BMI The Meriden Hospital

Quality Report

BMI The Meriden Hospital
Walsgrave Hospital Site
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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	Requires improvement
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

BMI The Meriden Hospital opened in February 2006 and is purpose built. The hospital is on the site of an NHS acute trust. The hospital is registered for 52 beds, 48 beds in the ward area and 4 day beds in the endoscopy suite.

The hospital undertakes a range of surgical procedures, to patients aged sixteen years and over. They also provide outpatient consultations to patients aged twelve years and over.

We carried out this inspection as part of our comprehensive programme of independent healthcare inspections. We carried out an announced inspection visit of BMI The Meriden Hospital on 24 and 25 May 2016 and an unannounced inspection on 6 June 2016.

Our key findings were as follows:

We rated the hospital as requires improvement overall. Out of the five key questions we always ask, namely is the hospital safe, effective, caring, responsive and well-led, were rated as requires improvement. Safety in surgery was rated as inadequate. Effective and well led was rated as requires improvement and caring and responsiveness were rated as good overall.

As a result of our findings, we have, under the Health and Social Care Act 2008, served the hospital with a warning notice because we believe that patients will or may be exposed to avoidable harm due to a breach of Regulation 12 (1) and (2)(a)(b)(c) and (g) which states that care and treatment must be provided in a safe way for service users.

Are services safe at this hospital?

- There was evidence of learning from incidents and complaints and effective processes were in place to reduce risk. However, incidents had not always been graded correctly.
- Staff were encouraged to report incidents and were aware of the duty of candour regulation.
- We were not assured that controlled medicines were safely stored or that the keys were secure.
- The management of medicine prescription pads in outpatients was not robust, meaning that there was the possibility for loss of, or inappropriate use of, prescriptions.
- The hospital did not employ, or have access to, registered nurses (child branch) to care for children and young people.
- Safeguarding systems were in place and staff knew how to respond to safeguarding concerns. However, not all staff had been trained to the required level.
- Patient bedrooms had not been refurbished since being built in 2006, which meant that they were not compliant with current Health and Building Note regulations 2013.
- Clinic rooms had not been refurbished since being built in 2006 which meant that they were not compliant with current Health and Building Note regulations 2013.
- The national early warning system was used, to recognise the deteriorating patient.
- There was access to appropriate equipment to provide safe care and treatment.
- The environment was visibly clean and there were systems in place to maintain the safety of equipment used across clinical areas.
- Staffing levels were appropriate to the needs of the patients and flexed according to the demands of the service, ensuring flexibility to meet patients' requirements.

Are services effective at this hospital?

- Care and treatment was generally delivered in line with evidence based-guidance.
- Policies were accessible, current and reflected professional guidelines. The hospital monitored adherence to policies with the use of local audits.

Summary of findings

- Patient outcomes were audited in surgery.
- Pain was well-managed and effectiveness of analgesia was audited.
- Patients' nutritional status was assessed and appropriate action taken if required.
- An induction programme was provided to all new staff.
- There was a process in place for checking professional registrations.
- The Medical Advisory Committee (MAC) ensured consultants were competent to practice and practising privileges were reviewed annually.
- Consultants were on call for 24 hours a day and seven days a week for their inpatients and day case patients. There was an RMO providing medical cover for patients and clinical support to staff.
- Outpatient and imaging staff provided patient appointments over weekends according to clinical needs. On call provision for MRI and CT emergencies out of hours was provided by the local NHS trust.
- There were arrangements to ensure staff were able to access all necessary information to provide effective care.
- Most staff we spoke with were unclear about what actions they would take if they had concerns about a patient's capacity to understand information and consent to treatment
- Staff had received training on the Mental Capacity Act and Deprivation of Liberty although had limited exposure to patients requiring mental capacity assessments.
- Multi-disciplinary teams worked well together to provide effective care. Multi-disciplinary team working included hospital staff, local NHS trusts, clinical commissioning groups and general practitioners.
- Not all staff had received an up to date appraisal to identify individual training needs, some staff had not had an appraisal in the previous twelve months and one staff member told us they had not had an appraisal for four years.

Are services caring at this hospital?

- Patients were treated with dignity and respect. Their preferences were taken into account with treatment planning and they felt informed of treatment plans and involved with decision making.
- Feedback from patients and those close to them was positive about the way staff cared for them and the treatment they had received.
- The friends and family survey results between July 2015 and December 2015 showed that over 97% of patients would recommend the hospital to family and friends. The response rates were varied with an average of 32%; this is equivalent to the England national average.
- Family and friends could attend appointments to support the patient and be included in discussions and decisions.
- Patients were informed of costs of services in a sensitive manner, and were able to discuss any concerns.
- Consultants visited patients' daily and were available to answer any questions they had.
- Patients were allocated a named nurse which meant they knew who was caring for them and who to approach if they needed assistance.

Are services responsive at this hospital?

- Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services.
- Appointments were consultant led, with a system in place to ensure patients were seen at appropriate times by the appropriate clinician.
- There was a policy in place to detail admission and discharge processes, and staff were aware of this.
- There was clear signage for patients to follow.
- The services had protocols and procedures in place to manage patients with complex needs, including those living with a learning disability and dementia.
- Staff had awareness and had attended training in caring for patients living with dementia.
- Appropriate service level agreements were in place for additional services such as dietetics and sterile services.
- The service had appropriate provision for patients and visitors requiring additional support, through hearing loops, translation services or access.

Summary of findings

- Information on complaints or how to raise a concern was available for patients. Complaints and concerns were always taken seriously and responded to in a timely manner. Patients were given opportunities to feed back on the care they received and we saw evidence that patient feedback was acted on and improvements made.
- Patients received and had access to appropriate written information about their condition and treatment. However, there was no provision of information leaflets specifically designed for children attending the departments.

Are services well led at this hospital?

- There was lack of risk management and quality measurement with in the hospital in relation to children's service and medicines management.
- The senior hospital management team had not taken reasonable practicable action to provide a safe service for children and young people.
- The senior hospital management team were unclear about the safeguarding training requirement for staff involved in the care and treatment of children and young people.
- One of the senior managers was unsure of the implications of Mental Capacity Act and Deprivation of Liberty Safeguards.
- The hospital had a vision and a set of values, although not all staff were aware of the corporate vision and values or the hospitals vision.
- The hospital had a governance structure and a clinical governance committee that met monthly to discuss a range of hospital issues.
- There were defined routes for cascading information to hospital staff.
- Senior managers at the hospital were visible, supportive and approachable.

We saw an area of outstanding practice including:

- A consultant orthopaedic surgeon had introduced an extra safety check when operating. When the size, type of prosthesis is confirmed this was recorded on the whiteboard so that the prosthesis could be checked against this information before being implanted.

However, there were also areas of poor practice where the provider needs to make improvements.

Importantly, the provider MUST:

- Ensure grading of incidents are consistent.
- Ensure the safe management of medicines at the hospital.
- Ensure that prescription pads are maintained appropriately with necessary audit trial detailing storage and issuing of prescriptions.
- Take reasonable practicable action to provide a safe service for children and young people.
- Ensure that it is recorded with whom a young person is discharged into the care of and where they are discharged to.
- Meet the requirements for staffing levels for children's services in accordance with the Royal College of Nursing standards for clinical professionals and service managers, 'Defining Staffing Levels for Children and Young People's Services', (2013) .
- Ensure there is access to a registered nurse (child branch) available to advise on the management and care and treatment of children and young people.
- Ensure staff that have responsibility for assessing, planning, intervening and evaluating children's care, must be trained to level three in safeguarding.
- Ensure there is a paediatric consultant or representative to attend the MAC meetings and that children's and young people's services are discussed.

In addition the provider SHOULD:

Summary of findings

- Although there were clinical hand basins in utility areas, there were no clinical hand basins in patients bedrooms. Therefore staff were using these patient sinks at the point of care when it was necessary to wash their hands. Clinical sinks should be available at point of care.
- Review the floor coving in patient bedrooms and bathrooms as this was not compliant with infection control guidelines.
- Ensure safe management of medicine cupboards in theatres as these were being left unlocked for convenience when theatres were in use.
- Ensure the fridge in the endoscopy theatre is kept locked.
- Consider formally collecting patient outcomes and participate in national audit programmes to enable benchmarking against national standards.
- Ensure compliance with BMI Care of Children Policy 2014.
- Ensure staff have annual appraisals.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires improvement 	Overall, we rated the surgical services as inadequate for safety and requires improvement for effective and well-led. Caring and responsive were rated as good. Incidents had not always been graded correctly. We were not reassured of the safe storage and security of the medication keys for controlled medicines. The medicine fridge in endoscopy was not locked, which meant that medicines were not stored safely. The hospital did not have access to registered nurses (child branch) to care for children and young people. In addition, there was no registered nurse (child branch) managing the care of young people admitted to the hospital. Staff caring for young people did not have the appropriate level of safeguarding training. Patient bedrooms had not been refurbished being built in 2006, which meant that they were not compliant with current Health and Building Note regulations. Consultants did not always follow good practice with regards to infection prevention and control. Most staff we spoke with were unclear about what actions they would take if they had concerns about a patient's capacity to understand information and their ability to consent to treatment. The five steps to safer surgery checklist was used correctly. The hospital audited and monitored avoidable harm caused to patients. Although there was a governance structure in place, there was lack of risk management and quality measurement in relation to children's service and medicines management. However, we found that: Staff understood the importance of reporting incidents and were aware of the Duty of Candour regulation of being transparent, open and honest. Lessons learnt from incidents were shared amongst the teams.

Summary of findings

The ward, theatres, recovery, and pre assessment areas were visibly clean and tidy.
A standard National Early Warning Score (NEWS) chart was used to record patients' vital signs and identify deteriorating patients.
Training levels on subjects such as infection control and both intermediate and basic life support training were consistent across the service. All staff had been trained in Acute Illness Management.
Staffing was appropriate, including that required for emergencies.
There was some good practice, for example, in pain management, and the monitoring of nutrition and hydration of patients in the perioperative period.
Patients told us they were pleased with the care received and were kept informed and involved in the treatment received. We saw patients being treated with dignity and respect.
There were arrangements to identify any co morbidities prior to admission of patients.
Discharge planning began during the pre-assessment process.
Written information was available in different languages. Staff could access an interpreting service when required.
Complaints were handled confidentially.
The hospital had an effective governance structure in place for managing adult services.
A consultant orthopaedic surgeon had introduced an extra safety check prior to operating.

Outpatients and diagnostic imaging

Requires improvement

Overall, we rated the service as requires improvement for safe, and well-led and good for caring and responsive. Effectiveness was inspected but not rated.
Staff within the outpatients, therapy and diagnostic departments did not have level three children's safeguarding training in place. This was not in line with recommended guidelines or organisational policy as children attended clinics and received treatment within the department.

Summary of findings

There was no registered nurse (child branch) managing the care of young people admitted to the hospital The hospital did not have access to registered nurses (child branch) to care for children and young people.
We were not reassured of the safe storage and security of the medication keys for controlled medicines.
The management of medicine prescription pads in outpatients was not robust, meaning that there was the possibility for loss of, or inappropriate use of, prescriptions.
Not all clinic rooms were suitable for clinical procedures. Clinic rooms had not been refurbished since being built in 2006, which meant that they were not compliant with current Health and Building Note regulations.
However, we found that:
Staff were aware of their roles and responsibilities for safely managing patients attending the department. This included reporting incidents appropriately and escalating concerns. There were systems in place to share learning from incidents and staff were aware of the duty of candour.
There were effective infection control procedures in place and all areas were visibly clean and well maintained. The outpatients department was undergoing a refurbishment programme, to ensure that they were compliant with Health Building Notes for flooring in clinical rooms.
Staff had competed mandatory training, reaching the hospital's target. There were systems in place to ensure induction to speciality areas which included competencies and peer support.
Equipment was suitable to service needs and maintained annually by appropriately trained staff. There was evidence to support testing of all equipment across all departments.
Policies and standard operating procedures were in place for all clinical activities and these were easily accessible for all staff. The service had an audit calendar to monitor compliance and used action plans to address any issues identified.
Staff reported effective multidisciplinary team working, with common goals for the provision of high quality patient care.

Summary of findings

The outpatients department flexed working hours to meet the demands of the service, with an on call system for imaging staff, and inpatient weekend physiotherapy services.
Patients' records were available for all appointments and were found to be thorough, and legible. Information was shared with GPs to enable continuity of care.
Patients were included in decision making regarding treatment plans and were generally positive about the care they received. Patient surveys showed high levels of satisfaction.
Information leaflets were available for a wide variety of treatments and the service provided translation services as necessary.
The service consistently achieved referral to treatment time targets.
Service level agreements were in place for the provision of support services and emergency transfers. Staff reported that the relationships with external providers were positive and inclusive.
There were systems in place for the monitoring of incidents and complaints. Information relating to this was shared across the team.
The service shared the organisational vision and staff reported that they were aware of the organisational aims.
Staff were positive about the teams they worked within and proud of the care they provided. Staff within each clinical area reported strong local leadership.

Summary of findings

Contents

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BMI The Meriden Hospital

Services we looked at
Surgery and Outpatients and diagnostic imaging

Summary of this inspection

Background to BMI The Meriden Hospital

BMI The Meriden Hospital opened in February 2006 and is purpose built. The hospital is on the site of the local NHS trust. The hospital is registered for 52 beds, 48 beds in the ward area and 4 day beds in the endoscopy suite.

The BMI Meriden Hospital is a 52 bedded independent hospital, which opened in February 2006. The hospital was developed on NHS land following agreement between BMI Healthcare and the local NHS trust. BMI retained the rights to complete all private work on the NHS site for 30 years and holds a 125-year lease on the land.

The hospital undertakes a range of surgical procedures, to patients aged sixteen years and over. They also provide outpatient consultations to patients aged twelve years and over.

There are three theatres all with laminar flow, an endoscopy suite and a dedicated cardiac catheter laboratory.

There are 16 consulting rooms situated on the ground floor which include one dedicated ear, nose and throat room, two ophthalmology rooms, one cardiology room and two pre-assessment rooms. There is a physiotherapy department and imaging diagnostics department which is a 50:50 joint venture with United Medical Enterprise (UME) for the provision of MRI and CT Scanning.

There are administration and management staff on site.

The hospital is managed by BMI Healthcare Limited and is part of a network of 59 hospitals across England, Scotland and Wales. The Executive Director had been in post for nearly two years.

The hospital provides private insured, self-pay and NHS funded care, mostly through the NHS referral system.

Our inspection team

Our inspection team was led by:

Inspection Lead: Julie Fraser, Inspector, Care Quality Commission.

The team of nine included a CQC inspection manager, CQC inspectors, and a variety of clinical specialists: a theatre nurse, a consultant surgeon, a children's nurse, and a radiographer.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We carried out this inspection as part of our comprehensive inspection programme.

Before visiting, we reviewed a range of information we held about the hospital and both core services.

We carried out an announced inspection visit on 24 and 25 May 2016 and an unannounced inspection on 6 June 2016. We spoke with a range of staff in the hospital, including nurses, consultants, and administrative, ancillary and clerical staff. During our inspection we reviewed services provided by BMI The Meriden Hospital in the ward, operating theatre, outpatients and imaging departments.

During our inspection we spoke with 10 patients, 44 staff, (including consultants, who were not directly employed by the hospital) from all areas of the hospital, including

Summary of this inspection

the wards, operating theatres and the outpatient department. We observed how people were being cared for and talked with patients and reviewed personal care and treatment records of patients.

Information about BMI The Meriden Hospital

The hospital has 48 inpatient rooms on the first floor, with ensuite facilities. They have three operating theatres all with a laminar flow ventilation system, an endoscopy theatre and cardiac catheter laboratory on the second floor. There are 16 consultation rooms, including one dedicated ear, nose and throat (ENT) room, two ophthalmology rooms, one cardiology room and two pre-assessment rooms on the ground floor. There is a physiotherapy department on the second floor.

In addition, on the ground floor, there is an imaging diagnostics department which is a joint venture with another company for the provision of MRI and CT scanning. These staff are employed by a separate registered provider.

BMI The Meriden Hospital provides outpatient services for various specialties to both private and NHS patients. This includes, but is not limited to, orthopaedics, gynaecology, general surgery and urology. There were 6,887 surgical procedures carried out between January 2015 and December 2015. Of these, 2,442 patients stayed one or more nights, the rest were day cases. A total of 21 young people between the ages of 16 and 18 years underwent surgical procedures in the same time period, 11 stayed overnight and 10 were day cases.

Between January 2015 and December 2015, 36,689 people were seen in outpatients. Of these, 268 were children aged between 12 and 18 years.

The hospital is accredited by all the major private medical insurers. Between January 2015 and December 2015, around 57% of patients having day or in patient treatment were funded by the NHS; the remaining patients were self-funding or paid for by their insurance companies.

There are 216 doctors that have practicing privileges and their individual activity is monitored.

BMI The Meriden Hospital has BUPA Breast Care accreditation.

All patients were admitted and treated under the direct care of a consultant and medical care is supported 24 hours a day, seven days a week by an onsite resident medical officer (RMO). Patients are cared for and supported by registered nurses, care assistants, allied health professionals such as physiotherapists who are employed by the hospital.

The hospital Accountable Officer for Controlled Drugs (CDs) is the Executive Director.

The hospital has a contract with the local NHS trust, which is on the same site, to provide pharmacy, pathology, microbiology and provision of blood components. In addition, decontamination services in relation to theatre instrumentation were provided by the local NHS trust.

BMI The Meriden Hospital has been inspected twice by the Care Quality Commission, once in October 2012 and again in February 2014, with 11 of the core standards being assessed during these inspections. All standards assessed were found to be compliant, except one, for supporting workers, in October 2012. However the hospital provided evidence to the Care Quality Commission in January 2013 to demonstrate that improvements had been made and the provider had taken the action required to improve outcomes for people using the service.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inadequate	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Good	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	Good	Good	Requires improvement	Requires improvement

Notes

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Requires improvement

Surgery

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

Information about the service

BMI The Meriden Hospital provides surgical services for various specialties to both private and NHS patients. The hospital admits adults and young people over 16 years of age for surgery.

There is a main inpatient ward offering 48 single ensuite rooms with an additional four day case beds in the endoscopy unit. Within the outpatients department there is a pre-assessment area where patients are seen before admission to the hospital.

There are three theatres with associated anaesthetic rooms and a recovery area. The hospital has an endoscopy theatre used for gastroscopy, colonoscopy, oesophageal dilatation, prostatic biopsy, and flexible cystoscopy. There were 6,425 visits to theatre between January 2015 and December 2015, mainly for elective surgery. This included 21 young people between the ages of 16-18 years. The hospital offers orthopaedic, ear nose and throat, cosmetic, gynaecology, urology, neurosurgery (spinal) and general surgery.

