITU) trained pharmacist for the critical care unit who attended the unit six days a week including on Saturdays when the pharmacist attended the morning ward round.
  - We reviewed four paper based prescription charts and saw that staff documented information on patient allergies and the risk of a patient developing blood clots. Where a medicine was not given, staff documented the reasons for that. We found that prescription charts were legible.
  - Controlled drugs were mostly stored and managed appropriately. Drugs were kept in lockable wall units and staff performed daily checks of the controlled drugs. There were no drugs stored in the high dependency unit (HDU). In ITU, medicines requiring cool storage were appropriately stored in the medicines fridge. However, records showed that there were instances where fridge temperatures went above the recommended temperatures.
  - The service had a range of medicines safety indicators to assess how they were performing, and to identify areas for improvement. These included medicines management, controlled drug audits and reconciliation audits.
  - The majority of the incidents reported in ITU between June 2015 and June 2016 related to errors in prescribing or administering medicines. The medicines management audit from October 2015 revealed that a high strength medicine known as heparin was being kept on the unit when no patients on the ward were prescribed it. The hospital policy was that these medicines should have been returned to the pharmacy. The controlled drug audit from April 2016 showed that staff on ITU were mostly compliant with the controlled drug management policy. However, it also showed that

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staff at times did not record stock properly. For example, the balance for a medication called midazolam had not been carried forward when a new page to record stock was opened.

- Medicines and fluids checked were all in date.
  - Records for checks of the fridge temperatures where some medicines were stored were not always completed fully. For example, an audit conducted by the unit in October 2015 showed that staff did not always record the action taken when the fridge or room temperature was above the temperature recommended for the storage of medicines. For example, the audit revealed that fridge temperatures were out of range between 13 and 25 October 2015 but no action taken had been recorded. Room temperatures were above the recommended temperature for the storage of medicines between 10 and 21 September 2015 and no action had been recorded. We raised this with senior staff in ITU and they told us that whenever temperatures were above the recommended temperature this would be escalated to the pharmacist who would take the appropriate action. We were told that an education programme for ITU ward staff was planned because there were concerns temperatures were not being recorded correctly.
  - Two patients whose prescription charts we looked at had been prescribed potassium, a controlled drug, and the prescription sheet was not completed fully. The prescription showed no time period over which to administer the potassium, no indication of dilution and no record of potassium level at which to trigger infusion. We highlighted this to the ITU consultant present on the day and the prescriptions were immediately rewritten. However, we were told that where potassium was prescribed staff referred to a prescription reference guide, which would inform staff how to administer potassium, the dosage, the duration and the level at which to start administering it. We found it was not clear looking at the prescription charts that staff had to refer to a separate document, which was not part of the prescription chart. We were concerned that not all staff would know to refer to a reference guide before administering potassium given that the reference guide was not placed in the prescription chart. We were told that there were plans to roll out ITU specific drug prescription charts which would make it easier to capture the details required when prescribing potassium.
  - The HDU did not have a drug store. The majority of staff we spoke with told us that in the event of an emergency in HDU, medicines would be taken from ITU. We raised concerns about whether this was safe taking into account the fact that HDU and ITU were geographically apart. Staff told us that medicines for HDU could be taken from the treatment room in the ward area next to the HDU. Staff gave inconsistent responses to where the medicines used in HDU were stored.
  - The drawer containing emergency cardiac drugs was labelled to indicate where the different drugs were located. However, the drugs were not always found in the location indicated by the label. For example the drawer should have contained pitressin and verapamil but we located verapamil in a different location. We also saw strips of pain relief medication (paracetamol and cocodamol) out of their boxes.
- **Records**
- Patient records were in paper form. The hospital had plans to move to an electronic system at the end of 2016. Records were stored securely in a locked cupboard on the unit.
  - We looked at four patient records and we found them to be legible and mostly fully completed. However, there were instances where care plans had not been completed fully. For example, staff did not always sign the three day care plan at the end of each shift. Not all signatures were present in two three day care plans we looked at.
  - Nursing staff used a three-day nursing care plan, which was filed in the patient records. Consultant records on patients were also filed in the same records. This meant that nursing, medical and other staff such as dieticians and physiotherapists could access the same information.
  - Patients' observation charts were kept by the patient's bedside and staff would input data at regular intervals. Once completed for the day it would be filed in the patient's records. The unit had recently reduced the size

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of this observation chart to make it easier to handle and store. Information governance was part of mandatory training and 99.5% of staff had completed the information governance training.

### • **Safeguarding**

- Safeguarding training was part of the hospital's mandatory training programme. In critical care, 100% of staff had completed safeguarding adults training and 95% had completed the safeguarding children training. The safeguarding lead was the director of clinical services. All staff undertook safeguarding level one training, with the ward manager undertaking level two safeguarding training and the safeguarding lead being trained to level three. The intensive therapy unit (ITU) accepted and admitted patients between the ages of 16 and 18 years old. Staff told us that patients between 16 and 18 years of age were admitted if assessed as being suitable to follow standard adult clinical pathways. However, NHS England recommends that all clinical staff should have safeguarding training for adults at level two and at level three for children up to the age 18. This meant that the training provision for safeguarding children in critical care was not in line with NHS England recommendations.
- Staff we spoke with were able to explain their understanding of and responsibilities in relation to safeguarding. Staff also knew who the safeguarding lead for the hospital was. Some members of staff did not know what level safeguarding training they had received.
- The hospital provided 'Prevent' training in line with Home Office guidance on preventing radicalisation. 99.5% of staff in HDU and ITU had completed this training.
- **Mandatory training**
- Mandatory training was made up of a combination of electronic learning, face-to-face learning, assessments, reading of policies and attendance to workshops. Staff were allocated protected time to allow them to complete training.
- The service did not have a practice educator, however, one of the senior nurses on ITU managed and

monitored mandatory training and competencies for staff in ITU. The quality and risk manager was also involved in training staff on incident reporting, patient safety principles and risk register training.

- The hospital and departmental targets for training were 90%. Completion rates for training were 100% for mental capacity act and Deprivation of Liberty Safeguards, 96% for infection control and prevention, and 100% for equality and diversity. Controlled drugs training and blood transfusion training rates were 100%. These rates were above the departmental and hospital target of 90%. However, 73% of staff had completed the advanced life support training and this was lower than the target of 90%.
- Non-clinical staff had also completed training such as basic life support and infection and prevention control.
- **Assessing and responding to patient risk**
- The hospital did not have a formal critical care outreach team. However, the hospital had a system in place whereby the ITU resident medical officer (RMO) and a senior ITU nurse reviewed and monitored deterioration in patients discharged from critical care for up to 48 hours following discharge and escalated as necessary to the on-call consultant intensivist (a physician whose speciality is critical care). A consultant intensivist was on call for the hospital 24 hours a day and undertook ITU rounds at least twice daily when on-call.
- Staff used the national early warning scores (NEWS) system to assess and monitor deterioration in patients. We saw the form used by staff to monitor deterioration in patients discharged from critical care and this form required staff to take into account the NEWS score when making a recommendation or a plan for treatment.
- Staff also used the Richmond Agitation Sedation Scale (RASS) to monitor agitation and sedation in patients. RASS is a method used to assess patients' level of sedation in the intensive care unit. Scores were recorded in patients' care plans.
- Management of sepsis was in accordance to the hospital's policy on sepsis recognition and management. Staff told us that they followed the United Kingdom sepsis trust guidance on the initial

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management of septic patients. The “sepsis six” approach was used. This is the name given to a bundle of medical therapies designed to reduce mortality in patients with sepsis.

## • Nursing staffing

- BMI The London Independent Hospital used the BMI nursing dependency and skill mix tool to plan the nursing skill mix required against predicted patient activity and acuity. This tool was used in critical care. It incorporated levels of care from zero to three with an allocated number of hours per patient per level. This tool was used up to seven days in advance to provide an overview and allow rotas to be managed. It was also reviewed on a daily basis to confirm staffing requirements for the following 24 hours. The tool calculated the number of hours that were required on the intensive therapy unit (ITU) and the high dependency unit (HDU) and when the rota data was entered managers could see if the amount of hours required were the amount of hours available, and if there was a mismatch they could arrange additional staffing through changing staff rotas, or sourcing bank or agency staff. The tool also indicated skill mix to ensure that it was appropriate, with a target to 64% qualified nursing staff and 36% health care assistants in ward areas.
- Nursing staffing levels met the requirements of the Royal College of Nursing (RCN). A nurse to patient ratio of 1:1 was maintained for patients in the ITU and a nurse to patient ratio of 1:2 was maintained in the HDU. Staff told us that because the ITU and the HDU were geographically apart there would always be at least two staff in HDU even if there was one patient. This allowed cover when one member of staff left the unit on a break or for an emergency.
- The unit used agency and bank staff. Data provided by the hospital showed that use of bank and agency in the critical care unit had reduced in the 12 months prior to our inspection. For example, in June 2015 22% of nurses came from an agency and 6% were bank staff. In October 2015, there was 51% of agency staff used and 9% bank staff used in ITU. However, in May 2016, 4% of staff used in ITU were agency and 12% were bank. In June 2016, 5% of staff were agency and 11% were bank. These figures did not include medical staff.

- The hospital’s induction policy included the induction of bank and agency staff. Agency staff underwent an induction to the unit and senior nurses told us that where possible they used the same agency staff that had been to the unit before. Staff including agency and bank received a 90-day induction handbook upon commencing work with the unit and hospital.