All patients were admitted and treated under the direct care of a consultant surgeon. Medical care is supported by a resident medical officer (RMO).

We carried out an inspection of the hospital on 24 and 25 May, with an unannounced visit on 6 June 2016. During our inspection, we visited the inpatient ward, pre-assessment clinic recovery area, theatres and endoscopy unit. We talked to 3 patients and acknowledged the view expressed by patients on Care Quality Commission comment cards.

We also spoke with 27 members of staff. We observed care and treatment and reviewed 14 patients' records. Prior to the inspection, we reviewed performance information about the hospital.

Requires improvement

Surgery

Summary of findings

Overall, we rated the surgical services as requires improvement. We rated the key questions for safe as inadequate, requires improvement for effective and well-led. Caring and responsive were rated as good because:

- Incidents had not been graded correctly.
- We were not reassured of the safe storage and security of the medication keys for controlled medicines.
- The medicine fridge in endoscopy was not locked.
- Staff caring for young people did not have the appropriate level of safeguarding children's training.
- There was no registered nurse (child branch) managing the care of young people admitted to the hospital. The hospital did not have access to registered nurses (child branch) to care for young people.
- Most staff we spoke with were unclear about what actions they would take if they had concerns about a patient's capacity to understand information and consent to treatment.
- Patient rooms had not been refurbished since being built in 2006, which meant that they were not compliant with current Health and Building Note regulations 2013.
- We observed three consultants not following infection prevention and control procedures during their ward round.

However, we found that:

- Most treatment and care was provided in accordance with evidence-based national guidelines. We saw all policies were current and followed the appropriate guidelines such as the National Institute of Health and Care Excellence (NICE).
- Staff understood the importance of reporting incidents and were aware of the Duty of Candour process of being transparent, open and honest. Lessons learnt from incidents were shared amongst the team.
- The ward, theatres, recovery, and pre assessment areas were visibly clean and tidy.
- A standard National Early Warning Score (NEWS) chart was used to record patient observations and identify deteriorating patients.
- Training levels on subjects such as infection control and both intermediate and basic life support training were consistent across the service. All staff had been trained in Acute Illness Management.
- Medical staffing was appropriate and there was a system in place should there be an emergency. The hospital used a staffing tool to ensure safe levels of nursing care. There was a staff induction and competency framework in use across the service.
- There was good practice, for example, in pain management, and the monitoring of nutrition and hydration of patients in the perioperative period.
- Patient records were easy to access and contained information on the patient's journey through the hospital which included the use of care pathways.
- The five steps to safer surgery checklist was used appropriately. The hospital audited and monitored avoidable harm caused to patients.
- Patients told us they were pleased with the care received and were kept informed and involved in the treatment received. We saw patients being treated with dignity and respect. The hospital had an open visiting policy.
- There were effective arrangements for the admission of patients. Discharge planning began during the pre-assessment process.
- Written information was available in different languages. Staff could access an interpreting service when required.
- There was an effective governance structure within the service. The hospital audited and monitored avoidable harms caused to patients.
- Staff felt supported by their team and the trust. Complaints were handled effectively and confidentially.
- A consultant orthopaedic surgeon had introduced an extra safety check when operating.

Requires improvement

Surgery

Are surgery services safe?

Inadequate

Although there were some good things about the service, it breached Regulation 12 (1) 'Care and treatment must be provided in a safe way for service users.' Therefore we issued the hospital with a warning notice.

Overall, we rated the surgical service as inadequate for safe because:

- Incidents had not been graded correctly.
- Medication keys, including those for controlled drugs, for the wards were kept within a key cupboard in the treatment room. However, there was no checklist or signing in or out procedure for keys. Other hospital keys were also kept in this cupboard. The keys were not checked at the beginning of each shift. There was no risk assessment conducted into this practice.
- We found that the medicine fridge in the endoscopy theatre was unlocked and drug cupboards within anaesthetic rooms were kept unlocked whilst theatres were in use. We saw no evidence of this practice being risk assessed.
- Staff caring for young people, aged 16-18 years, were not trained in level 3 safeguarding children and therefore may have been unable to identify potential safeguarding concerns.
- The hospital did not have access to registered nurses (child branch) to care for children and young people.
- Young people aged between 16-18 years of age were not always discharged safely following a surgical procedure. One young person was discharged at 11pm.

However we also found that :

- There was access to appropriate equipment to provide safe care and treatment.
- Staff said they were encouraged and confident in reporting all incidents which were also discussed at team meetings and ward handovers. Staff were aware of the importance of the duty of candour regulation.
- We observed the five steps to safer surgery checklists were being completed appropriately.
- The service had procedures for the reporting of all new pressure ulcers, and slips, trips and falls. Action was being taken to ensure harm free care.
- Nursing handovers were well structured within the surgical wards. There was a safety huddle in theatres each morning as well as a hospital wide safety huddle that senior management attended each morning.
- A standard National Early Warning Score (NEWS) chart was used to record patient observations and identify deteriorating patients.
- The environment was visibly clean and staff followed the hospital policy on infection control. Equipment was generally cleaned after use with an: 'I'm Clean' sticker placed on to it.
- There were policies and procedures in place to manage infection prevention and control.
- Resuscitation equipment for use in an emergency was regularly checked and ready for use in the theatres and ward area.
- Medicines in the ward area were contained in locked cupboards.
- Pre-operative assessments were carried out in line with National Institute for Health and Care Excellence (NICE) guidelines. Risk assessments were completed using nationally recognised tools.
- There was a policy and Service Level Agreement (SLA) in place to support transfer of patients to the local NHS trust.
- Patient care was consultant led. The service had registered medical officers (RMO) in attendance 24 hours a day who provided support to the ward and theatres.

Incidents

- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally.
- The systems, processes, and practices that were essential to keep people safe were consistently identified, put into practice, and communicated to staff.
- A paper-based incident reporting form was completed by staff involved in an incident which was then then forwarded to the risk manager who transcribed the incident onto an electronic reporting system. The director of nursing and clinical governance committee reviewed reported incidents to ensure the appropriate investigations and actions had been taken and only they had the authority to sign and close incidents.

- There were nine serious incidents reported between January 2015 and December 2015. All of these incidents occurred in the operating theatre and a full investigation had been carried out on each, no trends had been identified.
- We reviewed six incidents at random and found that three of them had not been graded correctly.

1. One had been graded as moderate, when it should have been graded as serious, this related to a patient that required a further hip revision following surgery. Therefore the patient experienced avoidable harm.
2. One related to a patient that had to undergo a CT scan to detect whether a pattie (a small swab) had been retained, as well as an additional wound investigation to detect the swab. This had been recorded that there was no harm to the patient. However, the patient had received a dose of radiation and the wound was investigated to see if the swab could be visualised. Therefore the patient experienced avoidable harm.
3. Another had been graded as moderate according the root cause analysis, when it should have been graded as serious. This was in relation to a patient that was transferred to the local NHS trust and required additional surgery after perforation of an organ during the initial surgery. Therefore the patient experienced avoidable harm. This had been reported to the Clinical Commissioning Group and the CQC.

Therefore we were not assured that there was consistency with reporting and grading of incidents.

- All serious incidents were analysed at clinical governance meetings to ensure that lessons were learnt. This information was disseminated to staff via head of department meetings through ward handovers, staff meetings, and safety briefings.
- There had been no never events reported in the last 12 months within surgery 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. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident (Serious Incident Framework, NHS England April 2016).
- From April 2015, independent providers of healthcare 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 were fully aware of the Duty of Candour regulation (to be honest and open) ensuring patients always received a timely apology when there had been a defined notifiable safety incident. We saw that this had been applied when we reviewed both incidents and complaints.

Safety thermometer or equivalent

- The NHS Safety Thermometer is a tool for measuring, monitoring, and analysing patient harms and 'harm free' care. Data was collected on a single day each month to indicate performance in key safety areas, for example, new pressure ulcers, catheter urinary tract infections, and falls. The hospital audited and monitored avoidable harms caused to all patients. Between May 2015 and April 2016 there were no falls, no pressure ulcers and no urinary tract infections associated with catheter management reported. This information was displayed on the ward.

Cleanliness, infection control and hygiene

- The ward, theatres, recovery and pre-assessment area were visibly clean and tidy.
- Within the endoscopy department there was a decontamination process and defined cleaning pathway for endoscopes after use. All endoscopes were electronically tracked. This meant that in event of a failure in the decontamination cycle/process or for infection control reasons they were traceable.
- The hospital had several infection control policies available on the hospital intranet, such as the management of patients with MRSA and how to manage an outbreak. We saw all the policies had been reviewed and were in date.
- The hospital had a SLA with the local NHS trust for infection control services. This included the consultant microbiologist attending the infection control

committee to review infection control incidents, audits, water testing results as well as offering advice on antibiotic prescribing and any new building works in the hospital.

- Most staff followed the hospital's policy on infection prevention and control, however, during our inspection we observed three consultants not using hand gel during their ward round. This meant that patients received healthcare from clinicians who did not decontaminate their hand immediately before and/or after every episode of direct contact of care. This contravened NICE QS61 Statement 3 guidance.
- Infection control audits were carried out monthly, such as environmental cleaning and hand hygiene. Between February 2016 and April 2016, hand hygiene audits showed a variance in compliance between 70% in theatres and 100% on the ward. There were specific action plans to improve compliance which included explaining the opportunities for hand washing and ensuring staff attended infection control training.
- Heads of departments shared audit results with staff via ward meetings and a governance notice board.
- The hospital had refurbished the ward corridors in 2015/2016. Patient rooms had not been refurbished since being built in 2006; this meant that they were not compliant with current Department of Health Building Regulations 2013. We observed a lack of clinical hand washing facilities within the ward area. Clinical hand basins were provided in utility areas but not in patient rooms. This meant that at the point of care, staff were washing their hands in patient's private bathrooms. Although the sinks in patient bathrooms had wrist operated taps, best practice would be to have dedicated clinical sinks within each ensuite rooms. Department of Health Guidelines 2013 HBN00-09 state that 'Ensuite single bed rooms should have a general wash-hand basin for personal hygiene in the ensuite facility in addition to the clinical wash-basin in the patient's room'. Therefore, the hospital was not compliant with infection prevention and control guidelines. The hospital was aware of the issue and it was recorded in the risk register. The implementation of clinical sinks would be rectified during the next refurbishment, but there was no timescales on this.
- The flooring in patient rooms had not been refurbished since being built in 2006 and was also non-compliant with Department of Health (DH) 2013 HBN0010 part A. The flooring in patient rooms was also non-compliant with Department of Health (DH) 2013 HBN0010 part A. The covering from the floor did not rise far enough up to the wall. This meant that cracks could appear where the floor met the wall and be a source for bacteria to collect. The hospital had updated their risk register to reflect this after our initial inspection when the issue was raised with the senior management team. The hospital planned to rectify this during the next hospital refurbishment although it was unclear as to when this would take place.
- Personal protective equipment, such as gloves and aprons were used appropriately and were available in sufficient quantities. We did not observe staff using the wash basins; this may have been because they were located in patient rooms. However; we saw most staff using hand gel that was readily available throughout the ward.
- We observed staff complying with 'bare below the elbow' policy in all the clinical areas inspected.
- Equipment was cleaned after use with an; 'I'm clean' sticker placed on it.
- The hospitals Patient Lead Assessments of the Care Environment (PLACE) 2016 indicators were better than the England average. Cleanliness scored 100% across all areas.
- MRSA screening was done prior to admission when required, for example for patients undergoing orthopaedic surgery. This involved taking a swab from the patient's skin or their nose to test for MRSA. This followed the national guidelines.
- There had been no incidents of reported MRSA or Clostridium difficile (C .diff) between January 2015 and December 2015.
- The hospital had an infection prevention and control lead nurse and link nurses in clinical areas. Link nurses were responsible for collating audit data of cleaning schedules and producing actions to address compliance when necessary. For example, they were involved in hand hygiene audits.
- There was dedicated housekeeping staff for the ward area that followed the daily cleaning schedule. They had all undergone infection prevention and control training and used different coloured mops and buckets for clinical and non-clinical areas. This was in line with national guidance and best practice
- There had been 20 surgical site infections reported between April 2015 and February 2016, which was lower than the national average. The patients involved had

undergone orthopaedic procedures. The infection prevention and control lead nurse reviewed all wound infections and carried out a root cause analysis and advised staff on the management of the infections. There had been no trends identified. Action taken included a review of antibiotic usage.

Environment and equipment

- There was sufficient equipment to maintain safe and effective care, such as anaesthetic equipment, theatre instruments, blood pressure and temperature monitors, commodes and bedpans.
- Resuscitation equipment, for use in an emergency in operating theatres and the ward area were regularly checked and documented as complete and ready for use. The resuscitation trolleys were secured with tags, which were removed daily to check the trolleys and that their contents were in date. There was no paediatric resuscitation equipment available and no evidence that this had been risk assessed.
- There were systems to maintain and service equipment as required. Equipment had undergone safety testing to ensure they are safe to use. The hospital engineer carried out general maintenance in the hospital and there was a specific maintenance contract for specialist equipment for example the endoscopy washers and anaesthetic machine. There was a dedicated electronic system to manage the maintenance programmes and alert staff when specific equipment required maintenance.
- The hospital had a service level agreement (SLA) with the local NHS trust for the maintenance and breakdown of equipment such as the electrocardiogram machine (ECG). We were informed these were generally repaired on the same day.
- The environment within the ward and all theatres and recovery areas was well maintained, clean and tidy.
- The PLACE report for 2016 showed the hospital's condition, appearance and environment was 100% compliant.
- Weekly water testing was carried out on the endoscopy equipment, the results between January 2016 and May 2016 had met all the requirements, such as testing and controlling the risk of exposure to **legionella** bacteria.
- Bi annual legionella water testing was carried out. Samples were taken from various taps, and the cold-water tanks. The results showed that all areas tested in August 2015 and February 2016 had met the requirements.
- The hospital was in the process of refurbishing one of its theatres. This meant that the theatre was closed and only two theatres were operational during our inspection. The hospital had planned in advanced for this and there had been no operations cancelled. During our unannounced visit to the hospital we saw that the theatre had been re-opened and all safety procedures, for example infection prevention and control testing and equipment commissioning, prior to this had been completed.

Medicines

- The hospital had a service level agreement with the local NHS trust who provided all pharmacy services. This included providing all medicines for use in departments, providing medical alerts, recalls and an emergency duty service. The trust also provided training for the hospital staff. The hospital received five hours of pharmacist time per week. The pharmacist visited the hospital daily; Monday to Friday and reviewed all patient prescription charts, and provided advice to medical and nursing staff on clinical safety issues. In addition, a pharmacy technician was allocated for three hours a week to the hospital. They were responsible for ensuring stock orders of medicines were completed.
- The ward manager told us that out of hours if medicines or advice was needed the pharmacist on call for the local trust would be contacted.
- The ward keys including medicine keys and controlled drug keys were stored in a key cabinet in the treatment room. All registered nurses working on the ward were given the security code to the cupboard. This process had not been risk assessed. There was no process for signing keys in and out of the key cupboard and there was no end of shift check completed. There was no process to ascertain who had access to the keys at any particular time. There were no daily checks and there was not a risk assessment in place. In addition, general hospital keys, for example those required by the on call engineer were stored within this cupboard. Therefore

we were not reassured that the safe management of medicines was in place. This was raised with senior management during our inspection and again on the unannounced inspection.

- During the announced inspection on 24 and 25 May 2016 we found that the medicine fridge in the endoscopy unit was unlocked. During our unannounced inspection to the hospital on 6 June 2016, this fridge was still unlocked. Staff told us that after our initial inspection a lock had been fitted to the fridge but this had been broken. This meant there was a risk of medicines being left unattended in an unlocked fridge when the unit was unstaffed and not in use. Our inspectors raised this issue with the senior management team which prompted staff to consider arrangements for moving the medicines at the end of the working day to a fridge elsewhere in theatre that could be locked. The senior management team told us that they would ensure a lock was fitted to the fridge as soon as possible.
- Ambient temperature of medicines storage rooms and fridge temperatures were checked and recorded daily, to ensure that stored medicines were safe for use. All temperatures were within the required ranges.
- Medicines were mostly contained in locked cupboards. However, we found that drug cupboards in anaesthetic rooms were being left unlocked whilst the associated theatre was in use to provide quick access to anaesthetic medicines and those that may be required in an emergency. There had been no associated risk assessment into this practice. This does not comply with the hospital's medication policy which states that: 'All storage facilities will remain locked unless under the personal supervision of a registered practitioner who has authority to access the specific facility'. This was raised with senior managers during the inspection.
- Each theatre used a key cupboard system to store all keys required for the theatre to be operational. We saw that keys were signed out daily. There was an incident in October 2015 whereby a controlled drug (CD) check showed some medicines were missing and unaccounted for. There was an action plan following the investigation into the missing medicines but it did not include a hospital wide or department risk assessment into the use of hospital wide key cupboards.
- Discharge medicines were also provided by the local trust pharmacy. The hospital was able to fax "take home" prescriptions through to the pharmacy initially with the original prescriptions being delivered by the hospital porters to the trust. Staff confirmed this process and told us that medicines were generally received in a timely manner.
- There were effective arrangements for the receipt, storage and disposal of unwanted medicines, managed by the pharmacist.
- We did not observe the administration of medicines during our inspection. However, we checked five medicine charts which had all been completed appropriately.
- Nursing staff were aware and were able to seek guidance from the hospital's medicines policy and British National Formulary (BNF), which was the latest up to date edition. The BNF is a pharmaceutical reference book and contains advice on prescribing and pharmacology.
- A snapshot medication audit had been completed in January 2016, which reviewed the number of medication omissions over a 24-hour period. The audit reported that five medication charts were reviewed, with 27 medications prescribed. Within the 24 hour audit period, these medications could have been administered on 67 occasions. The audit showed that medications had been omitted on four occasions. The pharmacy analysis showed that the nurse had recorded the reason for omission on each occasion.
- The local trust pharmacist reviewed prescription charts daily and brought to the attention of nursing and medical staff any clinical and safety issues. Nurses who worked in the pre-assessment area conducted a reconciliation of medicines although there was no formal audit of this.
- We saw evidence of audit of medicines errors between December 2015 and February 2016 and actions taken as a result. For example ensuring that the correct number of days that medication should be taken was clearly written on the medication box. There was evidence that CD medication was being audited and actions taken as a result of this audit. For example in January 2016 the audit showed that patient's own CD medication was documented incorrectly on return of the medication to the patient, all staff were reminded of the process and the night staff made additional checks.

Records

- Records were are accurate, complete, legible and up to date. However, they were not always stored securely. The hospital used a paper based records system for recording patient's care and treatment.
- Patient's records were stored in the nursing office on the ward. The door to the office was lockable with a keypad system. However; we observed it to be left open during our inspection. There was a ward clerk at the nursing station directly in front of the nursing office. Staff confirmed that the door would be locked when the ward clerk was not on duty or had cause to leave the desk area.
- When patients were discharged, their notes were placed in a locked box and collected by the medical records team to be stored according to hospital policy.
- We reviewed four sets of patient records. Information was easy to access and the records contained information on the patient's journey through the hospital including pre assessment, investigations, results and treatment provided. There were care pathway booklets for different types of procedures such as general surgical pathways and orthopaedic pathways. These pathways ensured that progress was made and any deviation from the prescribed pathway could be identified with the appropriate intervention made.
- The five steps to safer surgery checklist record, designed to prevent avoidable harm, was completed for patients undergoing invasive procedures. Completion of checklists was audited by the hospital, which considered the paper checklist only. During our inspection we observed a surgeon commencing surgery during the 'time out' step of the process.
- Five steps to safer surgery checklists were completed and audited, the audits checked completion of the paper document, there were no observational audits carried out.
- We reviewed a set of patient's notes in theatre which included the anaesthetic notes completed by the anaesthetist. We found these were not legible and it was difficult to read which medications had been administered. The completion of patient notes was being audited by the hospital and from January 2016 to March 2016, 94% to 97% of patients notes reviewed were found to be appropriately completed.
- When changes were made to theatre lists, the lists were reprinted and the wards informed. Lists were reprinted on different coloured paper, which meant that all staff were aware of the most current theatre list order. This is considered to be good practice.

Safeguarding

- The hospital had safeguarding policies available to staff on the intranet, which staff knew how to access. We saw flow charts on staff information boards to remind all of the process, so that they knew how to protect patients from abuse and avoidable harm.
- The hospital had safeguarding leads for adults and children. Staff were aware of who they were and how they could be contacted.
- Staff had received training on safeguarding children level 2, through electronic learning and had a good understanding of their responsibilities in relation to vulnerable adults and young people. They were able to explain how to raise a safeguarding concern. However, the Royal College of Nursing Intercollegiate document 2014: Safeguarding Children and Young People: Roles and competencies for Health Care Staff, states that: 'All clinical staff working with children and young people and/or their families and carers and who could potentially contribute to assessing, planning, interviewing and evaluating the needs of a child or young person should be trained to level 3 in safeguarding'. The hospital was not following this guidance, which meant that staff potentially did not have the correct qualifications, competence, skills and experience in safeguarding children and children and young people could be exposed to risk. This was raised with the senior managers during our inspection.
- Although the patients were under the direct care of a consultant, the consultant was not present for the duration of the young person's stay.
- Ward and theatre staff had completed 100% of mandatory training modules in safeguarding adults and children at levels 1 and 2.
- We reviewed medical notes of young people aged between 16-18 years that had been admitted onto the ward. Out of 10 sets of notes we found that six did not have comprehensive discharge information, follow up instructions or details of who the young person was being discharged with. One young person was discharged at 11pm and there were no details with whom they had been discharged. Therefore we were not

assured that young people were discharged safely and that staff were effectively assessing the risks to the health and safety of young people. This was raised with senior managers during our inspection.
- The hospital safeguarding policy contained guidance for staff on female genital mutilation and domestic violence.

Mandatory training

- Staff received mandatory training to enable them to provide safe care. Some of the training was completed through e-learning and some, for example, manual handling was provided through onsite training.
- At the time of inspection, 92% of staff had attended their mandatory training. This was above the BMI target of 90%. The hospital also offered mandatory training for consultants, who, although employed elsewhere, had practising privileges at the hospital.
- Mandatory training sessions could be accessed on the corporate intranet via 'BMI Learn'; an online resource of training modules. Sessions included: adult basic and intermediate life support, equality and diversity, control of substances hazardous to health, fire safety, infection prevention and control, moving and handling awareness, blood transfusion, safeguarding adults and children and PREVENT (protecting people at risk of radicalisation), acute illness management (AIMS), information governance and waste management.
- Resident medical officers (RMOs) were trained in advanced life support (ALS) and European paediatric life support (EPLS). Some senior nursing staff and operating department practitioners were also trained in ALS.
- The compliance co-ordinator monitored staff compliance with mandatory training and sent monthly reports to heads of department. The employee compliance co-ordinator also monitored non-attendance and re-scheduled staff onto sessions they had missed to promote compliance.
- Mandatory training was discussed at the induction day for all new starters. Staff signed an agreement on appointment about their responsibility to ensure they undertook the mandatory training relevant to their role
- Induction sessions were held regularly for new starters followed by a customer care course. The Hospital Director was involved in the induction to discuss the hospitals vision and values.
- We spoke with an agency nurse who told us she had undergone an induction of the ward and we saw written evidence that this had taken place.
- Staff said they had completed all of their mandatory training for 2016. The ward manager was able to show us records of staff training, which identified the members of staff who had training to complete. Training records were displayed on a staff notice board so staff could clearly see what training that was outstanding. The ward manager followed up staff members who had persistently failed to complete the training, or were having difficulties doing so. For example, the ward manager had spent time with staff who lacked confidence using the online system.
- There was a database showing attendance. There had been occasions where a member of staff had been unable to attend an induction session and these staff members were followed up to ensure compliance.
- All pre-assessment nurses had completed a pre-assessment course provided by an external provider, we saw evidence of their attendance.
- BMI Learn also allowed staff members to enrol on additional training courses to enhance their job role, should they wish; for example, pre assessment courses.

Assessing and responding to patient risk

- Children were exposed to the risk of not being cared for by staff with the correct qualifications, competence, skills and experience to carry out safe care and treatment. The hospital employed no registered nurses (child branch) neither did they have access to a lead children's nurse for advice or support.
- There was no evidence that the hospital management had implemented this policy or taken reasonably practicable actions to mitigate any such risks to children. The service was failing to prevent children and young people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. This meant that children were exposed to the risk of not being cared for by suitably qualified staff with the correct qualifications, competence, skills and experience to carry out safe care and treatment.
- There was non-compliance with BMI Care of Children Policy 2014, which states:

Requires improvement

Surgery

1. Surgical lists should only be scheduled when children's nurses are available to care for the children, peri-operative care staff, trained in caring for children must also be available. It is important that staff in theatre recovery have the correct skills.
2. An anaesthetic nurse or operating department practitioner (ODP) with paediatric training, experience and competence in the care of children in this category shall be available to assist the anaesthetist with anaesthesia. There must be a nominated lead consultant anaesthetist responsible for the oversight and organisation of all anaesthesia services for children in the hospital, including pain and resuscitation services, and for ensuring that suitable equipment, including children's resuscitation equipment, is purchased and maintained.
3. The lead paediatric consultant should be a member of the Medical Advisory Committee.
4. Children can be seen in outpatient departments even if no children are admitted to the hospital as long as this policy is adhered to. Each hospital solely undertaking out patients will still need to have access to a Lead Children's Nurse.
5. The lead nurse can be appointed or a Service Level Agreement set up with another hospital to provide access to a Lead Children's Nurse. This nurse will have responsibility for hospital children's policies and protocols, and auditing children's care in line with all relevant policies.
6. Access to the Lead Children's Nurse for support and advice shall be available.

- Risk assessments were carried out for people who used services and risk management plans had been developed in line with national guidance. Preoperative assessment is a clinical risk assessment where the health of a patient is appraised to ensure that they are fit to undergo an anaesthetic prior to the planned surgical operation. The pre assessment also ensured patients were informed about the surgical procedure, the post-operative recovery period and the admission, discharge, and post-operative care at home as required.
- Not all patients attended a pre-assessment clinic before their admission for surgery. Patients were assessed according to their clinical needs by completing a preoperative questionnaire. On receipt of the questionnaire patients were then triaged to determine who required a face-to-face consultation or a telephone call. All patients having planned major surgery, for example, a hip replacement attended a preoperative assessment clinic. Any preoperative investigations, for example; blood tests were carried out during the clinic visit. Preoperative assessments were carried out in line with NICE guidelines.
- Patients who required testing for MRSA were swabbed prior to admission. If the patients had a positive MRSA swab, the patients' GP was contacted and asked to prescribe treatment for the patient, to be commenced five days prior to their operation date. This ensured that patient's operation was not delayed. The hospital followed the microbiology department guidelines from the local NHS trust and used their microbiology services. We saw there was a SLA in place.
- The National Early Warning Score (NEWS) was used to identify deteriorating patients. Staff recorded routine physiological observations, such as blood pressure, temperature, and heart rate all of which were scored according to pre-determined parameters. We reviewed four NEWS charts in patient notes and found that scores were added up correctly.
- All clinical staff were trained in Acute Illness Management (AIMS) as part of their mandatory training.
- If a patient deteriorated the consultant would make arrangements for transfer to the local NHS trust. There was a policy to support this process and a SLA between the hospital and the local NHS trust. There had been 25 patient transfers to the local NHS Trust between January 2015 and December 2015.
- A senior member of nursing staff from each clinical area carried the emergency bleep for their period of duty which meant they were able to respond quickly to a deteriorating patient.
- There was access to a minimum of two units of O Rhesus negative blood. O negative blood can safely be given to most people. It is often used in medical emergencies when a patient's blood type isn't immediately known.
- The hospital had a 'massive blood loss' protocol and staff were aware of where the emergency blood was stored and how to obtain it. Further blood for transfusion was obtained through the local NHS trust blood bank and the details of how they were contacted were included within the flow chart attached to the blood loss protocol.
- The hospital's practicing privileges agreement required consultants to be contactable at all times when they

had patients in the hospital. The guidelines said that consultants needed to be able to attend the hospital within 30 minutes, according to the level of risk to the patient. The consultants were responsible for ensuring suitable cover arrangements were made with another approved practitioner in the event that they were not available, for example, holidays. The consultant's secretary advised staff and the hospital switchboard of the consultant cover and contact numbers. We saw a list in the nursing office of consultants that ware on holiday and who was covering for them.

- Risk assessment were completed using national recognised tools, for example, the Waterlow score to assess patients risk of developing pressure ulcers. The five steps to safer surgery checklist record, designed to prevent avoidable harm was completed for patients undergoing invasive procedures. Completion of the checklist was audited, from January 2016 to March 2016. Data showed compliance with checklists was between 92% and 99%. During our inspection we were told that audit results showed 100% completion of checklists. However, the audit considered the paper forms only and did not audit the checklist being physically completed correctly in the operating theatre, for example all staff taking part in 'time out' and patient checks.
- A consultant orthopaedic surgeon had introduced an extra safety check when operating. The size and type of prosthesis was confirmed and recorded on the whiteboard so that the prosthesis can be checked against this information before being implanted.
- Adherence to local policies and procedures were monitored with a schedule of local audits, for example, NEWS, five steps to safer surgery and medical documentation audits. NEWS documentation audits were conducted monthly. Samples of ten sets of patient records were reviewed for May 2016. Results showed that in seven out of ten sets of notes there was full documentation of NEWS assessments. In the remaining three sets of patients notes 90% of the NEWS assessment had been documented. There was some evidence of actions following the audit, for example the issues with the NEWS completion were going to be raised with the nurses involved. We asked the hospital to provide previous months audit data for comparison but the hospital was unable to provide this.
- Venous thromboembolism (VTE) assessments were recorded and were clear and evidence-based, ensuring best practice in assessment and prevention. Assessments were audited within the BMI audit plan. Compliance ranged between 67% and 100%, however, it was unclear whether this related to VTE audits only as several audits were included. There was no associated action plan to effect improvements.

Nursing staffing

- We saw evidence that all registered nurses and professional staff that worked in the wards and theatres had valid nursing and midwifery registration or were registered with the Health and Care Professions Council. This confirmed that nurses and other practitioners, such as operating department practitioners and physiotherapists, were trained and eligible to practise within the UK. There was a process in place to ensure these were updated which was reviewed monthly and staff reminded, when necessary, of the need to renew their registration. If for example a nurses registration had expired the head of department was notified that the employee was not permitted to undertake nursing duties.
- The hospital admitted young people aged between16-18 years old. The BMI Care of Children Policy includes children up until their 19th birthday. The Royal College of Nursing (RCN) guidelines 2013 states that: 'When children and young people are nursed in an adult ward, a registered children's nurse with the appropriate knowledge and skills must be employed to manage the care'. There were no registered nurses (child branch) employed by the hospital.
- According to the Royal College of Nursing (RCN) standards for clinical professionals and service managers, 2013 'Defining Staffing Levels for Children and Young People's Services:
  - A minimum of two registered nurses (child branch) must be available at all times when children and young people are being cared for.
  - There should be a minimum of one registered children's nurse on duty in recovery areas.
  - Providers must employ or have access to a senior children's nurse for advice and policy development.
  - Work collaboratively with the local NHS children's services network.
- Staff looking after children were trained to look after adults and did not have any appropriate training, skills and knowledge to care for children and young people. We raised this with the senior managers.

- The Heads of Departments (HODs) undertook the selection and interviewing of new applicants.
- If managers required advice regarding managing staff performance there was a regional employee relations department they could access.
- Nursing staff had received training to revalidate their professional practice, which included education about reflective practice.
- We saw that staff rotas were planned four weeks in advance. Bed occupancy varied therefore the hospital used a staffing tool which was based on an analysis of the dependency of the patients and the subsequent nursing activity required to meet the patients' needs. The numbers of nursing staff required was then adjusted accordingly. This was completed five working days in advance and was reviewed daily by the ward manager and bed coordinator to ensure that the ward had appropriate numbers of nursing staff to provide safe care to patients.
- The vacancy rates on the wards were 19% for nursing staff; bank and agency staff were booked in advance to assist with unfilled shifts.
- Theatre staffing was planned in line with the Association of Perioperative Practice guidelines. The vacancy rate in theatres was 17% at the time of the inspection. In order to ensure safe care for patients the hospital had used up to 40% of agency staff to cover shortfalls during the previous year. The hospital used a particular agency and long-term bookings were used to provide stability and continuity.
- There was an on-going recruitment programme.
- During our inspection, we saw that planned numbers of nursing staff had been met.
- We observed nursing handovers within the ward were well structured and gave clear concise information on each patient. Handovers were recorded on a small electronic device by each named nurse. This meant that nurses could continue to care for patients whilst the next shift of nurses were listening to the handover. The recording could be repeated for clarity if needed. A printed handover sheet was used in conjunction with the recording. This did not, however, give an instant opportunity for nurses to ask further questions about treatment plan and care. Staff we spoke with told us that they still had sufficient time to ask questions after handover and before the previous shift of nurses left the hospital.

Surgical staffing

- Patient care was consultant led. There were 216 consultants with practising privileges working at the hospital. The hospital practising privileges agreement required all consultants to be available within 30 minutes. In addition it was required that patients be reviewed daily on the ward, more frequently if necessary. Staff we spoke with confirmed that consultants were available and did review patients when requested to do so. We saw evidence of this in patients notes. We saw consultant contact numbers were available on the wards.
- The hospital management had not nominated a lead consultant anaesthetist responsible for the oversight and organisation of all anaesthesia services for children in the hospital.
- Resident Medical Officers (RMOs) were employed through an agency the company had a formal contract with. They worked a two weeks on two weeks off rota. The hospital employed RMOs of a senior grade with anaesthetic experience as the role required a doctor with a degree of confidence in managing an acutely unwell patient. The RMO told us that they were never asked to complete a procedure that they did not have the skills to undertake.
- The RMO was in attendance in the hospital 24 hours a day, seven days a week. The RMO provided medical support to the ward and theatres and was easily accessible via the hospital bleep system.
- The RMO attended the evening nursing handover to ensure that patient care and treatment overnight was discussed.
- The hospital had a database of consultants who had been granted practising privileges that was also monitored centrally as well as locally. This included the status of each consultant with regards to their indemnity, appraisal, General Medical Council registration and Disclosure and Barring Service (DBS) checks which helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. At the time of the inspection the consultants were seen to be 95% compliant with all checks.
- All consultants carried out procedures that they would normally carry out within their scope of practice within their substantive post in the NHS.

Requires improvement

Surgery

- The executive director's personal assistant managed the database and explained an email was automatically generated to remind a consultant if for example their appraisal or indemnity was overdue or expired. Those outstanding had received reminders. We saw evidence that the executive director had previously suspended consultants from practice, who had not complied with supplying required documents.
- We saw evidence that practising privileges were reviewed every other year in accordance with the hospitals practising privileges policy.
- Consultant anaesthetists had practising privileges within the hospital and provided on call cover when needed. The hospital switchboard were aware of this and had contact numbers.

Major incident awareness and training

- Staff were aware of the procedures required in the event of a major incident and there was a business continuity plan in place for emergency situations, for example, los of power and water.
- Nursing staff were able to demonstrate that they were able to access the major incident policy for the organisation.

Are surgery services effective?

Requires improvement

We found the service required improvement in effectiveness because:

- Staff had completed Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguarding (DoLS) training, however, some staff were unaware of the actions they would take if they were concerned about a patient's capacity and who would complete the formal assessment.
- We examined 10 medical and nursing records for young people aged between 16-18 years that had been admitted to the hospital. The consent process was not always being followed.
- Staff appraisals were low at 69% for the whole hospital and 38% in theatres.
- There was a risk that patients could be starved of fluids and food, for longer than recommended guidelines prior to surgery.

However we also found that :

- The hospital policies were current and based on professional and national guidelines.
- There was a link nurse for pain management who provided support to the clinical team ensuring best practice.
- Risk assessments of patient's nutritional status were completed.
- Essential training was provided to ensure staff worked safety and effectively in their roles
- The medical advisory committee ensured that consultants caring for patients were skilled and competent. Practising privileges for consultants were reviewed annually.
- There was participation in some national audits.
- Consultants were on call seven days a week with a 24 hour a day RMO clinical support.