- There was one charge nurse vacancy on ITU at the time of our inspection. However, management told us that the post had been recruited to with the new charge nurse expected to start in October 2016.

## • Medical staffing

- Six consultants worked on call in the hospital not just in critical care.
- Consultants were required to live within a 30 minute journey time of the hospital and to be available to provide advice to Resident Medical Officers (RMOs) when they had patients in the hospital. On call consultants were expected to attend regular daily ward within a reasonable timescale based on living within 30 minute of the hospital. Staff informed us that if an on call consultant was not available or was delayed in attending the hospital following a call this would be reported as an incident and investigated as such.
- Consultants assessed all patients within 12 hours of admission. This did not include cardiac patients who were discussed with the critical care consultant on call. A critical care consultant attended ward round everyday between 9am and 11am.
- The hospital employed one permanent RMO and five additional RMOs on long term contracts via a healthcare agency. There was onsite critical care RMO cover 24 hours a day, seven days a week. They attended the morning ward round with the ITU consultant.
- RMOs worked two to five day rotas. The hospital had implemented a system where nursing staff on the night duty would prepare anything that required the RMO’s attention to be ready for them when they attended to minimise any disturbance overnight to urgent needs only.
- The ITU manager was in contact with the RMO’s on a daily basis and if the RMO had a disturbed night and required rest, they would contact the agency to advise them and cover would be arranged. This allowed the RMO to rest. The permanently employed RMO followed

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BMI Healthcare's mandatory training programme. Training for the RMOs recruited via an agency was provided by the agency in accordance with the content of their contract with BMI Healthcare and the training requirements stipulated. The agency's mandatory training programme included teamwork, data protection, health and safety, equality and diversity, food hygiene and safety, mental capacity, personal safety, safeguarding adults, first aid essentials, fire safety, child protection, infection prevention and control, clinical medicine management, blood taking and transfusion, moving and handling, Caldecott principles, complaint handling and advanced life support. Prior to medical staff commencing employment at BMI The London Independent Hospital, the healthcare agency provided the hospital with a copy of the RMO's file and training record for approval.

- An ITU RMO and senior ITU nurse provided a service similar to that which would normally be undertaken by an outreach team. They monitored and reviewed patients discharged from ITU and HDU for up to 48 hours following discharge. The team assisted patients with their care and treatment and escalated to the on-call critical care consultant if it was necessary.
- **Major incident awareness and training**
- Staff took part in training drills where they practiced the evacuation of patients in the event of a fire. All staff received fire safety training as part of their mandatory training programme.
- The hospital's business continuity plan set out the major incident plan for the hospital. The policy covered a variety of scenarios for example loss of premises, loss of staff and loss of water supply. There was evidence that potential risk had been taken into account in the provision of patient care.

## Are critical care services effective?

Good 

We rated effective as good because:

- Staff gave care and treatment in line with national and international guidance and using established tools and systems. This included guidance from the National Institute of Health and Care Excellence (NICE) and the United Kingdom Sepsis Trust (UKST).
- The number of nurses with a post-registration qualification in intensive care medicine exceeded the minimum requirement of the Royal College of Nursing.
- Staff demonstrated a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards.

However,

- Patients were not routinely screened for delirium on admission and this was not in line with Faculty of Intensive Care Medicine (FCIM) guidance.

### Evidence-based care and treatment

- The critical care unit contributed to the Intensive Care National Audit and Research Centre (ICNARC) database. Submission commenced in January 2016 and the unit was expecting its first data report in September 2016. Following our inspection, we requested information on the data submitted to ICNARC to date. The information we received from the hospital shows that the data submitted was for the period 4 January to 31 March 2016. The critical care unit provided information related to the number of patients admitted to critical care during that period (86), patients' admission and discharge dates, status at discharge, whether planned admission was planned or was an unplanned transfer from other departments/units, whether there were any critical care visits post discharge, whether there had been any renal or respiratory support during the admission, and what level of care a patient received in critical care unit amongst other things.
- Patient records showed that patients had access to physiotherapy which was in line with National Institute for Health and Care Excellence (NICE) guidance for acute and critical care and intensive care society standards.
- Critical care bundles were part of the three-day care plan completed for every patient in critical care. Staff performed daily checks of care bundles and once completed this would be indicated in the care bundle prescription chart. Care bundle audits were completed on a monthly basis. Minutes of the ITU governance

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meeting in May 2016 revealed that care bundle audits showed overall good compliance in relation to peripheral cannulae, central venous catheter (CVC) and urinary catheter.

- Staff assessed patients on admission using the Glasgow Coma Scale (GCS). GCS is an objective assessment of impaired consciousness and coma which is based on eye opening and verbal and motor responsiveness. Findings were recorded in the patient's care plan.
- Delirium was not screened on admission and this was not in line with the guidelines for the Provision of Intensive Care Services, 2015 which states that patients must be screened for delirium and that this should be done with a standardised assessment tool and use a multi-professional approach. The service did not have a dedicated assessment for delirium.
- Staff screened patients for delirium but this was not routinely done. The service did not have delirium management guidance and it was up to the consultants how delirium was managed in patients.
- The critical care team worked with physiotherapists to meet rehabilitation needs in line with National Institute of Health and Care Excellence (NICE) clinical guidance 83.
- The service followed the United Kingdom sepsis trust guidance on the initial management of septic patients and used the "sepsis six" approach as recommended by the guidance.

## Pain relief

- A bank nurse who was not based on the unit covered ITU to provide pain management support. In the absence of the nurse, an ITU consultant and hospital anaesthetists provided pain management support.
- Pain management was audited locally each month with a more comprehensive audit being undertaken six monthly.
- The patient satisfaction survey for the hospital showed that 85 % of NHS patients were satisfied that staff did all they could to help control their pain. The figure for self-paying patients was 92%. Overall, 94% of patients were satisfied that staff did all they could to control their pain. This figure was similar to what the survey found in other BMI hospitals for the same question.

## Nutrition and hydration

- A dietician attended the unit to assess patients' needs. This was either following a request by critical care staff or routinely. Staff told us that in the absence of a dietician there was a protocol in place which allowed them to start a liquid diet until a dietician attended to review and make a plan. We saw evidence of dietician input in the patient notes
- Nutritional risk scores were updated and recorded appropriately on the patient's records.

## Patient outcomes

- The hospital collected data on incidents, near misses, complaints and patient satisfaction on a monthly basis. This information was compared against other BMI hospitals in order to measure performance. However, the service had not previously contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could not be benchmarked against other critical care units outside BMI nationwide. Data submission to ICNARC had begun in January 2016. We have requested information on the data submitted to ICNARC so far and are awaiting the hospital's response.
- There were no unplanned readmissions on ITU or HDU between June 2015 and June 2016.

## Competent staff

- There was no formal educator on the critical care unit. Two senior nurses assisted nursing staff in training and teaching and assessed the competencies of staff working on the unit. Staff were assessed on competencies based on the national competency framework for critical care. Any areas of improvement noted were recorded and an action plan was put in place and reviewed at regular intervals.
- We saw evidence of competency checks on the use of equipment such as staff ability to assist in carrying out intubation, inserting an intravenous line (IV) and IV drug administration.
- The Faculty of Intensive Care Medicine Core Standards for Intensive Care Units (FICM) recommends that 50% of critical care nurses should be in possession of a post registration award in critical care nursing. On the critical

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care unit, 60% of staff had a post registration critical care qualification. 12 staff out of 20 staff had this qualification. This meant that the unit was in line with the recommendations of the FICM.

- Where agency medical staff were used, a consultant on the unit would check their CVs to check for competencies before getting back to the agency to confirm their suitability to work on the unit.
- Staff were appraised yearly with the exception of new staff who would be appraised at three and six month intervals in addition to the yearly appraisal. RMOs had previously been appraised by ITU consultants but arrangements at the time of our inspection were that they were appraised externally. 88% of nursing staff in critical care had been appraised, 9% of staff had pending appraisals and 3% of staff were on maternity leave.

## Multidisciplinary working

- Doctors worked collaboratively with nursing and physiotherapy staff to plan and implement treatment plans for patients. Handovers were well attended and reflected the multidisciplinary nature of the team.
- A multidisciplinary team meeting took place every week to discuss treatment plans for patients as well as any issues on the unit.
- A dietician worked collaboratively with the intensive treatment unit (ITU) but was not based at the hospital site. The service had a pharmacist dedicated to ITU.
- There was evidence of good working relationships between consultants and junior doctors. For example, an RMO would usually write the initial treatment plan for a patient and the consultant would approve or add to it.

## Seven-day services

- The pharmacy was open six days a week between 9am and 6pm from Monday to Friday, and 9.30am to 12.30pm on Saturdays. There was a 24 hour on-call pharmaceutical advisory service via switchboard. There was a dedicated intensive treatment unit (ITU) trained pharmacist for the critical care unit.
- Clinical departments provided an on-call service out of hours, including cardiology, operating theatres, physiotherapy and radiography.

- The executive director and director of clinical services shared an on-call director rota. Consultant and junior doctor cover was provided 24-hours, seven days a week.

## Access to information

- Patient records were in paper form. Both medical and nursing notes were filed in the same file. This meant that all relevant information was easily accessible. Any referrals and assessments could be located in the patient records.
- Staff maintained an observation record which they completed throughout the shift. Once completed it would be folded and placed in the patient's records where other multidisciplinary staff could access it.
- Staff had access to computers where they could access the hospital website and intranet pages. They could also access the shared drive where standardised documents were saved.

## Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- Staff displayed a good knowledge of the Mental Capacity Act 2005 including the application of Deprivation of Liberty Safeguards (DOLS). There were key cards in the nursing office which staff could refer to for summaries of DOLS.
- We saw evidence of completion of mental capacity assessments in the records we looked at.
- Staff had received training on consent as part of their mandatory training. In ITU 100% of staff had completed the Mental Capacity Act and Deprivation of Liberty Safeguards training

## Are critical care services caring?

Good 

We rated caring as good because:

- Staff provided a caring, kind, and compassionate service to patients and their relatives.
- Feedback from patients was positive.
- We observed staff treating patients with respect and maintaining patients' privacy and dignity.
- Staff provided emotional support to patients.

# Critical care

## Compassionate care

- Patients told us that staff were caring and treated them with respect and dignity. We observed a member of staff joking with a patient who spoke the same language as him. The patient told us that this made him feel at ease because he did not speak English. The hospital's international team provided an Arabic speaking interpreter which enabled us to communicate with this patient.
- We also observed staff care for patients who were not well enough to speak and they maintained the patients' privacy and dignity.
- We looked at the results of the patient satisfaction survey for the hospital. 99.8% said they were treated with respect and dignity. This result was similar to other BMI hospital survey results for the same question.
- The survey showed that for the three months ending April 2016, 97% of patients said that they found hospital staff to talk to about worries or fears. 97% of patients said that they were likely to recommend the hospital to friends and family if they needed similar care or treatment. In comparison to the other BMI hospitals, the figure was consistent with the results for the same question.

## Understanding and involvement of patients and those close to them

- Staff introduced themselves and their role to patients who were awake in critical care. Patients told us that they were kept informed of the treatment plans and staff explained procedures before they carried them out.
- There was evidence of discussions of patient care with those close to them in the patient records.

## Emotional support

- Staff told us that they regularly assessed the patient's physical and emotional welfare and made referrals to the appropriate professionals.
- A multi-faith prayer room was located on the ground floor of the hospital.
- The service did not provide bereavement or counselling services. Staff could arrange chaplaincy services for patients by contacting the chaplaincy service at the Royal London Hospital.

## Are critical care services responsive?

Good 

We rated responsive as good because:

- Services were tailored to meet the needs of individual people and there was flexibility in the provision of care.
- Staff demonstrated a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met their needs and promoted equality.
- The critical care unit had an occupancy rate which did not exceed the 70% occupancy rate recommended by the Royal College of Anaesthetists.
- Cancellation of pre planned admissions was low and there was a low number of out of hours' transfers. The unit had no delayed discharges between June 2015 and June 2016.
- Support was available for international patients from Kuwait. This included translation support and liaison with the Kuwaiti embassy. The hospital had an international team working closely with the intensive therapy unit (ITU) in the admission and discharge of patients.
- The food menu was comprehensive and varied according to different cultural requirements and was available in Arabic to cater for Arabic speaking patients.
- There were no delayed discharges, no unplanned readmissions and one out of hours transfer in ITU and the high dependency unit (HDU) between June 2015 and June 2016.

However,

- A "please tell us" leaflet was available for patients and relatives; however, information on how to make a complaint was not obvious within the leaflet. Information was set out under "after you leave hospital". The leaflet stated that to make a complaint the person making the complaint had to write to the Executive Director but there was no address stated. The only address on the leaflet was that for a different BMI

# Critical care

Healthcare organisation. Furthermore, information on how to complain was only available in English even though the unit admitted a significant number of Arabic speaking patients.

- There was no visitors' waiting room for ITU or HDU but there were areas where visitors could sit outside the unit as well as at the hospital's reception.

## Service planning and delivery to meet the needs of local people

- Between 1 June 2015 and 30 June 2016 were 28 direct admissions from Kuwait to ITU. An international team based at the hospital liaised with the Kuwaiti embassy to arrange admissions and discharges. The international office provided interpreters when needed by the unit.
- There were 1,083 level two critical care bed days available in the hospital from April 2015 to March 2016. Of these, 990 level two critical care bed days were used. For level three bed days 574 of the 2196 available bed days were used during the same period.
- The service provided care to insured, self-paying and NHS patients. Between June 2015 and June 2016' 20.4% of critical care patients were insured, 1% self payed, 17.2% were NHS patients and 61.4% were international patients whose treatment was embassy funded.

## Meeting people's individual needs

- Visiting times were flexible and visitors could arrange to visit at a time outside the normal hours.
- The food menu was varied and was available in Arabic to cater for the Arabic speaking patients. However, patient information leaflets were only available in English.
- Interpreter services were readily available from the international office.
- The hospital did not have an outreach team however, an ITU RMO and a senior ITU nurse assessed and monitored patients from ITU for up to 48 hours following discharge. This meant that they were able to monitor patients for deterioration and refer back to the critical care unit if that was required. Cardiac surgery patients were seen once a day for seven days usually on the

night and international patients were seen once a day for three days following their discharge from ITU and any concerns were escalated to the responsible consultant.

- The unit did not have a follow up clinic where patients could reflect upon their critical care experience. This was not in line with Guidelines for the Provision of Intensive Care Services, 2015 which state that patients discharged from ITU must have access to an ITU follow up clinic.

## Access and flow

- The occupancy rate for ITU and HDU was 57% for June 2016. This was an increase compared to June 2015 where the occupancy rate was 44%. These rates did not go above the 70% occupancy rate recommended by The Royal College of Anaesthetists.
- There was one out of hours discharge and no delayed discharges in ITU and HDU between June 2015 and June 2016. There were no unplanned readmissions to ITU or HDU during the same period.
- Two elective surgical procedures were cancelled between June 2015 and June 2016 because of a lack of HDU beds. Staff told us that in both cases this was due to a lack of communication between consultants in the surgery department and the critical care unit. Consultants requested post-operative observation in HDU on the day that the patients were admitted without checking whether critical care would have sufficient capacity to accommodate the additional admissions.
- There were 1,083 level two critical care bed days available in the hospital from April 2015 to March 2016. A total of 990 level two critical care bed days were used, giving an occupancy rate of 91% for that period. There were 2,196 level three critical care bed days available in the hospital from April 2015 to March 2016). 574 level three critical care bed days were used, giving an occupancy rate of 26% for that period.

## Learning from complaints and concerns

- There were no formal complaints for ITU between June 2015 and June 2016. Staff showed an understanding of the hospital's complaints procedure.
- The investigation of complaints was the responsibility of the quality and risk manager and the director of clinical

# Critical care

services. Staff told us that if a formal complaint was made, it would be logged onto an electronic system and investigated before a decision about whether to uphold it was made.

- Formal and verbal patient complaints and concerns were discussed as a standard agenda item in ward and governance meetings for ITU. Minutes of ITU governance meetings showed that complaints were an agenda item in the meetings.

## Are critical care services well-led?

Good 

The service was led by an intensive therapy unit (ITU) manager who also managed the high dependency unit (HDU). There were five ITU charge nurses in ITU. We rated well led as good because:

- The leadership, management and governance of the service assured the delivery of high-quality person-centred care, supported learning and innovation, and promoted an open and fair culture.
- The leadership team had a clear vision and strategy and staff were aware of future plans.
- There was a strong culture of teamwork and staff we spoke with felt valued.
- A culture of openness and transparency was embedded in the unit and evident in staff we spoke with.

However,

- The unit did not have a critical care lead to represent leadership above the ITU manager.

### Vision and strategy for this service

- Staff told us that the vision for the service was to drive quality forward and have a safe organisation which maintained patient safety.
- Staff knew how their work contributed to the wider vision of organisation.
- There were no plans to increase the capacity of intensive therapy unit (ITU) or high dependency unit (HDU). Staff told us that there were plans to relocate the ITU within the hospital but this was not in the immediate future.

### Governance, risk management and quality measurement

- The unit had clear governance structures. The ITU manager led a team of charge nurses, senior nurses, junior nurses and health care assistants. There was no critical care lead at the hospital and the ITU manager reported to the director of clinical services.
- Above ward manager level, the management structure consisted of the director of clinical services and the executive director.
- Consultants were managed and supervised in the organisations they worked for outside the BMI hospital. The permanently employed resident medical officer (RMO) reported to the director of clinical services if they had any concerns. The RMOs employed via the external agency were supervised and managed by arrangements made by that agency.
- Governance meetings for critical care took place every three months. These were attended by the manager of critical care, ITU consultant intensivists, the director of clinical services, quality and risk manager, infection control lead, ITU pharmacist and the physiotherapy manager. Agenda items included incidents, risk register, medicines management and infection control.
- A clinical governance and quality risk bulletin was issued to ward managers to disseminate to staff at ward level. The bulletin contained lessons learnt across BMI Healthcare in relation to incidents as well as other issues such as medicines management.
- There were five risks on the risk register for ITU and HDU. The risks were identified as being the presence of a noisy dialysis machine in HDU affecting the comfort of patients, two dialysis points not working in ITU, Pseudomonas (a type of bacteria) being found in the sink in ITU, the lack of negative pressure isolation on ITU and the location of the dialysis unit away from HDU and ITU. Controls were in place to mitigate risks. For example, the sink in ITU was fitted with a filter in order to make it safe and compliant with infection control practices. There was ongoing monitoring by the infection control lead of the hospital and the ITU manager. Hand washing was also supplemented by hand gel.Cc

# Critical care

- Staff discussed the risk register at ITU governance meetings and reviewed the risks to reflect the appropriate risk rating of the location of the dialysis service.