Evidence-based care and treatment

- The hospital policies were current and based on professional guidelines, for example, NICE and Royal College guidelines.
- Policies were available on the intranet and staff were able to demonstrate how they gained access to them.
- We saw the hospital had systems in place to provide care in line with best practice guidelines (NICE CG50: Acutely ill patients: Recognition of and response to acute illness in adults in hospital). For example, an early warning score was used to alert staff should a patient's condition deteriorate, guidance was available on when to escalate if a patient condition deteriorated.
- Outpatient staff participated in the PROMS audit as part of the preadmission assessment process. The patient reported outcome measures (PROMS) captures details of patients health and quality of life pre and post operatively through a questionnaire. The information was shared through a database to assist in the improvement of quality of procedures within the NHS.
- Some policies were developed centrally such as infection prevention and control, which meant hospitals within the company when audited, could be benchmarked for compliance against one set of standards.

Pain relief

- The hospital had a pain relief link nurse to provide support to the clinical team ensuring best practice.

- The surgical care pathway used prompted staff to assess, record and manage pain effectively. Patient's records showed that pain had been assessed using the pain scale within the NEWS charts, appropriate medicines given as prescribed and effect of analgesia individually evaluated. The hospital completed a pain management audit in February 2016 which showed that pain was assessed on admission for all ten of the inpatients records audited. The audit also reviewed the prescription of regular analgesia (9/10), the prescription of ad-hoc analgesia (10/10), completion of pain scores for inpatients (9/10) and the number of patients reporting that their pain was managed appropriately (8/10).
- Pain management was discussed at nursing handovers.
- Most patients we spoke with had been offered pain relief and felt their pain was being managed appropriately.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess patients risk of malnutrition as part of their initial nursing assessment. This was updated if the patient's condition changed, during their stay.
- Intravenous fluids were prescribed, administered, and recorded appropriately.
- Nausea and vomiting were formally assessed and prescribed treatment given as required.
- Pre-operative fasting guidelines were aligned to the recommendations of the Royal College of Anaesthetists, (RCOA) with patients on morning or afternoon lists fasted appropriately. However the hospital issued guidelines to patients on an all-day theatre list to fast from midnight. The order of theatre lists were not clarified until as late as the day of surgery. This meant that depending on where patients were on the theatre lists some patients could have been fasting for extended periods of time. Staff we spoke with were aware of this and told us that advice would be sought from the anaesthetist in such cases and patients offered fluid and light diet if appropriate.
- An external company was employed by BMI to provide catering services. Meals were all prepared off site and then steamed at the hospital. The catering manager told us that a range of meals were provided to meet the individual dietary needs of all patients. When the catering department was closed, patients who came back from theatre in the late afternoon had access to food, for example sandwiches and fruit. The catering department ensured the ward had suitable supplies to meet patients' needs.
- The hospital restaurant menu provided a range of choice to patients and the quality of food in the Patient Led Assessment of the Care Environment (PLACE) audit for 2016 scored 100%.
- Patients we spoke with were positive about the food they had received.

Patient outcomes

- The hospital participated in some national audits, such as the elective surgery Patient Reported Outcome Measures (PROMS) programme and the National Joint Registry (NJR).
- The hospital received annual PROMS report and data for April 2014 to March 2015, showed that for the oxford knee score, of the 90 patient records reviewed 92% of patients reported an improvement in health after their procedure. Data for Oxford hip score showed that of the 81 patient records reviewed 98% of patients reported an improvement in health after their procedure. Data on groin hernias showed that of the 39 patient records reviewed, 64% of patients reported an improvement in their health, with 33% reporting a worsening of their health. All PROMS health scores were similar to the England national averages in all measures.
- The hospital had achieved 100% in their NJR submissions from April 2015 to April 2016.
- From January 2015 to December 2015 there had been 25 transfers to the local NHS trust, 18 readmissions to the ward and 9 unplanned returns to theatre. Each case had been reported as an incident and investigated, but no trends had been identified.
- There was a NEWS audit carried out in May 2016 which showed 95% compliance with completing the forms.
- The hospital did not have Joint Advisory Group (JAG) accreditation but were working towards this.

Competent staff

- Staff that had received an annual appraisal found this a positive experience. Information provided by the hospital confirmed that for 2015 all ward staff had undergone an annual appraisal .However in theatres only 38% of staff had received their annual appraisal. The remaining staff had an appraisal appointment booked with the theatre manager.

- Among the staff we spoke with, there was inconsistency in completion of appraisals with the longest gap between appraisals being four years. At the time of our inspection the hospital appraisal rate was 69% for all staff. This was raised with senior managers during our inspection who were aware that compliance with appraisals was low at the hospital.
- During the unannounced inspection we were informed that 80% of all hospital staff had received an appraisal and the remaining staff were booked for an appraisal in the following month.
- We reviewed five sets of staff records; two new-starters and three staff members who had been employed for over three years. Of the staff records all included two references, a health clearance and up to date DBS check.
- There were no registered nurses (child branch) employed by the hospital. Staff looking after children were trained to look after adults and did not have any specific training to look after children and young people.
- The hospital provided an induction programme for most new staff. There was only a verbal induction offered to agency staff working in the endoscopy department. Agency staff in theatre and the ward completed an induction checklist orientating them to the hospital and department during their first shift at the hospital.
- Newly appointed staff we spoke with said they had received formal induction before commencing their role. A newly appointed staff nurse was able to show us their competency document, which was comprehensive.
- Two newly recruited staff members we spoke with described a robust corporate induction which covered essential training that ensured staff could work safely and effectively in their roles. Staff said they felt supported in their new roles.
- The ward manager was able to show us the competency document for all new staff and told us that specialised competencies were being added to reflect the versatility of skills needed by ward staff in caring for various speciality surgery patients. We also saw evidence of completed competencies for two bank staff employed in the endoscopy unit.
- BMI had allocated new staff members with a 'buddy'. This may be a member of staff from another BMI hospital working in a similar role, who they could contact for advice. Staff spoke positively about this experience.
- Registered practitioners had completed intermediate life support training (ILS). Basic life support training was provided to other members of staff such as office staff and porters. This ensured that all staff were able to respond to a deteriorating patient's needs.
- We saw evidence that all registered nurses and professional staff that worked in the ward and theatres had either valid nursing and midwifery registration or were registered with the Health and Care Professions Council. This confirmed that nurses and other practitioners such as operating department practitioners and physiotherapists were trained and eligible to practise within the United Kingdom.
- The hospital had a Medical Advisory Committee (MAC). Their role included ensuring that consultants were skilled, competent, and experienced to perform the treatments undertaken. Practising privileges were granted for consultants to carry out specified procedures using a scope of practice document. In addition registration with the General Medical Council (GMC), the consultants' registration on the relevant specialist register, indemnity insurance and checks with the disclosure and barring service check were carried out.
- Practising privileges for consultants were reviewed annually. The review included all aspects of a consultant's performance which included an assessment of their annual appraisal, volume and scope of activity together with any related incidents and complaints. In addition, the MAC advised the hospital about continuation of practising privileges.

Multidisciplinary working

- Nursing staff reported good working relationships within the hospital management team, the local NHS hospital and GPs.
- The hospital had various SLAs with the local trusts and had access to some of their services, for example, stoma care and breast care nursing services.
- We observed effective team working among heads of departments, administrative, clinical, nursing and ancillary staff during our inspection.
- Staff described the multidisciplinary team as being very supportive of each other. Staff told us they felt supported, and that their contribution to overall patient care was valued. Staff told us they worked hard as a team to ensure patient care was safe and effective.

- The imaging department provided dedicated theatre radiographers to cover theatre sessions.

Seven-day services

- Consultants were on call seven days a week for patients in their care. Staff we spoke with confirmed that consultants reviewed patients at the weekend.
- There was 24 hour a day RMO cover in the hospital to provide clinical support to consultants, staff and patients.
- Pre assessment clinics were scheduled on Saturday mornings. This meant that patients who found it difficult to attend the clinic on a weekday had access to pre assessment services.
- Nursing staff could obtain emergency out of hours prescribed medicine, by contacting the on call pharmacist from the local NHS trust, where there was a trust hospital at night nursing team who had access to the out of hours pharmacy facility.
- Inpatient physiotherapy was available seven days a week.
- The imaging department was open Monday to Saturday with appointments completed according to clinical need. Emergency provision of MRI and CT scanning was completed by the local NHS trust under a service level agreement.
- There was a senior manager on call 24 hour a day for staff to access for support and advice.
- Patients requiring endoscopy out of hours would be transferred to the local NHS trust.
- There were on- call arrangements in place to provide staffing if a patient needed to return to theatre.

Access to information

- Computers were available in the ward and theatre areas. All staff had secure, personal log-in details, access to e-mail and all hospital systems. A member of staff was able to log on to the intranet system and show us how policies and procedures were accessed. It was clear they were familiar with this process.
- Staff had access to medical records for both private patients and those commissioned for treatment from the NHS. This meant when a patient was admitted for surgery clinicians had all the information they needed including test results.
- Test results, for example blood tests were undertaken at the local NHS trust. The hospital did not have access to the trusts online results system. However, results were sent to a printer in the ward office in order that they could be filed in the patients notes by the ward clerk. Any abnormal results would be telephoned to the department where the patient was being cared for. This meant there was no delay in communication or commencing appropriate treatment. The ward office was locked when not in use.
- Consultants were responsible for ensuring appropriate records were available to other staff caring for the patient. These included details of procedure completed for therapy staff, and planned treatments for nursing staff.
- Discharge letters were sent to the patient's GP, immediately after discharge, with details of the treatment provided, follow up care and medications provided. We saw a discharge checklist used to staff to ensure that patients were safely discharged and had all the information they needed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a consent policy which staff were familiar with.
- Staff understood consent, decision making requirements and guidance. The hospital had four nationally recognised consent forms in use. For example, there was a consent form for patients who were able to consent, another for patients who were not able to give consent for their operation or procedure and another for procedures under a local anaesthetic.
- There were no consent forms available in other languages. Interpreter services were available via telephone.
- Patients were asked for their consent to procedures appropriately and correctly. Patients were asked to re confirm their consent at the time of surgery.
- The service ensured there was a two week cooling off period between patients being seen in outpatients and a procedure taking place. This allowed the patient time to decide whether to have a cosmetic procedure and allow them time to 'cool off'. This is in line with national guidance from the General Medical Council and British Association of Aesthetic and Plastic Surgeons.
- We examined 10 medical and nursing records for young people aged between 16-18 years who had been admitted to the hospital. The young people had signed their own consent form. On two of the ten consent forms

reviewed there were no risks or benefits of the operation documented. Assessments were not carried out of their understanding and capacity to give consent to tests being performed and for the planned procedure.
- We reviewed four sets of adult patient notes and all consent forms were completed appropriately.
- Staff told us that they had received training in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguard (DoLS), at the time of inspection there was 100% compliance. We found staff had some understanding of when DoLS may be required but told us that they did not have much experience of the active use of MCA. However, some staff we spoke with were unclear of what actions they would take if they were concerned about a patient's capacity and who would complete the formal assessment. Most staff told us that they would seek advice from a senior member staff, which is in accordance with the corporate policy. However, we found senior managers were unsure of their responsibilities and who would undertake a formal assessment.
- All patients undergoing surgery were consented by the consultant providing care. All patients undergoing surgery had their consent documented. We saw that this process commenced within the outpatients department during consultations.
- The service ensured there was a two week cooling off period between patients being seen in outpatients and a procedure taking place. This allowed the patient time to decide whether to have a cosmetic procedure and allow them time to 'cool off'. This is in line with national guidance from the General Medical Council and British Association of Aesthetic and Plastic Surgeons.

Are surgery services caring?

Good

We found the service to be good in relation to caring because:

- Staff took measures to ensure patient's dignity and privacy was respected.
- Patients were pleased with the care they had received and would recommend the hospital to their family and friends.
- All patients we spoke with felt informed about their care and treatment.
- Consultants visited patients' throughout the day and were available to answer any questions they had.
- Patients were allocated a named nurse which meant they knew who was caring for them and who to approach if they needed assistance.
- Relatives we spoke with told us that they had been treated with care and compassion by staff.

Compassionate care

- Staff took measures to ensure patients' privacy and dignity, for example, patient room doors were closed unless patients wanted them open. Patients were asked if their names could be displayed outside their room and on the ward bed occupancy board. No further personal details such as the reason for their admission were displayed. During our inspection, we observed patients' dignity and privacy being respected.
- Patients described staff as behaving in a sensitive manner when transferring them onto theatre tables ensuring they were not unnecessarily exposed.
- The hospital carried friends and family test (FFT) for NHS patients to gauge feedback from patients about the quality of service and whether patients would recommend the service to their friends and family. The hospital records a 99% satisfaction rate for FFT with an average response rate of 32% which is similar to the England national average.
- The hospital also conducted its own survey for private patients and showed a 99% satisfaction rate.
- The patients spoken with on the ward were pleased with the care they had received and told us that they would recommend the hospital to their friends and family.
- Relatives said they had been offered tea, coffee and food during their time in the ward and that staff treated them with care and compassion.

Understanding and involvement of patients and those close to them

- All patients and relatives spoken with stated that they felt well informed about their diagnosis, care, and treatment.
- Patients told us they had been given opportunities to discuss their surgery and the risks and benefits involved with their consultant, and felt actively involved in decision-making.

- Consultants visited their patients throughout the day and were available to answer any questions they had. In addition, they were able to inform patients what to expect and their plan of treatment.
- Named nurses were allocated. This meant that patients knew who was caring for them and who to approach if they had any questions or needed any assistance. Patients confirmed that staff had introduced themselves to them at the beginning of their shifts.
- Patients told us that they felt comfortable asking questions and that staff took time to explain and answer their queries.
- We saw that parents of young people were able to stay with them in the anaesthetic room until they were asleep, to minimise distress and provide support.
- The hospital had open visiting this meant that patients could be supported by friends and family.

Emotional support

- There was information available to staff on how to contact members of the clergy to meet patient's different spiritual needs.
- We saw good interaction between an anaesthetist and a patient who felt anxious about the anaesthetic and side effects. The patient had time to ask questions and was reassured.
- Patients had access to clinical nurse specialists for example breast care and stoma care nurses as part of the hospitals SLA with the local NHS Trust. This meant that patients could receive specialised support with coming to terms and any adaptations in their everyday lives that may have happened as a result of their surgery.

Are surgery services responsive?

Good

We found the surgical services good for responsive because:

- Patients discharge plans took account of their individual needs, circumstances, and ongoing care.
- The hospital had an admissions policy which detailed criteria for NHS patients who could be safely treated at the hospital.
- Hospital staff were aware of the challenges for patients living with dementia and were informed when patients with a disability were due to attend the hospital. This meant that staff had all the necessary information to attend to their individual needs.
- The booking system for patients to be treated was flexible.
- An interpreting service was available for patients who did not speak English and staff could access patient information sheets in different languages.
- Written information on medical conditions, procedures, and finance was available.
- There was an open visiting policy within the hospital.
- Patients were given opportunities to feedback on the care they received and we saw evidence that patient feedback was acted on and improvements made.
- Information leaflets were provided to patients on how to complain if they were dissatisfied with any aspect of their care.
- The Medical Advisory Committee (MAC) and the clinical governance committee reviewed all complaints. Actions and learning from complaints was shared with all staff.
- The service ensured there was a two week cooling off period between patients agreeing to undergo cosmetic surgery and the surgery being performed.

However we also found:

- When young people were discharged home the person whom they were discharged with was not always recorded.
- Verbal complaints were not always recorded and were treated differently, depending on who the patient complained to. Therefore opportunities were lost to recognise trends and for the hospital to have a full oversight of all complaints.

Service planning and delivery to meet the needs of local people

- The hospital had good working relationships with the local clinical commissioning group to manage services for NHS patients. The hospital also assisted with additional work from the local NHS hospitals to assist with increased demand.
- The booking system was flexible allowing patients, where possible, to select times and dates for treatment to suit their family and work commitments.

- The hospital had a good relationship with local Care Commissioning Groups for planned procedures and a good relationship with the local trust which enabled them to work together to manage waiting lists.
- The hospital had an admissions policy which detailed the criteria for NHS patients that could be safely treated at the hospital. These criteria had been agreed with the clinical commissioning group's that commissioned NHS care at the hospital
- Consultants had planned and dedicated theatre lists which enabled patients to be booked onto these lists in advance.
- Patients attending the hospital had access to a small free car park in front of the hospital. Patients who were unable to park in this area could use the local NHS trust car park free of charge, which was a very short distance from the hospital. This was manned by a security guard who allowed access and exit.
- Details relating to hospital location and car parking were made available to patients prior to appointments.
- There was a service level agreement in place for the provision of several services with the local acute NHS trust. This included pharmacy, blood testing, sterile services, dietetics, stoma care and radiation protection.

Access and flow

- The hospital's pre admission policy and local contracts ensured all patients that required a pre-operative assessment had either a telephone assessment or a face to face appointment. This meant that patients, who had co-existing conditions, were identified, so that any pre-operative work up, for example blood tests, could be done. This minimised unnecessary cancellations.
- Staff began planning the patient's discharge during the pre-admission process where they gained an understanding of the patient's home circumstances and daily care needs.
- The hospital did not audit discharges which meant that it was not clear if patients were being discharged in a timely manner. A checklist had been introduced to ensure that all actions for discharge were completed, for example, that medicines had been ordered, and transport arrangements had been made. Outstanding actions to enable effective discharge were also discussed at ward handover. The ward manager told us that medicines for discharge were provided by the local NHS trust in a timely manner and audits of waiting times for discharge prescriptions confirmed that patients did not have to wait for take home medicines.
- Referral to treatment times for NHS patients were not being met. RTT monitors the length of time from referral through to elective treatment; the national average was 90%. However the targets are no longer collated and were stopped by the NHS in June 2015. From July 2015 to December 2015, 83% to 91% of patients were being treated within 18 weeks from the time of referral. Data for April 2016 showed that 79% of orthopaedic patients and 87 % of neurosurgical patients were being treated within the 18 week period. The hospital provided data that showed 16 NHS patients were waiting longer than 18 weeks from referral to treatment: some of this may have been due to patient choice.

Meeting people's individual needs

- An interpretation service was available to patients who did not speak English and staff were aware of how to access this. Staff were able to access patient information sheets about surgical procedures in different languages.
- Written information on medical conditions, procedures and finance were available and accessible in the ward.
- Patients discharge plans took account of their individual needs, circumstances, and ongoing care arrangements. For example one patient we spoke with said they would be given a discharged time but only if they felt comfortable and had the appropriate support at home, would they actually be discharged.
- Hospital staff had attended dementia training and had an awareness of the needs and the challenges patients living with dementia faced. Staff described setting up patient rooms that accommodated a carer for patients living with dementia.
- If patients with a learning disability were admitted to the hospital, staff would be aware of their needs as they were discussed at pre assessment. This meant that staff were able to understand their individual needs and accommodate their carers or relatives.
- The Patient Led Assessment of the Care Environment (PLACE) audit 2016 score for ensuring patients were treated with privacy and dignity was 91%, which was above the national average of 86%.