## Leadership of service

- ITU and HDU were managed by the same manager who was supported by the director of clinical services and the executive director. Leadership was stable at the time of our inspection and there were no senior management vacancies.
- Staff reported that leadership was very visible and approachable.
- A supernumerary shift coordinator who was usually a charge nurse was allocated to each nursing shift to provide immediate leadership and facilitate service delivery on the unit.
- The nursing and medical clinical leadership teams worked closely together to plan and deliver a safe and responsive critical care service..
- Resident medical officers said they were well supported by their consultants and other senior colleagues. The Medical Advisory Committee (MAC) approved new practicing privileges.

## Culture within the service

- Staff we spoke with told us that there was a no blame culture. Staff felt valued and respected. We found that honesty was embedded in the unit because it was a consistent theme amongst all staff we spoke with.
- There was evidence of staff and teams working collaboratively to deliver good quality of care. For example, we observed this in a ward round we attended during the inspection.
- Staff at all levels were proud of the service provided on the critical care unit and felt their work was recognised by the leadership team.

## Public and Staff engagement

- Staff distributed a hospital survey form to patients and relatives in order to gather their views and experiences. Results would be discussed in the ITU meetings and

action taken. For example in the May 2016 ITU meeting staff discussed that a patient had made an informal complaint about noise levels on the unit and the plan was for a member of staff to speak to the patient and discuss how the issue would be addressed.

- A patient experience steering group met monthly to discuss feedback received for the hospital including for critical care.
- The international office and the unit worked closely together and this facilitated more public and staff engagement. For example in February 2016 representatives from the Kuwaiti Embassy visited the hospital and spent time in ITU talking to staff and patients' relatives.
- Staff engagement was mainly via a variety of meetings such as the weekly ward meetings, monthly quality and monthly governance meetings and the clinical governance and quality and risk bulletin
- Staff felt involved and listened to when they brought new ideas to the leadership team. For example, the bedside observation chart had recently been made smaller as a result of staff initiation to the leadership. An external agency was responsible for recruiting RMOs also obtained feedback from RMOs throughout the year about their experience at the hospital. Feedback was shared with the director of clinical services. RMOs also met with the director of clinical services from the evaluation of their experience and workload

## Innovation, improvement and sustainability

- The critical care team were involved in a steering group where they were involved in developing innovative ways to improve . For example in the ITU meeting in May 2016 staff discussed the creation of an ITU specific drug chart.
- Staff told us that the ITU observation chart had been reduced to half its previous size and staff on the unit had come up with that idea. A smaller observation chart meant that it was easier to use and store.
- There were no plans to expand the critical care unit as the unit mostly coped with demand. Staff told us that there were plans to relocate ITU within the hospital but this was not in the immediate future.

# Outpatients and diagnostic imaging

Safe	Good 
Effective	Not sufficient evidence to rate 
Caring	Good 
Responsive	Good 
Well-led	Good 

## Information about the service

The outpatients department at BMI The London Independent Hospital provides a wide range of speciality appointments including cardiology, orthopaedics, gastroenterology and ear nose and throat. The diagnostic imaging service provides access to CT scan, plain film imaging, digital mammography, ultrasound, fluoroscopy and nuclear medicine. MRI is also available on site, however this service is offered by a different provider. Between April 2015 and March 2016, the outpatients department provided 18,284 new patient appointments and 23,660 follow up appointments. The majority of patients seen (96%) were between the ages of 18 to 74 years.

The outpatients department is open between 8am and 8pm weekdays and Saturdays 8am to 2pm. Diagnostic imaging services also operate from 8am to 8pm weekdays and Saturdays 8am to 2pm.

The outpatients department has 21 general consulting rooms and a treatment room.

We visited the outpatients service at BMI The London Independent for two announced inspection days. During our inspection we inspected the outpatients department, physiotherapy department and the diagnostic imaging department and spoke with 11 members of staff including nurses, radiographers, health care assistants and ancillary staff. We also spoke with five patients. We reviewed information provided by the hospital, 14 patient records and checked many items of clinical and non-clinical equipment.

## Summary of findings

Overall, we rated this service as good. We gave this rating because;

- Medicines were stored securely and well managed.
- Staff had a good understanding of how to report incidents and learning from incidents was shared at departmental level.
- Staff undertook appropriate mandatory training for their role and support was available for non-mandatory training.
- Patients were protected from the risk of abuse and avoidable harm.
- Hospital infection prevention and control practices were followed and these were regularly monitored by an infection control lead, to reduce the risk of spread of infections.
- Equipment was well maintained and tested annually or in accordance with manufacturers' guidelines.
- Staffing levels and the skill mix of staff was appropriate for both the outpatients department and diagnostic imaging services. Work pressures were manageable as there has been ongoing recruitment with posts being filled. Bank staff are used when the department gets busy and some bank staff were made permanent. Trained staff in basic life support were available to respond appropriately in an emergency situation.

We rated this service as good for safe because;

# Outpatients and diagnostic imaging

- Staff were appropriately trained in relevant areas and competency assessed. Staff mandatory training was up-to-date.
- Medicine was stored correctly and locked away.
- Staff were aware of how to cope with a deteriorating patient.
- Staff were aware of the procedures of incident reporting.
- Staff had safeguarding awareness.
- Staff were aware of duty of candour.
- Appropriate machinery/equipment checks were in place.
- Infection control was appropriately managed and checks were in place.

We inspected the effective domain but did not rate it. We found;

- Staff followed national and local guidance when providing care and treatment for example, guidance relating to diagnostic imaging to ensure safe practice.
- Staff were supported in their role through a corporate performance review process. Staff were encouraged to participate in training and development to enable them to deliver good quality care.
- Patients' pain needs were met appropriately during a procedure or investigation.
- The consent process for patients was well documented and staff demonstrated an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Clinics were available six days a week, Monday to Saturday.

We rated this service good for caring because;

- During the inspection we observed care being provided compassionately by caring staff.
- Patients' feedback through interviews were entirely positive; they commended the professionalism and kindness of staff. Patients praised all aspects of the service with comments such as "overwhelmed with

the service here", "friendly", "efficient", "caring" and "good intentions and good explanation". Patients were treated with dignity and respect. They felt they were fully involved in planning their care and treatment. Staff listened to and responded to patients' questions appropriately.

- Chaperone signs were clearly displayed in waiting areas and in clinical rooms.

We rated this service as good for responsive because;

- Services were planned and delivered in a way which met the needs of patients. Access to appointments was timely. Clinics were held on weekdays into the evening and Saturday mornings to suit patients' preferences.
- Interpretation services were available, however, staff could not recall the need to access this service for the patients they cared for.
- Patients were aware of how to provide feedback and complain about the service if needed.
- Complaints were investigated and changes and improvements made where necessary.

We rated this service as good for well led because;

- Effective governance and risk management systems were in place. Staff were well informed about issues relating to their department. They had opportunities to raise ideas and concerns when needed, which they were confident would be addressed by their managers.
- Service managers were committed to provide high quality care and facilities for patients.
- Local and senior managers were visible and approachable to all staff. There was an open and supportive learning culture.

# Outpatients and diagnostic imaging

## Are outpatients and diagnostic imaging services safe?

Good 

We rated this service as good for safe because;

- Medicines were stored securely and well managed.
- Patients were protected from the risk of abuse and avoidable harm. Staff had a good understanding of how to report incidents and learning from incidents was shared at departmental level.
- Staff had undertaken appropriate mandatory training for their role, were up-to-date with training and were well supported to undertake training.
- Clinical areas and waiting rooms were all visibly clean and tidy.
- Hospital infection prevention and control practices were followed and these were regularly monitored by the infection control lead, to reduce the risk of spreading of infections.
- Appropriate equipment was available for patient procedures and tests. Equipment was well maintained and tested annually or in accordance with manufacturers' guidelines.
- Staffing levels and the skill mix of staff was appropriate for both the outpatients department and diagnostic imaging service. Agency staff were not used, but, at busy periods bank staff were occasionally employed to provide cover.
- Patient records were available prior to a patient being seen.
- Staff understood their responsibilities under duty of candour.

However;

- The sluice room was not fit for purpose. The room was very hot (27 degrees celcius) therefore nothing that required storage below 25 degrees celcius could be stored there. There was no immediate action plan to rectify this.
- There were issues with the general fabric of the building. The outpatients department was carpeted, including treatment rooms. Flooring in clinical areas should be seamless and smooth, slip-resistant, easily cleaned and appropriately wear-resistant. The stairwells were old

and were in need of upgrading and the doors on the wards were not fire doors. We raised this as an issue that needed urgent attention. These issues were identified on the renovation plan shown to us by the senior management team.

- The health and safety audits for May and June 2016 recorded that, 'power tools and electrical tools in good working order, free from splits, cracks and deformities' was rated poor. We did not see an action plan to rectify this.

### Incidents

- Within the outpatients and diagnostic imaging service there were 45 clinical incidents in the reporting period April 2015 to March 2016. During the reported period there were 16 non-clinical incidents.
- Staff told us they were aware of their responsibility to report incidents. Staff reported incidents on a paper incident report form which was submitted to the hospital quality coordinator for entry onto the corporate electronic reporting system.
- All incidents were reviewed by the director of clinical services. Investigations took place to identify underlying causes. Learning was shared on the staff notice board and in monthly staff meetings. Staff informed that changes in practice were made if necessary. They said that incident reporting had been poor in the past but had improved in the last 18 months with the arrival of new management.
- Staff told us incidents that had occurred within the department were discussed and brought to the attention of staff as learning points.
- In the diagnostic imaging department, there were clear processes for reporting incidents regarding the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). We were not informed of any incidents reported.
- Minutes from the Radiation Protection Committee who met annually showed that the committee discussed any equipment testing issues and any incidents in nuclear medicine.
- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency, and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents.' Staff were aware of the principles of duty of candour. In the diagnostic imaging department staff discussed duty of candour at staff meetings. The diagnostic imaging manager recently dealt with an issue

# Outpatients and diagnostic imaging

regarding duty of candour. The manager met the patient, explained the mistake to the patient, apologised and offered support to the patient. Staff in outpatients physiotherapy told us that all staff in the department had undertaken duty of candour online training.

## Cleanliness, infection control and hygiene

- All outpatients and diagnostic imaging waiting areas and clinical rooms were visibly clean and tidy. Cleaning schedules were on display in each area which were signed as checked on a daily basis.
- A daily task checklist was also in place which was completed each morning at the early morning huddle and signed by the senior nurse.
- Hand sanitiser points were available to encourage good hand hygiene practice.
- The outpatients treatment room had a handwashing sink with a 'five moments of hand hygiene' notice. The X-ray room had separate sinks, one for equipment and one for handwashing only. We saw handwashing and health and safety audits which were all rated satisfactory.
- Personal protective equipment (PPE), such as gloves and aprons, were readily available for staff in all clinical areas. We observed staff used PPE appropriately. PPE was disposed of safely and we saw radiation protection audits rated satisfactory.
- Clean equipment was labelled to indicate equipment was ready for use. There was a yearly contract for companies to check equipment. An outpatients asset register in this regard was seen.
- Stickers were placed on equipment detailing equipment checks, all equipment checks were up-to-date and we saw a diary with dates of all equipment checks.
- The nuclear medicine department had a separate toilet for patients who emitted radiation following a procedure. Patients were tested for radiation before they were able to leave.
- All the infection control audits we saw were undertaken regularly, were up-to-date and rated satisfactory.
- There was a 0% MRSA rate (April 2015 to March 2016) in the outpatients department.

## Environment and equipment

- We observed equipment was labelled as serviced and electrical appliance tested. Staff told us they were clear on the procedure to follow if they identified faulty or broken equipment and who to report it to.
- The diagnostic imaging department had a diary to keep track of equipment checks and the diagnostic imaging manager undertook regular audits of the equipment to ensure that equipment is checked at the appropriate time.
- All equipment we saw had been appropriately checked. There was a maintenance service contract in place to check equipment within radiology annually. Staff told us an action plan is devised if equipment requires any work.
- Some equipment which falls under IRMER was checked three or four times a year. This is appropriate under the Health and Safety Executive guidelines IRR99 Regulation 32 (3,4).
- Staff told us radiation supervisors reported any issues to the Radiation Protection Committee who were contracted by the hospital and met once a year. The meeting minutes indicated that the committee review equipment testing issues, including recalibration and any incidents in nuclear medicine .
- Staff told us nursing and housekeeping staff safely managed clinical waste and non-clinical waste to ensure segregation and safe disposal.
- There was clear radiation hazard signage outside the x-ray rooms for staff and patients.
- We saw resuscitation equipment was maintained, in order and ready for use in an emergency. Staff told us trolleys were checked daily in outpatients and diagnostic imaging. Additional weekly checks were also completed. Records were kept to demonstrate that checks had been completed.
- Defibrillator printouts were checked daily. We saw trolleys were secured with tamper evident seal and information sheets were attached to the trolleys regarding all types of emergencies.
- We inspected various rooms within the outpatients and diagnostic imaging departments. We saw these rooms were tidy, sharps bins were signed and dated and stock was dated and labelled. Staff told us fridge temperatures were checked daily and the pharmacist was notified of any deviations in temperature. All rooms had an emergency call button.

# Outpatients and diagnostic imaging

- We saw the outpatients areas were well signposted and corridors were free from clutter. Rooms were key pad entry or locked if not in use.
- We saw the physiotherapy gym was well-equipped and equipment safely stored either on shelves or secured. Staff told us there were always two physiotherapists in the gym during patient treatments.
- The carpeted floor and the air conditioning was not appropriate for treatment rooms. Staff told us as each area is refurbished this will be upgraded.
- We saw there were no separate sinks in patient rooms for washing equipment and hand washing which could cause patient infection and a risk to infection prevention and control.

## Medicines

- We saw medicines were stored safely. All medicines cupboards were locked and the keys held by the lead nurse on duty. Medicines fridges were locked and staff told us temperatures were checked daily and logged, to ensure medicines were stored at the correct temperature. Staff were aware that they needed to inform the pharmacist if the temperature was incorrect.
- In outpatients, prescription pads were stored in a locked cupboard, the office was accessed securely via a door key pad.
- In the diagnostic imaging department staff told us medicines and prescription pads were stored in locked cupboards, only accessible to authorised staff.
- We saw medicines were well organised and those checked were in date.

## Records

- We saw that medical records and personal identifiable information were stored securely and only accessible to authorised staff. Records were kept on site at all times.
- Staff told us outpatients consultations within the hospital were consultant-led. All patients attending outpatients had an accompanying GP referral letter or their current medical records from a previous appointment or admission.
- Consultants retrieved their own patient records for patients who were self-funding or covered by medical insurance. Records are also kept on site in the medical records department.

- Patient notes required for the next day were transferred to the outpatients reception the night before. Administration staff in the outpatients department could call the secretary for private patients to acquire last letters if required.
- Staff told us records were obtained prior to clinic sessions. Records were tracked when removed from the medical records department. Data from referral forms and coding sheets were available for NHS funded patients and could be copied in the absence of patient records. All imaging, histology, microbiology and blood results were available on IT systems and could be printed for consultants.

## Safeguarding

- Safeguarding training for vulnerable adults was mandatory for all staff. All the staff we spoke with, were aware when to raise a concern and the process they should follow. We saw records that compliance with safeguarding training was 100% in diagnostic imaging.
- Staff were required to complete safeguarding training appropriate to their role. Staff told us all staff completed safeguarding awareness training, senior staff completed level 2 safeguarding training and the safeguarding lead was trained to level 3 in line with BMI policy.
- Staff were aware of who the hospital safeguarding lead was. Safeguarding information and contact numbers were available in the BMI Safeguarding Adults policy.
- Information regarding patients living with dementia and those without mental capacity was available to staff prior to the clinic. Support mechanisms such as appropriately explaining matters and ensuring they were comfortable were put in place.

## Mandatory training

- The BMI mandatory training matrix included training requirements for staff dependent on their role. For example, information security, moving and handling, infection prevention and control and sepsis was applicable to all staff. We saw records of staff mandatory training. The target of 95% for staff training had been met. Most training was done by e-learning, in some cases followed by workshops and assessments. Staff completed their training during their work time and all staff we spoke with said they were up to date with their training requirements and were encouraged to undertake training.

# Outpatients and diagnostic imaging

- Bank staff completed mandatory training in their main workplace, which was checked by BMI.
- The designated Radiation Protection Supervisor (RPS) within the diagnostic imaging department received radiation protection training. We saw up-to-date records which showed good compliance for radiation protection updates such as staff completing training on time.
- The managers monitored overall mandatory training uptake for all staff. All training was recorded online. We saw records within diagnostic imaging regarding when training should be reviewed and saw that overall the 95% target for completion of mandatory training was being met.

## Assessing and responding to patient risk

- Staff in outpatients were clear about how to respond to patients who became unwell and how to obtain additional help from colleagues in caring for a deteriorating patient. Patients who became unwell could be admitted or transferred to the local acute NHS Trust by contacting the emergency services (999).
- All radiographers and registered nurses in the outpatients and diagnostic imaging departments had completed training in immediate life support, with all other staff trained in basic life support.
- There had been 115 outpatient attendances of 16 and 17 year olds for the reporting period of April 2015 to March 2016. Information provided prior to the inspection stated that up to 210 permanent and bank members of clinical staff could be involved in the care of patients aged between 16 and 17. Young people were assessed to establish whether they could follow routine adult clinical pathways.
- There were 12 staff trained in safeguarding level 2 which is 6% of the total of staff involved in the care of patients under the age of 18. One staff member involved in the care of patients under the age of 18 was trained in safeguarding level 3. Five members of staff were trained in Advanced Paediatric Life Support (APLS) or equivalent.
- The director of clinical services is the location child safeguarding lead.
- Imaging request cards included dose, date and time and pregnancy checks for staff to complete to ensure women who may be pregnant informed radiographers before any exposure to radiation.
- Relevant staff within the diagnostic imaging department undertook regular Radiation Protection Supervisor

(RPS) training. The RPS role was to ensure that equipment safety, quality checks and ionising radiation procedures were carried out in accordance with national guidance and local procedures. Evidence was seen that these checks, procedures and training were being completed correctly.