- Patient satisfaction survey results for March 2016 showed that 86% of patients rated the care as good with 14% of patients rating the care as excellent. The scores for January and February 2016 were similar; the overall quality of care score was 99%.
- There was an opening visiting policy at the hospital and family and friends could visit between 9am and 9pm. This meant that patients could be supported by their families during consultations, and asks questions about their treatment and care.
- Information was available to staff on how to contact members of the clergy to meet patient's spiritual needs.

Learning from complaints and concerns

- BMI Healthcare had a corporate complaints policy that directed the management of complaints and associated timescales. All complaints were reviewed by the hospital director, the director of nursing, medical advisory committee (MAC) and clinical governance committee. We saw evidence of actions taken as a result of the complaint. These were shared with individual departments via ward meetings and staff briefings.
- From January 2015 to December 2015, the hospital received 118 complaints. The Care Quality Commission had received two complaints about the service during 2015/2016. We reviewed the identified themes, which were; consultant care and attitude, invoice and billing, waiting times and aspects of nursing care.
- Staff we spoke with managed verbal complaints and were aware of the need to escalate complaints that they were not able to resolve.
- There was information provided in patient rooms, which included how to make a complaint if there was dissatisfaction with any aspect of their care. All patients we spoke with could describe how to make a complaint should they wish to do so and felt comfortable raising concerns with staff.
- The Governance Manager was responsible for coordinating and ensuring complaints were managed and responded to in accordance with the hospital's complaint policy. Their duties included ensuring patients were acknowledged within 48 hours of receipt of a complaint using a personalised letter. Patients received a response within 20 working days or were kept informed of progress if the investigation was anticipated to take longer.
- Complaints were recorded and responded to including verbal complaints. There was a form available for staff to record verbal complaints to ensure these were managed appropriately. Most complaints were classed as incidents and reported on the incident reporting system. However, some verbal complaints were resolved locally and not reported onto the electronic reporting system. This meant that the hospital did not have an oversight of all complaints and may have missed an opportunity to learn from them.
- In addition, complaints were categorised as either formal or informal, but there was no rationale to support which complaints were formal and which were informal. When we raised this with the senior management team, they agreed that in future complaints would be categorised as either verbal or written. During the unannounced inspection we saw that all complaints were categorised as formal and determined as either clinical or non-clinical.
- If a patient was dissatisfied with the written response received about their complaint they would be offered a face to face meeting to gain a better understanding of their concerns.
- If a complaint was of a complex nature or litigation had been suggested there was legal assistance available to the hospital team. Where complaints related to treatment provided by the admitting consultant, the consultant would be informed and involved in the investigation. Some complaints required a multi-disciplinary team approach when several aspects of service were involved.
- We reviewed six complaint files and saw each point raised had been answered and duty of candour had been applied in each written response.
- During our inspection, we saw actions and learning from patient feedback displayed on posters around the ward. For example, one patient had commented that staff did not introduce themselves when providing care. As a result the hospital had implemented 'Hello my name is' campaign whereby staff should introduce themselves by name when meeting patients for the first time. Patients we spoke with confirmed this and were able to name their consultant and nursing staff.
- Displays on the ward also showed that intentional rounding had been introduced after a patient commented that they had not seen a nurse as often as they would have liked to during their stay. Intentional rounding involves nurses conducting regular checks on patients at specified time intervals throughout the day and night.

Requires improvement

Surgery

Are surgery services well-led?

Requires improvement

We rated surgical services as requires improvement for well-led because;

- There was lack of risk management and quality measurement with in the hospital, in relation to children's services and medicines management.
- The senior hospital management had not taken reasonable practicable action to provide a safe service for children and young people. The hospital staff did not have access to a registered nurse (child branch), there was no paediatric consultant representative on the MAC.
- The senior hospital management team were unclear about the safeguarding training requirement for staff involved in the care and treatment of children and young people and therefore had not identified the risk.
- Senior managers had not taken reasonable actions to ensure DoLS and MCA assessments were carried out in line with legislation.
- Appraisal rates at the hospital were low.
- Not all staff were aware of the corporate vision and values.

We also found that :

- The hospital had an effective governance structure in place for managing adult services.
- The Hospital senior management team were visible, approachable, and supportive.
- Staff could raise concerns or share ideas and feel that they were listened to.
- There was a relatively stable workforce who felt valued by the senior managers.
- The hospital sought feedback from all patients (NHS, insured and self-funded).This feedback was consolidated and reported on monthly. Feedback was reviewed and acted upon.

Leadership / culture of service related to this core service

- The hospital was led by an executive director, a director of nursing and an operations manager. All the heads of department reported to one of these three people. There was no dedicated lead nurse or nominated consultant for children's services.
- Staff reported that leadership within departments was very strong, with visible, supportive, and approachable managers. All felt that there was a positive working culture and a good sense of teamwork, which was open, honest, and transparent.
- Staff reported that their direct line managers were supportive and kept them informed of day to day running of the departments.
- Staff reported that the hospital executive director and director of nursing were visible and easily accessible and they felt able to escalate any concerns.
- The heads of department were positive about the services offered and the level of care provided.
- The nursing team, diagnostic team, physiotherapy team and administration team communicated well together and supported each other.

Vision and strategy for this this core service

- There was a clear corporate vision and a set of values. However, not all staff were aware of the overall corporate vision, which was: "we aspire to deliver high quality care and the best patient and the most convenient choice for our patients and partners as the UK leader in independent health."
- There were business plans around investment and equipment.
- Providing the best patient experience was one of the three priorities within the corporate vision. All staff spoken with said they were committed to providing a positive patient experience.

Governance, risk management and quality measurement for this core service

- There was lack of risk management and quality measurement within the hospital with regards to children's services and medicines management.
- The hospital's risk register was introduced in March 2016. It was part of a BMI corporate document, Unit Risk Management Plan which showed both corporate and local risks their level of risk and the actions to be taken to minimise the risk. All were due to be reviewed quarterly; the first review was due to take place in July 2016. As the document was so new, there had been no opportunity for the hospital to demonstrate how effectively risks were reviewed and managed.

Requires improvement

Surgery

- Each Head of Department was assisted by the governance manager to develop risk registers for their departments. A copy of the hospital and department risk register was available in each department.
- Each department we visited had an awareness of current risk to their service. For example, in the ward, the top three risks were identified and displayed on the staff notice board.
- Further issues for the hospital wide risk register were identified at clinical governance meetings.
- There were no risks referenced around the care of children and young people.
- The senior hospital management team had not taken reasonable practicable action to provide a safe service for children and young people. The hospital did not have access to a registered nurse (child branch) available to advice or manage the care and treatment of children and young people, there was no paediatric consultant representative on the MAC.
- The senior hospital management team were also unclear about the safeguarding training requirement for staff involved in the care and treatment of children and young people. This meant that children were exposed to the risk of not being cared for by suitably qualified staff as there was poor compliance with safeguarding training.
- Staff and senior managers lacked understanding of the actions to be taken to carry out an MCA or DoLS assessment. Senior managers had not taken reasonable actions to ensure the requirement to manage and carry out DoLS and MCA assessment had been implemented. Staff told us that they had received training in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguard (DoLS). However, some staff we spoke with were unclear of what actions they would take if they were concerned about a patient's capacity and who would complete the formal assessment. Most staff told us that they would seek advice from a senior member of nursing staff and could not tell us who would complete a formal assessment of capacity. We raised this with a senior manager during our inspection, who was also unsure of their responsibilities and the staff to undertake a formal assessment.
- Appraisal rates at the hospital were low, average of 69%. Although we were told many were planned to be undertaken within the next month, low appraisal rates had been historic.
- There was a governance structure within the hospital, which consisted of various appropriate committees, which ultimately reported to the BMI board. All these committees had terms of reference, which reflected their role in the hospital, their structure, and purpose.
- Clinical effectiveness and audit meetings were attended by departmental leads, heads of clinical services, and the governance facilitator. These committees monitored and discussed a range of hospital issues such as safety alerts, shared learning from incidents, policy updates and reported to the clinical governance (CG) committee.
- The CG committee met every month. The hospital subcommittees reported into the CG committee, which had an overview of governance, risk, and quality issues for all departments. Senior department leads attended these meetings and were responsible for cascading information back to their department.
- The role of the MAC included ensuring that all consultants were skilled, competent and experienced to perform the treatments undertaken. Practising privileges were granted for consultants to carry out specified procedures using a scope of practice document, these were reviewed annually. Registration with the General Medical Council (GMC), the consultants' registration on the relevant specialist register, DBS check and indemnity insurance were all checked by the hospital and ratified by the MAC. An email was automatically generated to remind a consultant if for example their appraisal or indemnity was overdue or expired. Those outstanding had received reminders. The executive director had suspended consultants from practice, who had not complied with supplying required documents. At the time of the inspection the consultants were seen to be 95% compliant with all checks.
- Governance and safety issues were reviewed before introducing new services or rolling out any new arrangements within the hospital. Consultants were required to apply to undertake a new technique or procedure not undertaken previously by the practitioner at the hospital. The introduction of the new technique or procedure had to have the support of the MAC, which may have taken specialist advice such as that from the National Institute for Health and Care Excellence or the relevant Royal College. The practitioner was also required to produce documentary evidence that they were properly trained and accredited in the undertaking of that procedure.

- The hospital had a schedule of annual audits with associated timescales. Audit reports were reviewed locally at clinical governance meetings and MAC and results shared with staff through the heads of department. We saw evidence of this in the meeting minutes and staff we spoke with were able to confirm this. For example the ward had a governance notice board and recent audit results for cannula and hand hygiene were shared.
- Representatives from each service attended a daily 'huddle' meeting with the executive director and director of nursing to discuss any issues, incidents and expectations for the day. The huddle meeting lasted 10-15 minutes. Daily huddle update sheets were produced and displayed daily in all departments to update all staff.

Public and staff engagement

- The hospital sought feedback from patients both those who were funded privately or by the NHS. Monthly friends and family test results were collected. The friends and family test (FFT) is a survey designed for NHS patients to gauge feedback from patients about the quality of service and whether patients would recommend the service to their friends and family. The hospital also conducted its own survey for private patients. The hospital records a 99% satisfaction rate for FFT and 99% for its own hospital survey. Results were presented in a patient satisfaction dashboard with identified actions to improve patient experience. Improvement plans included introduction of regular 'comfort rounds for patients, 'you said, we did,' boards and ward hostess training.
- The hospital conducted an annual staff satisfaction survey. In 2016, there was a 67% response rate to the survey. The key strengths included high job satisfaction and a good sense of aims and purpose across the organisation. The areas of improvement included staff did not feel valued, change management and leadership. We saw action plans that included; leadership and management training, a review of committee structures and standardisation of job titles across the organisation.
- There was an organisation newsletter, which was distributed throughout the hospital to update staff on current issues and plans.

Innovation, improvement and sustainability

- A consultant orthopaedic surgeon had introduced an extra safety check when operating. The size and type of prosthesis was confirmed and recorded on the whiteboard so that the prosthesis could be checked against this information before being implanted. This was an additional check to ensure the correct prosthesis was being used.

Requires improvement

Outpatients and diagnostic imaging

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

Information about the service

BMI The Meriden Hospital is a 52 bedded independent hospital, which opened in February 2006. The hospital was developed on NHS land following agreement between BMI Healthcare and the local NHS trust. BMI retained the rights to complete all private work on the NHS site for 30 years and hold a 125-year lease on the land.

The outpatients department is located on the ground floor and consisted of 16 consulting rooms, one minor operations room, and one treatment room. The department had rooms dedicated to ear, nose and throat (ENT), gynaecology, ophthalmology and cardiology investigations/appointments with specialist equipment in place. The remaining clinic rooms were used by all specialities. The outpatients department is open between 8am to 8pm Monday to Friday and 8am to 4pm Saturdays.

The hospital had a dedicated physiotherapy department on the second floor, which provided outpatient assessments and treatments as well as inpatient services. Physiotherapy services were available 7am to 7pm Monday to Friday.

The diagnostic department consisted of a general x-ray room, one fluoroscopy room, one ultrasound room on the ground floor and a cardiac catheter laboratory on the third floor. The service had the additional use of two mobile units and two image intensifiers in theatres. The service was open 8am to 8pm Monday to Friday and 8am to 4pm on Saturdays. An on call service was maintained for emergency requests.

The outpatients and diagnostics departments had 36,689 visits from January to December 2015, 14,939 of which were first attendances. These appointments/ attendances were made up of 40% NHS patients and 60% private patients.

Patients seen within the department were aged between twelve to over 75 years old. The largest category being adults aged 18-64 years (70%).

The teams within outpatient, imaging and physiotherapy services, consisted of qualified nursing staff, health care assistants, radiographers and allied health professionals. Each clinical area had a head of department who reported directly to the executive director or director of nursing. We inspected all areas during the announced inspection, and spoke with 17 staff and seven patients. We also reviewed 12 sets of medical and nursing notes.

Requires improvement

Outpatients and diagnostic imaging

Summary of findings

Overall, we rated the service as requires improvement for safe and well-led and good for caring and responsiveness. Effectiveness was inspected but not rated.

- Staff were aware of their roles and responsibilities for maintaining safe management of patients attending the service. This included the appropriate use of incident reporting and escalation of concerns. There were systems in place to share learning from incidents and staff were aware of the duty of candour.
- There were effective infection prevention and control procedures in place and all areas were visibly clean and well maintained.
- The outpatients department was undergoing a refurbishment programme, to ensure compliance with Health Building Notes for flooring in clinic rooms.
- Staff were compliant with hospital targets for mandatory training and there were systems in place to ensure they were inducted into speciality areas which included completing competencies and a peer support system.
- A standard National Early Warning Score (NEWS) chart was used to record patients observations.
- Equipment was suitable to service needs and maintained annually by appropriately trained staff. There was evidence to support testing of all equipment across all departments.
- Policies and standard operating procedures were in place for all clinical activities and these were easily accessible for all staff. The service had an audit calendar that monitored compliance and used action plans to address any issues identified.
- Staff reported effective multidisciplinary team working, with common goals for the provision of high quality patient care.
- The outpatients department flexed working hours to meet the demands of the service, with an on call system for imaging staff, and inpatient weekend physiotherapy services.
- Patients records were accessible for all appointments and were found to be thorough, and of a high standard. Information was shared with GPs to enable continuity of care.
- Patients were included in decision making regarding treatment plans and were generally positive about the care they received. Patient satisfaction surveys showed high levels of satisfaction with services experienced by patients.
- Information leaflets were available for a wide variety of treatments and the service provided translation services as necessary.
- The service consistently achieved referral to treatment time targets.
- Service level agreements were in place for the provision of support services and emergency transfers. Staff reported that the relationships with these were positive and inclusive.
- There were governance systems in place for the monitoring of compliance with policies, incidents and complaints. Information relating to this was shared across the team.
- The service shared the organisational vision and staff reported that they were aware of the organisational aims.
- Staff were positive about the teams they worked within and proud of the care they provided. Staff within each clinical area reported strong local leadership.

However we also found:

- Registered staff within the outpatients, therapy and diagnostic departments did not have level 3 safeguarding children training in place. This was not in line with national guidance as children attended clinics and received treatment within the department.
- The departments had no facilities for children attending the department such as toys and books in waiting areas, or information leaflets specifically for children.
- The management of medication prescription pads was not in line with national guidance, with no daily checks in place of stock levels, or audits.
- Not all clinic rooms were suitable for clinical procedures.

Requires improvement

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Requires improvement

Overall we rated the service as requires improvement for safe because:

- Clinical staff within the service did not have level 3 safeguarding children training in place, or have access to a registered children's nurse for planned appointments of children, or young people.
- We were not reassured of the safe storage and security of the medication keys for controlled medicines. The management of medicine prescription pads in outpatients was not robust, meaning that there was the possibility for loss of, or inappropriate use of, prescriptions.
- Not all clinic rooms were suitable for clinical procedures, and were not in line with Health Building Notes (HBN). However, they were undergoing a refurbishment programme to address the issues.

However, we also found:

- The service had systems in place to identify, investigate and share learning from incidents, and change practice to prevent reoccurrence.
- There was evidence that patients were told when things went wrong and an apology offered.
- All areas were clean and well maintained. There were systems in place to reduce the risks of infection and maintain equipment throughout the department.
- The service had systems in place to maintain safety of patients, staff and public during radiation investigations.
- The service had good compliance with mandatory training, and utilised a buddy system to orientate staff to clinical areas.
- A standard National Early Warning Score (NEWS) chart was used to record patients' vital signs and identify deteriorating patients.

Incidents

- Staff were aware of their roles and responsibilities for the escalating of, and reporting of concerns and near misses both internally and externally using the organisation's incident reporting tool. The system in place involved a written report of incidents locally, which were investigated by the head of department and organisation to identify root cause and any learning outcomes. Staff were observed completing the reporting tool during the inspection.
- We reviewed incidents raised within the service and found that these reflected incidents described by staff and local investigation and actions had been taken in response to them.
- The service completed weekly incident updates, which was a log of incidents and actions across the hospital which was shared electronically with all departments. We observed these during inspection and staff were familiar with the contents and learning and were able to demonstrate how these related to their department.
- There had been no never events reported by the service from January 2015 to March 2016. A never event is described as a serious largely preventable patient safety incident that should not occur if the available preventable measures have been implemented by the healthcare providers (Serious Incident Framework, NHS England, March 2015).
- There had been no serious incidents, within outpatients or imaging reported from January 2015 to March 2016.
- The service reported two incidents relating to Ionising Radiation (Medical Exposure Regulations IR(ME)R from January 2015 to March 2016. These happened in August 2015 and November 2015, and included the radiographing of a requested lumbar spine, instead of cervical spine. The second incident related to the completion of a wrist x-ray rather than the requested ultrasound. Both incidents were investigated locally and lessons learnt. Staff shared learning from this at team meetings, and action plans were in place. Staff displayed historical data regarding incidents within the department, and we observed this during inspection.
- Nursing staff reported that recently, an invasive procedure was carried out on a 14 year old during a clinic which was not in line with the BMI care of the child policy. This was identified following the consultant confirming that the patient had been the child in attendance to the appointment and the request for equipment to be cleaned. The staff were aware that patients under 18 years, should not receive treatment within the department and this was escalated and reported using the incident-reporting tool. The incident was under investigation at the time of inspection; however, nursing staff reported that they had taken additional actions to ensure this did not reoccur. Staff

had implemented additional checks of clinic lists to identify children or young adults, and responsible consultants were reminded prior to the appointment that invasive procedures were not permitted.