## Nursing staffing

- Information submitted prior to the inspection showed the established staffing in the outpatients and diagnostic imaging departments were 2.8 health care assistants and 5.0 registered nurses.
- There were sufficient staff working in outpatients, physiotherapy and diagnostic imaging to meet the workflow and patients' needs in a safe manner.
- At the time of the inspection collectively outpatients and diagnostic imaging had five registered nurses and three health care assistants. A senior nurse had recently been recruited but had not started yet.
- In diagnostic imaging there were two radiographers, administration staff and health care assistants. The nuclear medicine specialist in the diagnostic imaging department was a member of agency staff.
- The physiotherapy department had made three bank staff permanent.
- Outpatients had not used any agency staff for the period April 2016 to July 2016. However, staff told us when needed regular bank nurses were employed who were familiar with the service and local procedures.
- The physiotherapy department had funding for an extra physiotherapist, but had not commenced recruitment. When required to recruit, nuclear medicine had issues recruiting as there is a national shortage of radiographers. Prospective nuclear medicine candidates are invited to spend time in the department. There were no vacancies in outpatients at the time of the inspection.
- In the previous six months the staff sickness and staff turnover had impacted on the small outpatients team, however this had improved and recruitment had taken place for a senior nurse. Staff turnover had been due to staff leaving but also internal staff promotion.

## Medical staffing

- There were no issues with availability or contacting consultants in the imaging department.

# Outpatients and diagnostic imaging

- There was sufficient consultant staff to cover outpatients clinics, including Saturday clinics. There were no concerns raised about the availability of consultants to cover their clinics.
- In the diagnostic imaging department, there was a service level agreement for consultant radiologist support from the local NHS acute trust hospital.

## Major incident awareness and training

- We were told that in the event of a major incident, consultants would leave to return to their NHS trust where appropriate. The BMI London Independent hospital would be used if required in a support role to take less seriously injured patients.

## Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate 

We inspected but did not rate 'effective' as we do not currently collate sufficient evidence to rate this;

- Staff took account of national and local guidance when providing care and treatment. For example, working in line with guidance related to diagnostic imaging to ensure safe exposure.
- Staff were supported in their role through a performance review process, they all had regular appraisals and we saw that these were all up-to-date.
- We saw certificates for staff training in administering treatment and staff competence was assessed.
- The hospital ran clinics from 8am to 8pm, Monday to Friday and 8am to 2pm on Saturdays in order to meet patients' needs. There was an out of hours on call service for diagnostic imaging.
- There was electronic access for patient results and a 24 hour turnaround for access to reports in the diagnostic imaging department.
- We saw evidence that policies and procedures were up-to-date. Two copies of each policy were placed in a file to allow staff access to policies and procedures in case a copy was in use by another staff member.
- Staff demonstrated an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Ionising Radiation results indicated (Medical Exposure) Regulations 2000 (IR(ME)R) audits were undertaken in

line with regulatory requirements. We saw copies of these audits, outcomes, actions and results during our inspection. Results indicated service performance was in line with local standards.

## Evidence-based care and treatment

- In the diagnostic imaging department, there was evidence that compliance with national guidelines (Medical Exposure) Regulations 2000 (IR(ME)R) was audited including audits against radiation exposure. For example, radiation exposure/diagnostic reference levels were audited regularly as part of the service's quality assurance checks and were within the service standards.
- We observed staff adhering to guidelines and standards to ensure patient care was effective.

## Pain relief

- Records showed that staff discussed options for pain relief with patients prior to any procedure being performed.
- Written advice on pain relief to be used at home was given to patients, and patients we spoke to confirmed this.

## Patient outcomes

- A patient-led assessment of the care environment (PLACE) audit took place at the hospital between February 2015 to June 2015. PLACE scores were the same or higher than the England average for cleanliness, dementia, food, organisational food, privacy, dignity and wellbeing and ward food, but lower than the England average (92%) for Condition, appearance and maintenance which scored 88%.
- Staff told us that patient outcomes were monitored through patient satisfaction questionnaires and incidents which helped to improve the service to patients. We were not informed of any improvements which had been undertaken as a result of these questionnaires.
- Results on patient outcomes are compared with other sites across BMI Healthcare through the quality dashboard, this dashboard is reviewed monthly. Comparisons can be made regionally and by type or complexity of the service provided. We could not compare these outcomes as we did not have full data for this.

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- The hospital works with the Private Healthcare Information Network (PHIN) ([www.phin.org.uk](http://www.phin.org.uk)) to assess patient outcomes against that of other private healthcare providers. The national data from private hospitals is being collated by PHIN and has a proposed date to have the data available in April 2017.

## Competent staff

- We saw that staff had access to training and development opportunities to advance their professional skills and experience and develop their service.
- All nurses responsible for taking blood were required to undertake phlebotomy training first.
- We saw evidence that in the period October 2015 to September 2016 all staff in outpatients and the diagnostic imaging department had received an appraisal. The physiotherapy department reported staff appraisals were 100% complete at the time of our inspection.
- Physiotherapists had inpatient and outpatients training and also had access to BMI physiotherapy training to develop their knowledge and skills.
- New staff underwent an induction programme, were assigned a mentor who checked their competencies, and had access to E-learning.
- Staff told us consultant practice was monitored for negative incident or outcome trends. Any concerns about performance were discussed by the hospital management team with the Medical Advisory Committee (MAC). Consultants may be restricted to only undertaking procedures and treatments that they also carry out within their NHS practice if concerns were identified. We were not told of any consultants who had been suspended or restricted practice in the previous 12 months.
- Consultant practising privileges were renewed annually and consultants were required to provide evidence of ongoing registration, professional indemnity insurance, and appraisal/revalidation. Each year, consultants were also required to complete a self-declaration form to confirm that there were no restrictions on their practice. Renewal of practising privileges were confirmed in writing by the Executive Director when all checks were completed.

## Multidisciplinary working (related to this core service)

- We were informed of community links, for example GP services with The BMI Independent London Hospital. There was a GP representative who was a member of the MAC and the provider held GP events throughout the year.
- We observed there was effective team working between all staff groups. Staff said colleagues were supportive. This was facilitated by a daily morning meeting called the "10@10 Meeting", where a representative of each department was present.
- There was a service level agreement between the hospital and a mobile magnetic resonance imaging (MRI) provider (which was part of another organisation and not subject to this inspection process).

## Seven-day services

- The majority of outpatients clinics were held Monday to Friday 8am until 8pm. Clinics were also held on Saturdays between 8am and 2pm. Patients we spoke with reported good access to appointments and at times which suited their needs.
- In the diagnostic imaging department, x-rays and ultrasounds were available between 8am and 8pm weekdays and 8am – 2pm on Saturdays. Radiographers provided an on call service out of hours.

## Access to information

- Staff told us patient notes were always available to ensure continuity of care. We did not see any records of any audits in this regard. We saw medical records with referral letters from GPs and letters to GPs regarding patient progress.
- Records are kept at the medical records department. Consultants also held their own separate private records and information provided prior to the inspection stated that consultants were registered with the Information Commissioners Office as data controllers.
- Staff we spoke with reported timely access to diagnostic imaging results and told us this enabled prompt discussion with patients on the imaging findings. Most results were reported electronically.
- At the time of the inspection staff told us the practice was that diagnostic imaging had a 24hr turnaround for written results reports. We did not see any audit records in this regard. Imaging results were available electronically for consultants to view in the clinic.

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- Physiotherapy staff kept their own patient records but a copy was also available in the hospital records for each patient.
- We saw guidelines for the safe transfer and accessibility of patient records.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

- We saw that information about the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards was included in the mandatory safeguarding training. Staff demonstrated an awareness about their role with regard to the Mental Capacity Act.
- Staff said they obtained verbal consent for general x-ray procedures, outpatients procedures and physiotherapy treatments carried out.
- Consent forms were completed for all minor surgical procedures. We reviewed 14 medical records. One file did not appear to have a consent form for surgery scheduled between 14/9/15 – 12/10/15 and the medical record was not dated. The other 13 medical records had risk assessment plans, theatre charge sheets, care plans, discharge plans and recovery records these were all dated and included consent forms.
- On consent forms we saw verbal consent was documented in patient notes.

## Are outpatients and diagnostic imaging services caring?

Good 

We rated caring as good because;

- During our inspection we observed staff provided care in a compassionate and respectful manner. Patients were treated with dignity and respect.
- Patients commended the professionalism and kindness of staff. Patients praised all aspects of the service with comments such as “overwhelmed with the service here”, “friendly”, “efficient”, “caring” and “good intentions and good explanation”.
- Patients felt they were fully involved in planning their care and treatment. Staff ensured they listened to and responded to patients’ questions appropriately. Patients commented that they had been well supported

- Chaperone signs were clearly displayed in waiting areas and in clinical rooms.

## Compassionate care

- We saw staff treated patients with dignity and respect. We observed patients’ privacy was maintained. The main outpatients reception desk was located sufficiently away from waiting areas so patients could speak to reception staff confidentially, without their conversation being overheard.
- During our conversations with staff it was clear they were passionate about caring for patients and clearly put patients’ needs first. One staff member told us they “always want to put the patients first and do what is best for the patients”.
- Patients we spoke with were very positive about their experience of the care from BMI The London Independent Hospital. We received the following comments; “overwhelmed with the service here”, “friendly”, “efficient”, “caring” and “good intentions and good explanation”.
- We observed all clinical activity was provided in individual consulting rooms and doors were always closed, to maintain privacy and confidentiality.
- Patients who attended the diagnostic imaging department told us that there had been no long waits to be seen; appointments came through quickly, staff were caring, consultants were good communicators and provided good explanations.
- Throughout the inspection, we witnessed caring interactions between staff and patients and staff were motivated by their work.
- All the patients we spoke with told us that staff were helpful, pleasant and caring. Throughout the inspection, we saw staff speaking in a calm and relaxed way to patients. We witnessed a health care assistant in the diagnostic imaging department fully explain a procedure to a patient and relative in a caring manner.