- The service shared information of incidents across the organisation by weekly updates of incidents and actions taken. It was reported that through this process, another incident was identified whereby a ten year old patient had been treated within the physiotherapy department. The physiotherapy team discussed this at the weekly incidents report and a member of staff informed the team that they had treated a child under 12 years old, and had not been aware that this was against policy. The incident was under investigation at the time of inspection in line with the BMI Incident Policy. In response to this incident the physiotherapy lead informed us that they were now responsible and would treat all children between 12-18 years old requiring physiotherapy treatments, as they were trained in children's therapy and had completed Level 3 safeguarding children training.
- Staff completed radiation reviews annually within the imaging department and we saw evidence to confirm this during inspection. Radiation reviews are an evaluation of the service to ensure that regulatory requirements are met and radiation exposures to workers and the public as low as reasonably achievable.
- From November 2014, 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 understood their responsibilities with regard to the duty of candour legislation. All staff were able to describe actions taken when an incident occurs and demonstrated awareness of informing patients and those close to them that an error had occurred. For example, the patients involved with the imaging incidents were informed of the actions taken to prevent further occurrence as well as an apology.
- We saw that duty of candour had been applied when we reviewed both incidents and complaints.

Cleanliness, infection control and hygiene

- We saw that a refurbishment programme was in progress throughout the outpatient's department with three rooms out of 16 rooms being updated with new flooring. The updated rooms were compliant with Health Building Note (HBN) 00-10 regulations and had appropriate flooring and sinks. Nursing staff informed us that the remaining rooms (with carpets) were not used for any clinical procedures, but mainly used for consultations only. The use of carpets within clinical areas is not deemed as best practice due to the elevated risk of infection. However, the carpets were visibly clean. The HBN regulations consider that floors should be washable, and have curved edges to prevent bacterial growth. Staff reported that carpets were cleaned regularly, however the schedule was not seen during inspection.
- The refurbishment programme included the removal of carpets to clinical treatment rooms and corridors. Nursing staff reported that they were unaware of the timescale for completion of refurbishment.
- Rooms used for clinical procedures were adequately equipped to maintain safety and complied with infection control standards. Appropriate air filtering systems and air changes were in place for the minor operations procedure room.
- Nursing staff told us they cleaned the equipment in clinic rooms between patients and at the end of clinic. We observed that during our unannounced inspection, staff regularly attended rooms to assist with preparation for the next patient.
- All areas were visibly clean and tidy during inspection. We saw that staff used weekly checklists to monitor and track room cleaning and stocking of equipment. Nursing staff told us that each staff member was responsible for the cleaning and stocking of allocated rooms, and this was monitored by the head of department.
- The departments were cleaned twice daily by domestic staff, and a cleaning schedule was in place. The heads of departments completed twice weekly walk rounds to check compliance with cleaning schedules.
- Domestic staff were observed using colour coded equipment in line with national hospital guidelines.
- Equipment within the Ear, Nose and Throat Clinic (ENT) was observed to be cleaned appropriately between patients using sanitising wipes. The scopes were cleaned by the endoscopy unit weekly. Appropriate track and trace procedures were observed to be in place

for this process. This included the recording of patients' details against equipment used, and information relating to date and time of cleaning and staff using equipment.
- The hospital had no occurrences of reported MRSA from January 2015 to March 2016.
- We saw staff cleaning equipment after use and attaching "I'm clean" stickers to signify that they were appropriately cleaned and ready to be used.
- Waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste and sharps, clearly marked with foot pedal operated lids. Bins were not overfilled.
- We saw all rooms had appropriate facilities for disposal of clinical waste and sharps.
- Spillage kits were available as required. Staff were able to tell us what they would do in regards to decontamination following patients with suspected communicable diseases or blood spillage. This was noted to be in line with local policy.
- Toilets were clean and well equipped with sufficient soap and paper towels.
- Hand sanitising gel dispensers were available in corridors, waiting areas and clinical rooms. Staff were observed using hand sanitisers and personal protective equipment as appropriate.
- Local hand washing audits were completed monthly. During inspection we observed several audit results, which showed compliance of 87% to 90% in outpatients department. 80% to 92% in physiotherapy and 100 % in the diagnostics department from February to March 2016. The audit was completed by the infection prevention and control lead. The outpatients nursing staff also allocated the role for local audit completion to link nurses. The action plans for improved compliance included additional infection control training and feedback to staff locally through team meetings and team newsletter.
- We inspected seven consulting rooms and noted all had gloves, aprons and hand washing facilities available.
- Diagnostic imaging rooms were cleaned daily with only radiology staff cleaned the equipment. This was to ensure the safe maintenance of the equipment and staff.

Environment and equipment

- The outpatient environment was appropriate to meet the needs of the service with a large reception area, 16 clinic rooms, plus a minor injuries room (with adjoining preparation/ recovery area), a treatment room, dirty utility area and nurses' work station.
- All rooms were locked when not in use with either keypad or key access. Keys were held by all nursing staff.
- Doors to imaging areas were noted to be locked and 'do not enter' signs lighted prior to the commencement of radioactive or ophthalmology treatments.
- A medical physics expert completed annual radiation protection reports, which were escalated through the clinical governance committee. This review detailed equipment was appropriate and safe to use.
- The service had rooms allocated to specialities which were prepared with appropriate equipment for investigations or treatment. This enabled equipment to be easily accessible to reduce waiting time.
- There were systems to maintain and service equipment as required. Equipment had stickers with dates of safety check completion recorded. The hospital engineer carried out general maintenance in the hospital and there was a specific maintenance contract for specialist equipment, for example the ophthalmology equipment.
- During inspection, we saw nursing staff contacting the estates department directly and reporting malfunctioning equipment. It was reported that maintenance staff should attend within 24 hours to review the equipment and ensure it was appropriately fixed for future use.
- Personal protective equipment (PPE) was available in all clinical areas.
- Staff within the imaging department were seen to wear appropriate tags to monitor exposure to radiation. Details of activity were shared with the local NHS trust to ensure levels were appropriate and staff were not placed at risk.
- Lead aprons were observed to be tested annually for suitability of use. Staff maintained records to demonstrate usage and this was observed during inspection.
- All departments had access to emergency equipment. On inspection, we saw that each resuscitation trolley was checked daily for appropriate stock level and expiry dates.
- There was a service level agreement with the local acute NHS trust for the decontamination and maintenance of

equipment. Staff reported that equipment was usually returned to the department within 24 hours, and stated they had sufficient equipment to meet the demands of the service.
- Clinical waste was segregated appropriately and removed from the department at regular intervals.
- The service had a lone working policy in place which included notifying main reception of the situation, who escalated the situation to the security staff. Regular department checks were then completed to ensure all staff were safe.

Medicines

- The hospital had a service level agreement with the local acute NHS trust for the provision of medications and pharmacy services. This included weekly attendance to outpatients department to review medications, provision of stock items and prescription pads.
- All medications were observed to be stored in a locked treatment room, in locked cupboards. Within outpatients, the nurse in charge held the keys to the medication cupboards.
- Consultants attending the department for a clinic would be issued with a prescription pad upon request. There was a robust system in place which required consultants to sign out the prescription pads, and the nurse confirmed return at the end of the clinic. However, there was no process in place to check the usage of prescriptions, or the number returned. There was no record of daily serial numbers or an audit trail that shows the serial number of prescriptions from issue to prescription. This was raised with senior management during the inspection, as we could not be reassured of safe management of prescription pads.
- Staff within the cardiac catheter laboratory used the refrigerator in the endoscopy unit for the storage of temperature sensitive medications used within the department. During inspection, we saw that medication keys were stored in a key safe, which were accessible to qualified staff only, using a key code. Keys were returned to the key safe once medication had been obtained. There were no checks in place to ensure keys were in the key safe between clinical shifts and no traceability of who had access to the keys throughout the day. Therefore we were not reassured that the safe management of medicines was in place. This was raised with senior management team during our inspection and again on the unannounced inspection.
- During the unannounced inspection, we identified that the refrigerator within endoscopy unit which stored drugs for the cardiac catheter laboratory was not secure. Staff had arrived for duty that morning and identified that the newly fitted lock, had been broken. Following local investigation it was found that the lock had been broken three days prior to inspection by a member of agency staff working within the cardiac catheter lab. Nursing staff confirmed that the lock had been reported to the estates department; however, steps had not been taken to secure the medication or report the incident. This was raised with senior management team during our inspection who reassured us that the medication would be moved to another fridge and an incident form would be completed.
- Keys for locked medication cupboards within the imaging department were held by the senior radiographer during working hours and maintained in a key safe out of hours.
- Contrast media was used for some imaging investigations and staff reported that prescribing of contrast media was completed by the consultants prior to the investigation.
- Nursing staff were aware of the local requirements regarding the safe storage and management of medications.
- Staff confirmed that the pharmacy team regularly checked that stock levels were appropriate. Locally staff returned items with a short expiry date or identified as not being used to the main pharmacy, this reduced the number of medications stored within the department.
- The outpatient department did not store any controlled medications, but could access these from the inpatient area if necessary. However, the nursing staff confirmed that this rarely happened.
- Nursing staff demonstrated how they would access local policies and advice from pharmacy regarding unfamiliar medications.
- Temperature sensitive medications were stored appropriately in locked refrigerators, which were checked daily for temperature compliance. The records

detailed actions to be taken if erroneous temperatures were recorded. Records for the previous month did not show any issues or periods where temperatures were outside the recommended levels.
- The temperatures within the treatment rooms were also recorded to confirm safe storage.
- Nursing staff informed us that medication information was available for patients, and they explained that new medications were discussed with the patient detailing side effects.
- The hospital had plans to implement pharmacy services on site, however the timescale for completion was not known during inspection.

Records

- Patient records were maintained and stored in accordance with hospital policy and managed in a way that kept people safe.
- Records were found to be paper based and were either held by the hospital internally, or maintained by the consultant who had responsibility for the patient care. Consultants maintaining their own records were made aware of their responsibilities for keeping information secure by the senior management team.
- We reviewed twelve patient records during inspection. Nursing notes were handwritten, thorough and detailed.
- Patients' records were audited with regards to their completion and results showed 95% compliance from January 2016 to March 2016.
- Information contained within the notes varied according to what stage of their treatment they were attending, for example, patients who were attending follow up appointments had detailed records of the treatment received, consent forms and copy of any communication with other practitioners.
- Data entries included name and role of practitioner completing the entry.
- There were systems in place to ensure medical records were available for appointments. The medical records department prepared notes for patients due to attend clinics and transferred them to the department in time for the appointment. Consultants were responsible for bringing their own patient records to appointments if they chose to maintain their own records. Nursing staff reported that there was never occasions when notes were not available for appointments. We did not see any audits relating to this during inspection.
- Consultants reported that notes were accessible for appointments if they were held by the hospital.
- Investigation samples were sent to the local NHS trust for analysis and reported through a printed report as electronic reporting was not possible. Nursing staff in the outpatients department confirmed that paper copies of results were sent to the department and were checked by nursing staff and allocated to the correct consultant. Any abnormal results were telephoned through to the department, and passed onto the consultant for action. This was observed during inspection when abnormal blood results were telephoned through to the department.
- Appointment details were shared with patients GP through written records of patient attendances. Nursing staff completed a letter detailing treatment plans, actions taken, medication and details of next appointment, which was given to the patient to deliver to their GP.
- The five steps to safer surgery checklist record, designed to prevent avoidable harm was completed for all patients undergoing invasive procedures. This was observed being used for outpatients procedures. Completion of the checklist was audited quarterly by the division leads and findings shared with the appropriate teams. During the inspection where we observed completed audits showing 100% compliance in completion of the checklist within each department. However, we noted that the audit consisted of considering the paper check lists only and did not audit whether the process, prior to surgery or procedure taking place had been observed and was part of the audit.
- The imaging services held records to evidence registration of ability to work with ionising radiation with the Health and Safety Executive (HSE).

Safeguarding

- All staff were able to describe their roles and responsibilities in the escalation of safeguarding concerns and told us that they would speak directly to the head of department or director of nursing if they were concerned.
- The hospital had organisational policies relating to safeguarding children and adults.
- The BMI Care of Children Policy 2014 stated that children were not to receive invasive procedures within outpatients, physiotherapy and diagnostic

departments, and that a registered children's nurse should be accessible when treatment is completed. In addition, the BMI safeguarding children's policy 2016 stated that staff undertaking treatment of young people under 18 years should have level 3 safeguarding training. The Royal College of Nursing Intercollegiate document 2014: Safeguarding Children and Young People: Roles and competencies for Health Care Staff, states that: 'All clinical staff working with children and young people and/ or their families and carers and who could potentially contribute to assessing, planning, interviewing and evaluating the needs of a child or young person should be trained to level 3 in safeguarding'.

- Nursing staff confirmed that they did not have access to a registered children's nurse or had received level 3 safeguarding children's training. The hospital was not following national guidelines, which meant that staff did not have the correct qualifications, competence, skills and experience in safeguarding children to the required level 3 and children and young people could be exposed to risk. It was recognised that, outpatients is an area where treatments would rarely be carried out, the risk had been considered and there were arrangements in place for clinical staff to gain advice and support from senior staff.
- The physiotherapy lead had confirmed that they were responsible for the treatment of all children within the department. This was following the identification of an incident relating to treatment of a ten year old within the physiotherapy unit the previous year. The physiotherapy lead informed us that one person had level 3 safeguarding children training in place within the department of over 30 staff.
- The director of nursing was the lead nurse for safeguarding and had level 3 training in place. Staff were aware of this role.
- Nursing staff reported that they had safeguarding children's training level 2.
- The imaging department had appropriate processes in place to ensure that patients received the correct investigation. This included a check of investigation planned, patient details and when necessary the five steps to safer surgery checklist.
- Hospital data confirmed that 100% staff had completed the level 1 and 2 safeguarding and consent training.
- The hospital safeguarding policy contained guidance for staff on female genital mutilation and domestic violence.

Mandatory training

- All staff reported that their mandatory training was up to date. This included infection prevention and control, basic life support and consent.
- The heads of departments oversaw records of mandatory training. Staff reported that they were alerted of the need to complete training through email, and then had a specified time scale to complete the training.
- Mandatory training was predominantly completed through electronic teaching packages, and staff reported that these worked well as it enabled them to learn at their own pace.
- Staff utilised a buddy system to enable new personnel to become familiar with the environment and equipment used within each department.
- An induction programme was available for both substantive and bank staff, which included training on equipment.
- Staff reported that all administrative and outpatient staff were trained in basic life support, radiographers were trained in intermediate life support and staff working within the cardiac catheter lab, were trained in advanced life support. This training was provided by an external company, and regular scenarios were completed to ensure competence maintained.
- Outpatient staff were recorded as being 88% compliant with mandatory training.
- Diagnostic and physiotherapy staff were recorded as being 98% compliant with all mandatory training.

Assessing and responding to patient risk

- There was no registered nurse (child branch) available within the hospital. According to the Royal College of Nursing (RCN) standards for clinical professionals and service managers, 2013 'Defining Staffing Levels for Children and Young People's Services', all providers must employ or have access to a senior children's nurse for advice and policy development, and work in collaboration with the local NHS children's services network. Therefore children and young people were unsupported and assessments were not carried out with regards to their understanding and capacity to give consent to tests being performed. This meant that

children were exposed to the risk of not being cared for by suitably qualified staff with the correct qualifications, competence, skills and experience to carry out safe care and treatment.

- Nursing staff were aware of the risk assessments required for patients admitted to the service. This included a pre admission assessment to identify if the patient was appropriate to attend the hospital. Patients with complex past medical histories or at high risk were referred to the local NHS trust.
- Prior to admission, patients were asked to complete a preadmission checklist, which detailed past medical history, medications taken and details of the condition. This information was reviewed and appointments allocated to the consultant as appropriate.
- Clinical observations were recorded for all patients using the National Early Warning Score (NEWS), which is a point system for monitoring and tracking clinical condition. Staff recorded routine physiological observations, such as blood pressure, temperature, and heart rate all of which were scored according to pre-determined parameters to help identify deteriorating patients.
- The hospital carried out emergency scenarios to enable staff to practice their skills and test the procedures to be taken.
- Patients identified as being unwell upon arrival to the department were reviewed and their condition was discussed with the consultant. Following any decision to admit, patients were referred to the inpatient area for admission. All staff were able to describe situations when this had occurred and stated that the inpatient area was generally flexible to their needs, finding appropriate bed space.
- Patients undergoing cardiac investigations were allocated observable beds within the inpatient ward to ensure safety and ease of monitoring. Staff reported that the inpatient nursing team were accommodating to additional patients and were able to flex bed usage to enable all patients to be appropriately monitored after investigations and procedures.
- The service had processes in place for managing acutely unwell patients. The consultant and resident medical officer (RMO) were called to review the patient in a clinical emergency; transfer to the local NHS trust was arranged via ambulance. Nursing staff were able to describe previous occasions when this system had been used.
- Any deteriorating patients could be transferred to the local acute NHS hospital trust in line with the NHS Standard Acute Contract. The responsible consultant led on the arrangements of this to ensure continuity of care. An incident report was completed for all transfers to local NHS trusts using the hospital incident-reporting tool.
- Daily children environmental risk assessments were observed to be in place within the physiotherapy department, with 100% compliance. Risks assessed included ensuring equipment was secure, restricted opening of windows plug socket covers and sharps bins being stored out of reach.
- Staff within the imaging department informed us that the radiation protection supervisor had recently left the department and two radiographers were training to complete this role. The interim supervision and support was provided by the local NHS trust.
- During inspection we noted that the imaging department had a variety of policies and standards of practice in place relating to the safe management of patients undergoing investigative procedures. This included the safe use of contrast medium and guidelines for patients with underlying clinical conditions.
- Imaging staff reported that they organised staffing levels around clinics and cardiac catheter cases. This ensured availability of staff at peak times.
- The imaging department maintained a list of staff that were eligible to request radiation diagnostic tests. This was noted as being easily accessible for staff and updated regularly when changes to staffing occurred.
- Signs in relation to radiation exposure and pregnancy were seen throughout the imaging department.
- Radiographers conducted a check on the pregnancy status of all women of childbearing age prior to imaging in line with national guidance. Pregnancy status checks were audited by the radiation protection supervisor to ensure that these were conducted and patients were kept safe.
- Staff within the cardiac catheter lab reported that team briefings occurred before each patient procedure, which was recorded in medical notes. This was to ensure staff were aware of the procedure and patient related risks, and clarity of roles.

Requires improvement

Outpatients and diagnostic imaging

- There was a clear process in place in outpatients and diagnostic imaging departments to check the identity of the patient by using name, address, and date of birth. We observed staff obtaining this information from patients that attended for appointments.
- The outpatients staff used the five steps to safer surgery checklist record patients undergoing invasive procedures such as colposcopies in the treatment room. A colposcopy is the examination of the cervix. This was designed to prevent avoidable harm and it was integrated into treatment pathways for common procedures. Audit results showed 96% compliance with five steps to safer surgery from January 2016 to March 2016.
- Emergency alarms and bleeps were checked regularly to ensure that they were working and fit for use.
- Nursing staff reported that they did not routinely treat patients with underlying mental health issues, due to their complex medications or medical histories.

Nursing staffing

- We saw evidence that all registered nurses and professional staff that worked in the outpatients and diagnostic departments had valid nursing and midwifery registration or were registered with the Health and Care Professions Council. This confirmed that nurses and other practitioners, such as physiotherapists, were trained and eligible to practise within the UK. There was a process in place to ensure these were updated.
- The spreadsheet was reviewed monthly and staff reminded of the need to renew their registration. If for example a nurses registration had expired the head of department was notified that the employee was not permitted to undertake nursing duties.
- Nursing staff had received training to use the revalidation of their professional practice which included education about reflective practice.
- There were no baseline staffing tools used in outpatients department to monitor staffing levels. However, observation and interviews with staff confirmed that there were adequate numbers to safely manage the outpatient's department clinics. During the inspection, actual staffing levels met the planned rota for staff needed per area. The physiotherapy department was undergoing a service review by the newly appointed head of department to ascertain appropriate staffing levels.
- Staffing levels within the outpatients department varied according to the activity planned. Nursing staff were allocated shifts depending on the number and type of clinics planned. For example, orthopaedic clinics used a higher number of nursing staff due to the increased number of dressings required for the patients attending.
- Nursing staff described the service and staff as being flexible to the clinic needs, with staff changing shifts if necessary to meet the demands.
- Staffing numbers per shift were displayed at the nurses' station and we observed these to be accurate to the date and time, and changed between shifts.
- It was noted that some clinics had one qualified nurse on duty, with the support of health care assistants. We were informed that additional nursing support could be sought from the inpatient area if necessary. Nursing staff felt that staffing levels and competence was appropriate to the needs of the department.
- We were informed that agency staff were not used within the departments, but staff did have access to bank staff members who were familiar with the hospital, the processes and were trained and competent to organisational standards.

Medical staffing

- There were 216 doctors using the services provided by the hospital from January 2015 to December 2015. The number of treatments completed from January 2015 to December 2015 varied with 44 consultants' completing less than nine treatments, 44 completing 10-99 treatments and 91 completing more than 100 treatments. Consultants would request consulting rooms at either regular intervals or ad-hoc depending on their requirements. The nursing team would review capacity within the department prior to agreement to ensure that they could provide the appropriate space and staff for the planned consultation.
- Consultants were reported as arranging appropriate cover for any planned or unplanned leave. Nursing staff told us that consultants would provide a list of staff and contact details for any absences and if necessary they would call the RMO if any problems arose.
- The role of RMO was maintained through an external provider. The outpatients service did not routinely use the RMO, as they worked predominantly in the inpatient area. However, the RMO could be called if required.

Requires improvement

Outpatients and diagnostic imaging

- The senior management team and medical advisory committee (MAC) monitored the competence of the consultants. This ensured that consultants were able to perform the procedures they were proposing to complete within the hospital.
- Consultants completed mandatory training within their base hospitals, and provided evidence of completed sessions to the service. This training was also provided by BMI The Meriden if required.
- Consultants and radiologist attended the outpatient department and diagnostic department on set days at set times. This meant that the managers knew in advance which consultant was attending and were able to allocate staff appropriately to the clinics.
- Medical staff were contacted by telephone, email or via their secretaries to offer advice to staff if they were not present at the hospital.
- Nursing staff told us that consultant's late attendance at clinic was recorded and any repeated occurrences were escalated to the senior management team, who addressed this. It had been identified that one consultants clinic times had been amended due to repeated late attendance following difficulties leaving another hospital.

Major incident awareness and training

- Staff were aware of the procedures required in the event of a major incident and there was a business continuity plan in place for emergency situation, for example, loss of electricity and water.
- The imaging department were aware of actions to be taken if a radiation incident occurs.
- Nursing staff were able to demonstrate that they were able to access the major incident policy for the organisation.
- Staff were aware of fire safety precautions and emergency evacuation procedures.

Are outpatients and diagnostic imaging services effective?

We inspected, but did not rate the service for effective. We found:

- Staff were aware of and able to access hospital policies and guidance.
- Regular audits were in place to monitor compliance and appropriate action plans were in place to address issues identified.
- Staff appraisals and support mechanisms were in place for all staff. Nursing staff were supported to complete revalidation.
- Medical revalidation processes were monitored for compliance.
- Peer support was regularly used and seen to be beneficial to development within the physiotherapy team.
- Staff reported effective multidisciplinary team working.
- Outpatient staff provided patient appointments over weekends according to clinical need, with an on call provision for imaging emergencies at weekends.
- Patient treatments were shared with the relevant GPs, with plans for on-going treatment and care.
- Staff had limited exposure to Mental Capacity Act (MCA, 2005) and Deprivation of Liberty Safeguards (DoLS) processes seeking support from senior managers if necessary.

Evidence-based care and treatment

- We saw that patient assessments were comprehensive. Patient's care and treatment took account of procedures planned and were delivered in line with evidence based guidelines. For example, we saw a variety of pre-printed treatment plans in use. These detailed best practice and required staff signatures against actions completed. Nursing staff reported that these were updated when new guidance was available.
- Policies were current and referenced according to the hospital clinical governance policy.
- All policies were accessible through the hospital intranet and based on national guidance from professional bodies such as the National Institute for Health and Care Excellence (NICE). This included the pre-operative assessment policy.
- Procedures such as hysteroscopy were carried out in the outpatients department treatment room. We saw that care pathways were based on professional guidance such as the Royal College of Obstetricians and Gynaecologists (2001).
- Staff we spoke with were aware of how to access policies and procedures. Staff could also locate further guidance on the hospitals computer system, which was demonstrated to us.

- The imaging department used diagnostic reference levels (DRLs) as an aid to optimisation in medical exposure. DRLs were cross-referenced to national audit levels and if they were found to be high, a report to the radiation protection advisor would be made.

Pain relief

- Patients we spoke with had not required pain relief during their attendance at the outpatient department.
- Pain relief was not routinely administered within the service as patients attended for short periods and usually took analgesia prior to attendance.
- Patients attending for clinical procedures were offered appropriate medications for pain relief and prescriptions to take home if necessary.
- The service did not offer specific pain management services, but nursing staff informed us that consultants referred to specialist nurses or teams at other locations directly and they often attended appointments with consultants. Specialists attending the service worked under a SLA with the trust.

Nutrition and hydration

- Refreshment facilities were available on site which enabled patients to have access to drinks and food during their visit.
- Patient appointment letters detailed whether patients were able to eat and drink prior to their appointment for scheduled procedures.
- The hospital restaurant menu provided a range of choice to patients and the quality of food in the Patient Led Assessment of the Care Environment (PLACE) audit for 2016 scored 100%.

Patient outcomes

- The imaging department completed radiation dose audits in line with the corporate calendar. Imaging staff confirmed that annual imaging audits and radiation protection audits were completed. We reviewed the results from the most recent audits and noted that action plans had been put in place to correct the light beams and output rates of the equipment to ensure compliance with national output rates.
- The hospital's clinical audit schedule outlined when various audits were due for completion. This included, patient records, infection prevention and control, safeguarding and falls.
- The division did not currently participate in the imaging services accreditation scheme (ISAS) or improving quality in physiological services (IQIPS).

Competent staff

- Staff we spoke with confirmed that they had regular updates on mandatory training and competency assessments and were able to cite recent training in all cases.
- The hospital provided an induction and learning programme for all new staff. This was reported by all nursing staff as being thorough and including an overview of the organisational aims and objectives as well as clinical skills required for roles.
- Staff within the imaging department were required to complete a departmental induction handbook, which was maintained in the personal file once completed. The imaging department maintained a record of procedures consultants were competent in to ensure that patients were not placed at risk.
- Imaging department staff were noted as being competent and trained in the administration of radiation, and were appropriately supervised by the local NHS trust whilst awaiting head of department's commencement in post.
- In addition to training staff were offered regular appraisals. The staff spoken with reported completed appraisals and clear objectives for learning. Organisational data confirmed 100% compliance with annual appraisal for physiotherapy and imaging staff, with 87% compliance for outpatient staff.
- We were told that heads of department were offered support through a buddy system with equivalent practitioners in other organisational hospitals and support through regional team leads. This enabled staff development and maintenance of clinical skills and supervision.
- Nursing staff reported that the hospital had support mechanisms in place to assist nursing staff with revalidation. This included practical advice with assistance in compiling evidence and emotional support through the process.
- The physiotherapy services used a large room for patient classes or multiple patient sessions at one time. This enabled staff to be supervised at a distance or

second opinions on treatments to be completed without patients being overwhelmed by therapists' attendance. Staff reported that this was beneficial to their development.
- Medical revalidation was completed by consultants' substantive trust and shared with BMI The Meriden.
- There were processes in place for checking registration with the general medical council and nursing and midwifery board. The management team maintained this.
- The management team reviewed competency of the consultants and checks were in place with the consultant's trust to ensure practice was current. There was 100% compliance with this at the time of inspection.

Multidisciplinary working (related to this core service)

- Medical and nursing staff reported good working relationships. Nursing staff reported that they would contact consultants directly to discuss patients care, and felt that this was always responded to positively.
- Heads of departments reported holding regular staff meetings, which were well attended by the team members. Staff reported it was important to share information.
- Specialist nurses were available through particular consultants and nursing staff reported that they often attended patient appointments with the consultant responsible for the patients care.
- The imaging department provided dedicated theatre radiographers to cover theatre sessions.
- The imaging department had a service level agreement with the local acute NHS trust to provide medical physics support. Staff reported that the interdepartmental working relationship was effective, and staff were readily available and willing to assist where necessary.
- Where possible, previous images from other organisations were made available to consultants, however staff reported that most consultants reviewed previous test results in their base hospital.
- The physiotherapy department offered placements for students from the local university, and this was observed during inspection.
- We observed effective team working amongst clinical teams with clear escalation processes and open discussion in place.
- We were informed that the patients GP were kept informed of treatments provided; follow up appointments and medications to be taken on discharge.

Seven-day services

- Physiotherapy provided a seven day service. Outpatients' service and imaging department were open Monday to Saturday.
- Appointments were available at weekends in outpatients.
- The imaging department provided an on call service for plain images and ultrasound, with out of hours provision of MRI and CT scans being completed by the local NHS trust.
- Outside normal working hours, patients were advised to contact the inpatient area for advice regarding treatments.

Access to information

- Medical notes included all information pertaining to assessment and treatment plans including details of multidisciplinary team meetings. Copies of all external communications (such as GP letters) were also stored in the patient's notes enabling tracking of patient care.
- Consultants were responsible for ensuring appropriate records were available to other staff caring for the patient. These included details of procedure completed for therapy staff, and planned treatments for nursing staff within outpatients department.
- All staff had access to the hospitals intranet to gain information relating to policies, procedures, NICE guidance, and e-learning.
- There were systems in place to flag up urgent unexpected findings to GPs and medical staff. This was in accordance with the Royal College of Radiologist guidelines.
- Clinic information was shared with patients GPs in letter format. These were produced by the clinician following the appointment and copies sent to GPs and patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a hospital policy to ensure that staff were meeting their responsibilities under the Mental Capacity Act (MCA, 2005) and Deprivation of Liberty Safeguards (DoLS). We found staff were aware of the MCA and DoLS, however did not have experience of the active use of

MCA. Staff told us that they would seek advice from a senior member of nursing staff or a doctor if they had any concerns. Although when we raised this with the senior managers, they were unsure of actions to be taken.

- All staff reported that they were aware of the consent policy and how to access this on the organisation intranet. They also explained that any concerns would be escalated to the head of department or director of nursing for further advice or assistance.
- Nursing, diagnostic imaging, therapy and medical staff understood their roles and responsibility regarding consent and were aware of how to obtain consent from patients. Verbal consent was gained as a minimum prior to any diagnostic procedures.
- Nursing staff reported that consent training was amalgamated with safeguarding training. Compliance was 100%.
- Nursing staff reported limited experience and exposure to patients that lacked capacity or any safeguarding concerns but were able to inform us of the clinical lead for safeguarding.
- Staff were able to recall an incident whereby a patient living with dementia had attended the outpatients department for treatment, and was unable to consent to the procedure. Staff reported that this was escalated to the director of nursing, and the treatment was cancelled. Staff reported that this incident was under investigation.
- Patients told us that staff were very good at explaining what was happening to them prior to asking for consent to carry out procedures or examinations.

Are outpatients and diagnostic imaging services caring?

Good

Overall, we rated the service as good for caring because:

- Patients were treated with dignity and respect.
- Patients told us they felt informed of treatment plans and involved with decision making.
- Family and friends could attend appointments to support the patient and be included in discussions and decisions.
- Patients were informed of costs of services in a sensitive manner, and were able to discuss any concerns.

Compassionate care

- We observed staff were kind, compassionate and caring in all patient interactions in all areas of the services visited including reception, waiting areas, consultations and treatment areas.
- Nursing staff reported that patients undergoing invasive procedures were chaperoned throughout their clinic appointment which was in line with local policy.
- Interactions between staff, patients and relatives were observed to be inclusive, polite and respectful.
- Nursing staff were observed confirming with patients how they wished to be addressed.
- Staff gained permission and consent prior to completing treatment or attending to tasks.
- During our inspection, we spoke with four patients in the department. All patients felt that staff respected their privacy and dignity and that their confidentiality was maintained throughout.
- All patients told us that staff introduced themselves and explained what their role was in their treatment. Patients could name their doctor and care staff.
- Patients spoke positively about staff and described them as: 'brilliant', 'polite' and 'friendly'.
- All written feedback we received from patients was complimentary of the service provided and the hospital environment.
- Patients were asked to complete a satisfaction survey, which related to whether they would recommend the hospital to their family and friends. The results for March 2016 stated that 99% of patients would recommend the service with a 41% response rate, which was higher than the national average of 36%.

Understanding and involvement of patients and those close to them

- All patients we spoke with told us they received written information regarding their care and treatment. Patients felt well informed and were encouraged to make their own decisions.
- There was no provision of patient information specifically designed for children attending the service.
- Patients described examples of nursing staff involving them in their care and understanding their needs. For

example, a patient who had been given a diagnostic monitor to take home told us that the named nurse had always been reachable by phone to offer advice and answer any queries.

- Due to small numbers of nursing teams being in place, patients regularly saw the same nurse, which promoted continuity of treatment and an effective patient nurse relationship.
- Patients were informed of all charges and costs for treatments in a sensitive manner and patients confirmed this during inspection who explained that they were informed of all charges in advance of treatments during private consultations. Patients were also provided with information relating to charges prior to agreement of treatment.
- Patients said they were kept informed of the clinic waiting times and clinics announced waiting times at regular intervals to keep patients informed.
- Patients were provided with copies of correspondence with their GPs.

Emotional support

- Patients' family members informed us that they were able to accompany patients to appointments and felt included in conversations and planning.
- Most patients we spoke with felt that their emotional needs had been taken into account. One patient told us that they had been worried about what their private medical insurance company would cover when having diagnostic procedures. Staff had listened to concerns raised and helped to resolve any issues, and the patient felt reassured as a result.
- Written information regarding support groups was not available within the outpatients department; however nursing staff reported that this information was available through the specialist nurses.
- Audits were completed by the service to monitor patient satisfaction and patients were observed being given feedback cards at each attendance. The hospital dashboard included response rates and trends identified. The results for March 2016 stated that 99.5% of patients would recommend the service with a 41% response rate.
- Written feedback we received from patients included positive comments about staff ensuring patients were relaxed, reassured and had a pleasant experience.

Are outpatients and diagnostic imaging services responsive?

Good

Overall, we rated the service good for responsive, because:

- Appointments were consultant led, with a system in place to ensure patients were seen at appropriate times by the appropriate clinician.
- There were policies in place to detail admission and discharge processes, and staff were aware of this.
- Services had clear signage for patients to follow.
- Patients reported that referral to appointment times were well managed and met RTT targets.
- Appropriate service level agreements were in place for additional services such as dietetics and sterile services.
- The service had appropriate provisions for patients and visitors requiring additional support, through hearing loops, translation services or access.
- Leaflets were readily available for a wide variety of clinical conditions or treatments.
- There was a system in place for monitoring and responding to complaints, and these were reviewed by the medical advisory committee.

However, we also found that:

- There was no provision of information leaflets specifically designed for children attending the departments.

Service planning and delivery to meet the needs of local people

- All departments had appropriate facilities to meet the needs of adult patients awaiting appointments. This included adequate comfortable seating, access to bathrooms, drinks machines and reading material. However, there was no provision of toys or books for children attending the departments either as a patient or attending with adults. The service reported that they encouraged children to bring their own books and games to reduce risks of cross infection of shared items.
- Scheduling of appointments was completed in line with requirements for the procedure, for example availability of equipment and specialists.

Requires improvement

Outpatients and diagnostic imaging

- The outpatient and imaging departments were signposted from the entrance of the hospital and all areas were within a short walking distance. Signage around the outpatient and diagnostic imaging department was in English only.
- The physiotherapy department was under review for additional services that could be provided by the team. This included the possible use of a local swimming pool for hydrotherapy treatments.
- Written information on medical conditions, procedures and finance was available and accessible throughout the department. Patients told us information leaflets with relevant information about treatment options were provided and they had received written information in the post. Staff informed us that information in specific formats could be accessed on request.
- Appointments were arranged for Sundays if necessary and nursing staff would attend the outpatients department if the inpatient area were not able to manage the additional workload. An example of this was given during inspection, when the outpatient sister opened the outpatients department on a Saturday and Sunday to complete dressings for one patient. Nursing staff confirmed they were happy to do this as it enabled continuity of care and treatment
- Patients attending the hospital had access to a small free carpark in front of the hospital. Patients who were unable to park in this area could use the local NHS trust car park free of charge, which was a short distance from the hospital. This was manned by a security guard who allowed access and exit.
- Details relating to hospital location and car parking were made available to patients prior to appointments.
- There was a service level agreement in place for the provision of several services with the local NHS trust. This included pharmacy, blood testing, sterile services, dietetics, stoma care and radiation protection.
- The service reported a good working relationship with the Clinical Commissioning Group and the local trust which enabled them to flex the services provided. For example, the local NHS trust would make spot purchases to complete treatments or procedures within the cardiac catheter laboratory when they had an increased demand. Spot purchases are a contractual agreement between two organisations to provide a specified service for a fee.
- At the time of the inspection, the physiotherapy lead was new to post and had commenced a review of the service provided within all departments to ensure the correct level of service was available. This included how effective the team were at meeting individual's complex needs and planning to meet the needs in the future for current and proposed treatments.