## Understanding and involvement of patients and those close to them

- Patients we spoke with, told us they had been provided with relevant information, both verbal and written, to make an informed decision about their care and treatment.

# Outpatients and diagnostic imaging

- We witnessed interactions between staff and patients which demonstrated information was conveyed at an appropriate pace, understanding was checked by staff and patients asked if they had any follow up questions.

## Emotional support

- Patients commented that they had been well supported emotionally by staff. For example, in relation to the recovery process following outpatients surgery.
- Staff told us they routinely offered a chaperone service to patients so that patients had access to emotional support before, during and immediately after they were examined.

## Are outpatients and diagnostic imaging services responsive?

Good 

We rated responsive as good because;

- Services were planned and delivered in a way which met the needs of patients. Patients had timely access to appointments. Clinics were held on weekdays into the evenings and Saturday mornings to suit patients' preferences.
- Patients were complimentary about the efficiency of the service as a whole.
- Interpreting services were available.
- Staff made adjustments to accommodate patients' individual needs, for example hearing loops were available for patients with hearing difficulties.
- Patients were aware of how to provide feedback and complain about the service if needed and any complaints were investigated in accordance with guidelines which we were provided with.
- At the time of the inspection some areas of outpatients required upgrading. For example upgrading the carpeted areas to comply with infection control. The diagnostic imaging department required a hearing loop. The hospital is undergoing refurbishment.

However;

- We saw only one hearing loop in outpatients. Other areas accessible to patients did not have hearing loops.

- We saw that information was in English only. Although staff have access to interpreters, there was no translated literature and no translated signage.
- The reception desks in outpatients and in diagnostic imaging did not have lowered areas for accessibility to wheelchair users.
- We were informed and saw that the changing room in the nuclear medicine area did not have direct access to the consulting rooms, patients had to wear gowns and walk down the corridor where they could be seen by other patients.

## Service planning and delivery to meet the needs of local people

- Staff told us that services were well planned in advance and the facilities appropriate to support the running of clinics. Clinics were held Monday to Friday 8am to 8pm, and Saturdays 8am to 2pm to accommodate patients with commitments during the week.
- The hospital was a provider of Choose and Book. This is an NHS electronic booking system used by GPs for booking outpatients appointments. This offered patients a degree of choice in booking their appointment, including which hospital and date and time to suit their needs.
- Patients told us they were provided with appointment letters, maps and information about the hospital prior to their appointment,
- Patients informed that their appointments ran on time. Staff did not inform us of any strategies or audits on patient appointment times as they told us there was enough resource to provide a good service.
- In the diagnostic imaging department we saw an X-ray booklet for patients on how procedures are undertaken.
- We were informed that plans to introduce a new digital switchboard system in August 2016 were in place to provide a more efficient call handling service.

## Access and flow

- We observed there was clear signage for patients to move around outpatients and the diagnostic imaging department.
- Patients entered the hospital via the main entrance and were registered at the main reception desk.
- Staff asked patients to wait in the main waiting area or the smaller waiting area near the physiotherapy and imaging departments depending on their appointment.

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- In the diagnostic imaging department there were cubicles for patients to use to change before their appointment. There were separate toilets for use by nuclear medicine patients as chemicals were disposed of through their urine which needed to be tested after four hours. Patients could remain in the waiting room and were tested before they left the hospital.
- We were informed that patients' appointments were arranged through the consultant's individual secretaries and with the outpatients reception team.
- Staff in outpatients told us that "patient flow is variable, it is never unmanageable as there is always more than one staff nurse and there is good communication between staff".
- Patients we spoke with felt the availability of appointments was good and appointments were provided at times that fitted in with their needs.
- Patients were complimentary about the efficiency of the service as a whole.
- Between April 2015 and March 2016, more than 95% of non-admitted patients received treatment within 18 weeks of referral.
- Between April 2015 and March 2016, the waiting period for dexta scans for seven NHS patients was longer than six-weeks in August 2015 and one patient in each of April 15, May 15, June 15, September 15 and March 16.
- Diagnostic imaging staff said they liaised with outpatients staff accordingly to schedule patients for imaging. They also said that they worked with other departments to co-ordinate appointments. However where other departments opened at different times, diagnostic imaging staff had to ensure they had sufficient cover and this is an area which requires discussion.
- The X-ray department was open 8am to 8pm Monday to Friday and 8am to 2pm on Saturdays. An on-call service was provided when the department was closed and the radiographers slept at the hospital when on call. The radiographers said there were no issues with accessing a radiologist when required.

## Meeting people's individual needs

- Patients were sent appropriate information prior to their first attendance. This contained information such as the consultant or clinic they were to attend, length of time for the appointment and written information on any

procedures which may be performed at the first appointment. Information also included the cost of the appointment and subsequent procedures (for self-funding patients).

- Staff told us they recognised the need to support people with complex or additional needs and made adjustments wherever possible in accordance with patient needs for example patients with mental health issues would be seen quickly and would always have a member of BMI staff with them throughout their appointment.
- All consulting rooms and communal spaces were wheelchair accessible.
- We observed all written information and signage, including pre-appointment information was provided in English only. Staff had access to an interpreting service; however, they said it was very rarely required for the patients who attended.
- In diagnostic imaging we observed a range of leaflets were available and provided to patients about diagnostic imaging procedures. There was also an X-ray booklet which described procedures.
- We saw written information leaflets in the reception area about general health and wellbeing and services offered by BMI Healthcare.
- We saw patient toilets were accessible for patients in wheelchairs and baby changing facilities were provided.

## Numbers of complaints relating to Outpatients and Diagnostic Imaging

- Information provided prior to the inspection stated that there had been 94 complaints throughout the hospital for the reporting period of April 2015 to March 2016. This had been a decrease from 2014 to 2015. The number of complaints relating to outpatients and diagnostic imaging was 25.
- We were informed that patients were encouraged to leave comments and feedback via the BMI patient satisfaction survey, 'How well did we do?'. These surveys were collected on a daily basis and concerns were posted on the notice board to inform staff. They were actioned, lessons learnt and a change in practice made if required. We were not informed of any changes made.
- We saw notices in the hospital to inform patients how to complain. Staff told us that they receive few complaints from patients and any complaints were resolved locally.

# Outpatients and diagnostic imaging

- The Executive Director was responsible for providing formal complaint responses and ensuring compliance with the complaints policy. The Director of Clinical Services was responsible for overseeing all complaint investigations and responses. The Quality & Risk Manager coordinated the investigation and findings following complaints, linking in with heads of departments and individuals named in complaints. The Group Quality & Risk Manager was responsible for reviewing 'stage 2' complaints if the complainant remains unhappy following response from the hospital. Any trends or themes were reviewed at the Medical Advisory Committee meetings.
- Patient satisfaction and complaints information was provided to heads of departments and displayed in clinical areas for staff awareness. Specific issues were raised at departmental meetings, including improvement actions which had been identified. For example, as a result of complaints during the last year, pathology price lists were available in the outpatients department to enable accurate estimates of costs to be given to patients. Additionally, outpatients reception staff improved customer care skills and the pre-admission assessment department has reviewed processes.
- Staff we spoke with knew about the complaints procedure and how to respond to patient concerns. If a patient wanted to complain, staff would sit down and talk to anyone who wants to complain and this would be documented.
- All staff received information about the complaints procedure as part of their induction.
- Managers were committed to provide high quality care and improve services and facilities for patients.
- Staff felt supported and were able to develop to improve their practice. Staff in all areas stated they were well supported by their immediate line managers. All staff spoke highly of their senior management team, stating that they provided a visible and strong leadership within the hospital.
- Staff had a good understanding of the organisation's visions and values.
- There was a good working culture and staff were happy.
- Innovative management had developed staff Saturday morning meetings with breakfast provided.
- In physiotherapy management decreased the usage of bank staff.
- Physiotherapy clinic times were extended from 4.30pm to 8.30pm.
- There was an open and supportive learning culture.
- Patients were given opportunities during and after treatment to provide feedback.

## Vision and strategy for this this core service

- Staff were aware of the strategy for the department in line with the overall vision of the hospital, which was to provide a high quality safe efficient service that was well run to meet the needs of all patients, whether private or NHS.
- Information provided by the hospital stated that 'The BMI London Independent Hospital's strategy was to grow business and develop services to be a financially viable provider of care and treatment which meets regulatory standards and is recognised as being of high quality and value'. The strategy for the outpatients department involved developing the service to improve facilities for patients by providing a safe, efficient, well managed department to meet the needs of all patients. We were also told of future aspirations for new equipment and new treatment rooms.
- Management within diagnostic imaging informed us that they had plans for a new treatment room and intend to create a business plan for when new equipment is required.

## Are outpatients and diagnostic imaging services well-led?

Good 

We rated well-led as good because;

- Effective governance and risk management systems were in place. Staff were informed about issues relating to their department. They had opportunities to raise ideas and concerns when needed, which they were confident would be addressed by their managers.

## Governance, risk management and quality measurement for this core service

# Outpatients and diagnostic imaging

- There was a clear governance and reporting structure in line with the corporate governance framework. The performance of outpatients and diagnostic imaging was reviewed at the monthly hospital governance committee.
- The Governance Committee monitored performance on quality and risk issues through reports relating to incidents; near misses; complaints; clinical practice; audit; health & safety; infection prevention & control; water safety; resuscitation; medicines management and information security.
- The Radiation Protection Committee considered any equipment testing issues, recalibration of equipment and any incidents within nuclear medicine.
- The Medical Advisory Committee approved new practising privileges and reviewed any consultant related issues.
- A health and safety risk assessment undertaken in June 2016 was rated satisfactory. The documents we saw which were rated satisfactory included sharps protocol, prevention of sharps injuries and health and safety audits. Staff informed us that carpets were in the process of being changed to laminate/vinyl flooring.
- Staff in diagnostic imaging said there was a corporate risk register and the diagnostic imaging department also had a smaller risk register (which we saw). The main items on the risk register regarding diagnostic imaging matched some of the concerns identified during the inspection such as patient privacy at the reception desk and the lack of a hearing loop. We were told a confirmed date for changes was not yet in place but the plan was to change the whole front desk and telephone call area for better patient privacy and to add a hearing loop. We were told there were no plans to lower the reception desk to make this more accessible to wheelchair users.
- Practising privileges were renewed annually. Throughout the year consultants must provide evidence of ongoing registration, indemnity insurance, appraisal/ revalidation when current ones are due to expire. If a consultant did not have up-to-date professional indemnity insurance the consultant could no longer work at The BMI London Independent Hospital. The executive director said that there was a zero tolerance policy in relation to this. Each year, consultants are

required to complete a self-declaration form to confirm that there are no restrictions on their practice. All departments including outpatients department were represented in the MAC meetings.

## Leadership / culture of service

- The outpatients leadership structure consisted of an outpatients manager, two senior nurses (one senior nurse is clinical lead) and a physiotherapy manager. A new senior nurse had been recruited but was yet to join. The diagnostic imaging leadership structure consisted of a diagnostic imaging manager and a senior nurse.
- Front line staff were very positive about the leadership at departmental and senior management level. They told us the leadership team was visible, approachable and contactable during business hours. The executive director attended team meetings.
- The staff in outpatients spoke very highly of the senior nurse. They stated the senior nurse was “incredibly supportive, works very hard and is a good manager, multi-tasks well and is a good role model”.
- The outpatients and diagnostic imaging departments tried to hold monthly staff meetings but due to time restraints this was not always possible.
- Staff spoke well of the of the new executive director and were optimistic about the future of the hospital.
- Managers in the outpatients, radiology and physiotherapy departments had clinical leadership roles and were easily accessible. Staff reported good support and guidance from their managers. Managers in all three departments were passionate about their teams and caring for their patients.
- New staff were in post and others yet to join. The majority of staff were long standing. All staff we spoke with were happy and positive about working at The BMI London Independent Hospital, and they expected to remain working there in the foreseeable future. Staff described an open and supportive workplace culture where work was manageable and there was sufficient time to provide care for patients and raise concerns if needed. There was a positive attitude amongst staff with regard to assisting colleagues and learning from incidents across the hospital and organisation.

## Public and staff engagement

# Outpatients and diagnostic imaging

- Patients were encouraged to complete satisfaction questionnaires to leave feedback about their experience. We saw patient feedback cards were available in the waiting areas and posters were clearly displayed to inform patients.
- We saw evidence that the leadership team was responsive to patient feedback. For example, as a result of complaints during the last year, pathology price lists were available in the outpatients department to enable accurate estimates of costs to be given to patients.
- Staff were kept informed of changes in practice and any incidents, feedback and lessons learnt were provided on the staff notice board and at staff monthly meetings. We were not informed of any changes in practice.
- Staff told us they felt happy to raise concerns with the leadership team and make suggestions for improvement.
- The management team told us they were working on a reward system for staff.
- The leadership team told us they were planning to compose a business plan for a new treatment room in the diagnostic imaging department, as well as a separate designated area for phone calls to and from patients. Physical change to the layout of the reception area in the diagnostic imaging department was due to take place as well as a gradual change to staff workflow so that staff undertook new and varied tasks for service improvement.
- At the inspection estate and facilities staff told us that air conditioning will be installed when each area is refurbished. The fire service had inspected the building and the building had the latest fire alarm system.
- In the physiotherapy department, management developed a grading system and pay reviews, we were told this drives quality but were not provided with any examples. Management also decreased the use of bank staff by converting three posts filled by bank staff to full-time posts.

## **Innovation, improvement and sustainability**

- We were informed that the building was being refurbished and a programme of replacing carpets with vinyl washable flooring to meet infection control requirements was underway. This would include outpatients which had carpeted flooring in some areas.
- A cleaning schedule had been developed in outpatients with a traffic light system. The cleaning schedules are audited and at the time of the inspection was at 93%.
- Physiotherapy was only available during daytime working hours and patients had to spend additional nights on the ward because physiotherapy assessments were not available outside of clinic times. Management put together a business plan and modified the service so physiotherapy was available from 8.30am to 8.00pm. There is now extra funding and an on call physiotherapist.
- Saturday morning staff meetings were arranged with breakfast provided, minutes were taken. Management told us these meetings were well attended.

# Outstanding practice and areas for improvement

## Outstanding practice

- The endoscopy suite had been recently refurbished and was purpose built with excellent patient and treatment facilities...

## Areas for improvement

### Action the provider **SHOULD** take to improve

- Review and ensure full compliance with the World Health Organisation (WHO) surgical safety checklist by all surgical staff.
- Take steps to ensure that theatres have access to an uninterruptible power supply UPS.
- Provide designated hand wash sinks in patient rooms on wards, to comply with hand hygiene protocols.
- Review and implement safeguarding training sufficient to comply with recommendations from NHS England.
- Although numbers of patients aged 16-18 are low, review safeguarding, paediatric nurse cover and assessment of suitable patient pathways for these patients.
- Provide information, including information on how to complain, in other languages as well as English.
- Provide a visitors' waiting room for ITU or HDU.
- Ensure that reception desks in outpatients and in diagnostic imaging have lowered areas for accessibility to wheelchair users.
- Take appropriate steps to preserve patient dignity in the nuclear medicine area by providing direct access to the consulting rooms from changing areas.
- Take steps to modify the temperature in the OPD sluice room.
- Complete its replacement programme for fire doors.
- Prepare an action plan to address the health and safety audit results for May and June 2016 which recorded that 'power tools and electrical tools in good working order, free from splits, cracks and deformities' was rated poor.
- The above list is not exhaustive and the provider should review all elements of the report in order to continually improve the quality of its services to patients.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

#### Regulated activity

#### Regulation

Treatment of disease, disorder or injury

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

**12 (1) Care and treatment must be provided in a safe way for service users including:**

(a) assessing the risks to the health and safety of service users of receiving the care and treatment

(b) doing all that is reasonably practical to mitigate any such risks.

- The World Health Organisation (WHO) Five Steps to Safer Surgery checklist was in use within theatres and hospital audit results indicated 98-100% compliance between July and September 2016. However we observed that compliance with this checklist was variable. We observed that the checklist was not always completed with a physical list in front of the surgical team, which is not line with WHO recommendations, and that some aspects from the checklist were missed out. For example, we observed the patient's airway and risk of blood loss were not covered during the pre-anaesthesia aspect. We also saw that the surgical site was not always physically marked on the patient.
- We observed recovery staff filling in the WHO Five Steps to Safer Surgery checklist form retrospectively for the theatre activity which had taken place, although this staff member had not been present in theatre during the procedure. This was not appropriate practice.

#### Regulated activity

#### Regulation

Treatment of disease, disorder or injury

Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control

**12 (1) Care and treatment must be provided in a safe way for service users including:**

## Requirement notices

(h) assessing the risk of, and preventing, detecting and controlling the spread of infections including those that are health care associated.

- Staff working in theatres were required to wear scrub uniforms, including a theatre cap. Staff told us they were able to leave theatres in their scrubs but were required to change their scrubs when returning if they had been out of the department for an extended period of time, however staff were unclear what the timeframe for this was. We were concerned that patients could be placed at risk of infection if staff returned to theatre in scrubs which had been worn out of the department, particularly those worn by theatre porters who moved between theatres and the rest of the hospital frequently. This was not compliant with NICE CG74 (surgical site infections; prevention and treatment).
- There were no staff handwashing sinks within the patient rooms, or in the ward corridors. This meant staff had to wash their hands in patient sinks, which was not in line with hand hygiene protocols.

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

**15 (1) All premises and equipment used by the service provider must be clean, secure, suitable for the purpose for which they were being used, properly used, properly maintained and appropriately located for the purpose for which they are being used.**

- Theatres did not have access to an uninterruptible power supply UPS, which meant they would temporarily lose power in the event of a power cut, before generators would begin to provide power to equipment, including patient ventilators. Senior staff told us this was documented on the risk register and plans were in place to address this in September 2016. However, surgeons and anaesthetists working in the theatres were not routinely made aware of this during their induction to the hospital or prior to performing surgery, which could place patients at risk.

This section is primarily information for the provider

## Requirement notices

- There was one oxygen port (air and suction) per bed space in the high dependency unit (HDU). This was not in line with the building regulations for critical care (HBN 04-02) which suggest three to four oxygen outlets per bed space. We took into account the fact that the regulations came into force after the building of HDU however; we have asked the provider to consider the requirements set out within the building regulations for critical care (HBN 04-02) in terms of risk and patient safety, and the requirements for providers in circumstances set out above, and to mitigate those risks.

This section is primarily information for the provider

## Enforcement actions

### Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.