Access and flow

- The service had a robust standard operating procedure in place relating to the admission and discharge process.
- The hospital monitored referral to treatment times for services. Hospital data confirmed that patients waited three to ten days for all services offered, with the exception of hand and wrist clinic and follow up colorectal clinic appointments, which were 30 days. Appointment scheduling was in line with consultant recommendations and availability, with high risk patients being seen as early as possible.
- Hospital data showed that 95% of patients were admitted for treatment within 18 weeks of referral from January to December 2015.
- Consultants and radiologists informed teams of their availability for sessions to ensure that patients attended the department when the appropriate consultant was available. We were told that consultants had set days for clinic appointments, but could access rooms out of normal scheduling if they needed to see a patient urgently. Staff reported that there had been no occasions where patients attended for appointments and the consultant had not been available.
- Patients unable to attend the departments for the appointment were offered an alternative following discussion with the head of department. This was to ensure that rescheduling was appropriate and the necessary staff were available for the new time. Each clinical area had a diary, which enabled logging of activity.
- Appointments were available at weekends in the imaging department, according to clinical need. Urgent or emergency MRI and CT scans were facilitated by the local NHS trust, out of hours. Staff reported that chest x-rays were the most frequently requested image out of hours, however this was infrequent.
- Patients requiring an investigation following an outpatient appointment were generally seen on the same day.
- During inspection, we observed that patients were attended to immediately upon arrival in departments.

Requires improvement

Outpatients and diagnostic imaging

- No excessive waiting times were observed during our visits and staff reported that any delay over 15 minutes was discussed directly with the patient and an explanation and expected delay times explained by the reception staff. The service tracked availability and use of appointments for each speciality and waiting times monthly. These were used by the organisation to benchmark against other providers within the organisation.
- Patients spoke positively about access to care with one patient receiving an appointment within days of referral.

Meeting people's individual needs

- Patients treatment plans were arranged on an individual basis and medical records showed discussion between nursing and medical staff to identify the individual's pathway.
- Patients we spoke with felt their individual needs had been taken into account by staff in the department. For example, one patient had an appointment rescheduled to a suitable time when relatives could also attend.
- All areas of the hospital were easily accessible for patients and relatives who had mobility restrictions. Transport was not normally arranged by the service and staff reported that patients usually provided their own transport.
- All departments were able to accommodate patients in wheelchairs, with sufficient space for manoeuvring safely.
- There were waiting areas available for patients attending all departments, and these included low level reception desks, adequate seating, access to drinks and snacks, information leaflets and hand gels.
- Hospital staff had attended dementia training and had an awareness of the needs and the challenges patients living with dementia faced. Patients living with dementia or those with special needs could be offered a longer appointment if required.
- There were no separate waiting areas for children in any departments within the service.
- Clear signage was in use across the hospital and staff were readily available at reception areas to assist patients with directions and assistance to appointment areas.
- The outpatients were decorated to a level, which took into account visual impairment. This included contrasting wall and door colours and large signage.
- An interpreting service was available for patients who did not speak English, and staff were aware of how to access this if necessary. Leaflets were not routinely available in non- English languages.
- Hearing loops were available throughout the hospital.
- Patients and their relatives were able to access refreshments from the hospital restaurant if they wished. Leaflets were available regarding specialist conditions and procedures. Information leaflets were not available in non-English languages although all departments had access to telephone interpreter services.
- The imaging department had a separate area for male and female patients who were required to wear a gown for a procedure, which enabled them some privacy whilst waiting for their procedure.
- There was no provision of books or toys in the waiting area for any children who attended each clinical area. The service reported that they encouraged children to bring their own books and games to reduce risks of cross infection of shared items.
- The service participated in the patient-led assessment of the care environment (PLACE) audits. Data confirmed that the hospital scored better than the organisation and national average for all measures with the exception of organisation food. For this measure the hospital scored 94% against a national score of 88% and organisational average of 100%.
- Staff and patients told us that there were insufficient parking facilities with staff attending up to half hour earlier than their shift start time to ensure they were available for duty.

Learning from complaints and concerns

- The hospital had a robust complaints management procedure. Where possible complaints were managed locally and staff felt they were equipped to do this.
- Nursing staff reported that complaints were very infrequent. Data provided stated that the service had received a total of nine complaints from January to June 2016. Six out of nine complaints had final responses completed within four weeks, with two further complaints receiving a final response within five weeks of date received.
- The organisational complaints policy was accessible for all staff through the intranet, and staff told us they knew how to access this. The policy was reviewed and found to be in date.

Requires improvement

Outpatients and diagnostic imaging

- The medical advisory committee (MAC) meetings reviewed complaints to identify trends, which enabled issues to be addressed.
- Nursing staff told us that consultant's late attendance at clinic was recorded and any repeated occurrences were escalated to the senior management team, who addressed this. It had been identified that one consultant's clinic times had been amended due to repeated late attendance following difficulties leaving the base hospital.
- Nursing staff reported that they received weekly organisational and hospital newsletters, which highlighted changes to practice, company and hospital news and updates.
- All patients we spoke with received feedback questionnaires at every outpatient appointment they had attended. Feedback forms were also available in waiting areas and at reception. Information collected was analysed and a dashboard produced, which was displayed.
- Patients were aware of the hospital complaints procedure and most understood how to complain should they need to.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

Overall, we rated the service as requires improvement for well-led because:

- The senior hospital management had not taken reasonable practicable action to monitor risks in order to provide a safe service for children and young people.
- Risk assessments for the safe management of children were not completed relating to either attendance as a patient or visitor.
- The senior hospital management team were also unclear about the safeguarding training requirement for staff involved in the care and treatment of children and young people and therefore had not identified risks.
- The senior hospital management had not taken reasonable practicable action to ensure that risks were mitigated to ensure that medicines were safely managed at the hospital.
- Risk assessments were not completed relating to the safe management of medications and prescription pads within outpatients department.

However we also found

- The service had a clear vision.
- The service had a governance process in place which reviewed activity and complaints to monitor compliance and effectiveness.
- Staff reported strong departmental leadership.
- Staff were positive about the working environment and reported strong teamwork.

Leadership / culture of service

- Both outpatients and imaging were led by a head of department who held appropriate specialist qualifications and skills to manage the department and worked as the clinical lead.
- Each head of department worked within or in close proximity to the service and completed a number of clinical hours depending on departmental and hospital activity. This process enabled them to understand the local pressures on service and benchmark standards of quality care expected from their teams.
- The heads of department were positive about the services offered and the level of care provided.
- Staff reported that leadership within the department was very strong, with visible, supportive and approachable managers. All staff felt that there was a positive working culture and a good sense of teamwork which was open, honest and transparent. Good staff morale was evident in all clinical areas.
- Nursing staff reported that their direct line managers were supportive and kept them informed of day to day running of the departments.
- Nursing staff reported that the hospital executive director was visible and easily accessible and they felt able to escalate any concerns.
- There were clear lines of accountability and responsibility and staff were aware of expectations.
- Staff felt that they could approach managers with concerns and were confident that action would be taken when possible. We observed good, positive, and friendly interactions between staff and local managers.
- Staff told us they had annual appraisals and were encouraged to access training in relevant topics.
- Staff were proud to work at the hospital and were passionate about their role and the work that they did.

- Staff sickness rates were generally very low with minimal turnover of staff.

Vision and strategy for this core service

- The organisational vision included: "providing the highest quality outcomes, the best patient care and the most convenient choice" for patients.
- The hospital had clear values embedded into all aspects of patients care. All staff were aware of these and were able to discuss the aims of the organisation and the actions required in achieving these.
- Development plans were noted to be in place, however time scales were not determined. This included full refurbishment of outpatient clinic rooms and the development of cardiac catheter lab and physiotherapy service.

Governance, risk management and quality measurement for this core service

- The hospital had a governance structure in place, with regular meetings taking place against a set agenda. Minutes of these meetings were reviewed as part of the inspection and found to be comprehensive. Items discussed included local actions to be completed following a review of incidents, a review of medical equipment, updates on national clinical guidance, audit results and a breakdown of complaints.
- Quarterly governance and Medical Advisory Committee meetings discussed some patient outcomes as part of a structured agenda. Each department had a nominated lead who attended as a representative for the speciality. Information gathered was shared across the teams locally.
- There were no risks referenced around the care of children and young people. There was also no evidence of risk assessments associated with the management of children within the outpatients or diagnostic departments.
- The senior hospital management team had not taken reasonable practicable action to provide a safe service for children and young people. The hospital did not have access to a registered nurse (child branch) available to advice or manage the care and treatment of children and young people, there was no paediatric consultant representative on the MAC.
- The senior hospital management team were also unclear about the safeguarding training requirement for staff involved in the care and treatment of children and young people. This meant that children were exposed to the risk of not being cared for by suitably qualified staff as there was poor compliance with safeguarding training.
- There was no evidence of a risk assessment associated with the management of medications or prescription pads within the outpatients department. With no data entry on the risk register.
- The senior hospital managers had not taken reasonable practicable action to ensure safe management of medicines at the hospital. The medicine keys and controlled drug keys for the endoscopy unit, which stored the drugs for the cardiac catheter lab were stored in a key pad lock, which did not have a signing in/out to establish who had access to the keys at any particular time. There were no daily checks and no risk assessment in place. This was raised with the hospital management team at the time of our inspection and during the unannounced inspection.
- The medical physics team completed annual radiation protection reports, which were escalated through the clinical governance committee meetings.
- Nursing staff reported that communication across the team was easy due to specialities having such small teams.
- Each clinical area had designated notice boards, which contained information relating to infection control, policy updates, and departmental meetings.
- Risk registers were reviewed during inspection and found to be updated regularly. Actions were taken to mitigate risks and were detailed in risk assessments and included results of investigations being reviewed prior to appointments, consultants not attending clinics and poor utilisation of pre admission appointments due to cancelled operations. However, the risk register did not detail any risks associated with the management or treatment of children, which meant that there was no identification or monitoring of potential and actual risks within the department.
- Medical services completed audits in line with the hospital audit calendar. Results were shared and displayed within departments and actions taken to address any issues and improve performance. Audits completed included completion of patient records, pain management, VTE prophylaxis assessment, MDT compliance, and hand hygiene.
- The senior management team and MAC were responsible for ensuring that consultants and visiting

clinicians had the appropriate skills and qualifications in place. Specialist nurses attending the department under SLA agreements completed tasks under direct supervision by the consultant.
- Information pertaining to procedures that the consultant undertook and any complaints and incidents, was shared with their NHS base hospital to enable this to be considered during appraisals.

Public and staff engagement

- Outpatients and diagnostic imaging staff told us that there was a good working relationship between all levels of staff.
- We saw that there was a positive, friendly, but professional working relationship between consultants, nurses, allied health professionals, and support staff.
- Satisfaction survey feedback forms were available for patients in waiting areas. The hospital reported a 99% satisfaction rate in March 2016. A comparison between March 2015 and March 2016 data shows that patients' satisfaction with departure times, planning, aftercare, food choice and information about medication had improved. Whereby there had been a decrease in patient satisfaction with care of visitors, response times of nurses, friendliness of staff, comparison to expectations and overall quality of care. In response to this the senior management team had commenced a staff engagement programme. This included presentations of the survey findings and details of actions to be taken to issues, giving staff the opportunity to share their thoughts and ideas.
- Hospital data showed that patient satisfaction audit response rates had increased from less than 10% in March 2015 to 40% in March 2016.
- The organisation newsletter was distributed monthly throughout the hospital to update staff on current issues and plans.

Innovation, improvement and sustainability

- During inspection it was noted that the physiotherapy department was undergoing a series of changes to all aspects of the department including storage of equipment, team meetings and services provided by the team. This included the advertising and development of additional services such as hydrotherapy.
- The imaging department staff were working towards an agreement with the NHS trust to provide additional cardiac catheter facilities for NHS patients.

Outstanding practice and areas for improvement

Outstanding practice

- A consultant orthopaedic surgeon had introduced an extra safety check when operating. When the size, type of prosthesis is confirmed this was recorded on the whiteboard so that the prosthesis could be checked against this information before being implanted.

Areas for improvement

Action the provider MUST take to improve

- Take reasonable practicable action to provide a safe service for children and young people.
- Meet the requirements for with staffing levels for children's services in accordance with the Royal College of Nursing standards for clinical professionals and service managers, 2013 'Defining Staffing Levels for Children and Young People's Services', and the Royal College of Nursing Intercollegiate document 2014 ' Safeguarding Children and Young People'.
- Ensure there is access to a registered nurse (child branch) available to advise on the management of the care and treatment of children and young people.
- Staff who have responsibility for assessing, planning, intervening and evaluating children's care, must be trained to level 3 in safeguarding.
- Ensure young people aged between 16-18 years of age are discharged safely to a responsible adult and this is documented in the notes.
- Ensure there is a paediatric consultant or representative to attend the MAC meetings and that children's and young people's services are discussed.
- Ensure the safe and secure management of medicines at the hospital, including a safe and secure procedure to manage the drug cupboard keys and the security of controlled medicines.
- Ensure that prescription pads are maintained appropriately with necessary audit trial detailing storage and issuing of prescriptions.
- Ensure risk management and quality measurement are in place with in the hospital, especially for children's services and safe management of medicines.

Action the provider SHOULD take to improve

- Ensure that grading of incidents are consistent.
- Although there were clinical hand basins in utility areas, there were no clinical hand basins in patients' bedrooms. This does not comply with Health and Building Notice (HBN) 009 (2013). Therefore clinical sinks should be available at point of care.
- Ensure that the floor coving in patient bedrooms are compliant with infection control guidelines or HBN (2013), 0010 part A.
- Ensure safe management of medicine cupboards in theatres as these were being left unlocked for convenience when theatres were in use.
- Ensure the medication fridge in endoscopy theatre is kept locked.
- Consider formally collecting patient outcomes and participate in national audit programmes to enable benchmarking against national standards.
- Ensure staff have a clear understanding of what actions they would take if they had concerns about a patient's capacity to understand information and consent to treatment.
- Ensure staff have annual appraisals.
- Ensure compliance with BMI Care of Children Policy2014.

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
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(1) (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance** How the regulation was not being met: The provider did not operate effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. Risks were not always identified, monitored and mitigated, especially for children's and young people's services and management of medicines. There was inconsistency with reporting and grading of incidents. Medicines cupboards were left unlocked in theatres and endoscopy and effective systems to assess, monitor and mitigate the risks had not been identified.

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.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 **Regulation 12 (1) and (2)(a) (b) (c) and (g) which states:** **12.**—(1) Care and treatment must be provided in a safe way for service users. (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; (g) the proper and safe management of medicines. We have served the hospital a warning notice for a breach of this regulation. How the regulation was not being met: Not all staff who were responsible for assessing, planning, intervening and evaluating children, were trained in safeguarding to level 3. This did not meet the Royal College of Paediatrics and Child Health (RCPCH) guidelines or those contained in the Intercollegiate Document (March 2104) which stated safeguarding level 3 training should be provided for clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns'.

This section is primarily information for the provider

Enforcement actions

The hospital did not have access to a registered nurse (child branch) or a lead nurse with the appropriate competence, skills and experience to carry out safe care and treatment for children's services. This included offering

advice, to assist, supervise, support, assess and chaperone children and young people. This did not meet the guidelines in the Intercollegiate Document (March 2104) or the BMI Care of Children Policy 2014.

There was no lead paediatric consultant as a member of the Medical Advisory Committee, or clinical governance committee and children services were not discussed at these meeting. This did not meet the guidance in the BMI Care of Children Policy 2014.

This meant that children were exposed to the risk of not being cared for by suitably qualified staff with the correct qualifications, competence, skills and experience to carry out safe care and treatment. There was non-compliance with Intercollegiate Document, (March 2014) and BMI Care of Children Policy 2014 and the hospital managers had not taken reasonably practicable actions to mitigate any such risks to children. The service was failing to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.

When young people aged between 16-18 years old were discharged from the ward there was not always comprehensive discharge information, follow up instructions or details of who the young person was being discharged with. One young person was discharged at 11pm and there were no details with whom they had been discharged with. The BMI Care of Children Policy 2014, states: 'Parents/guardians and carers should receive clear instructions on follow-up care and written information on arrangements to deal with any post-operative emergency (including out-of-hours contact telephone numbers. This was not being met.

Therefore we were not reassured that young people were discharged safely and the staff were not assessing the risks to the health and safety of service users of

Enforcement actions

receiving care or treatment. There was non-compliance with BMI Care of Children Policy 2014 and the hospital management had not taken reasonably practicable actions to mitigate any such risks to children.

There was not proper and safe management of medicines in place at the hospital and hospital management had not taken reasonably practicable actions to mitigate any such risks.

The medicine keys for the ward were stored in a keypad cabinet with other keys. There was no in/out signing to establish who had access to the keys at any particular time. There were no daily checks. There was not a risk assessment in place.

During the inspection we saw that prescription pads were being distributed to consultants to use in their outpatients clinics. There was no risk assessments undertaken, or audit trail in place. The Security of prescription forms guidance updated August 2015 by NHS Protect states:

1. The distribution of prescription forms to prescribers is the responsibility of the organisation. A record should be kept of the serial numbers of the prescription forms, including where, when (date/time) and to whom the prescriptions have been distributed.
2. Organisations should undertake a risk assessment to identify potential location specific threats. Suitable physical security measures that address identified risks and are supported by a strong pro-security culture among staff provide further protection for prescription forms.
3. Access to the lockable room or area where prescription form stocks are kept should be restricted to authorised individuals. Keys or access rights for any secure area should be strictly controlled and a record made of keys issued or an authorisation procedure implemented regarding access to a controlled area, including details of those allowed access. This should allow a full audit trail in the event of any security incident.
4. Records of serial numbers received and issued should be retained for at least three years.

This section is primarily information for the provider

Enforcement actions

5. There should be an audit trail for prescription forms so that organisations know which serial numbered forms they have received and which have been issued to each prescriber.