# BMI Fawkham Manor Hospital

## Quality Report

Manor Lane,
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Longfield,
Dartford,
Kent
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Date of inspection visit: 15, 16 and 22 August and 1 November 2016
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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 | Inadequate |
| Are services safe? | Inadequate |
| Are services effective? | Requires improvement |
| Are services caring? | Good |
| Are services responsive? | Requires improvement |
| Are services well-led? | Inadequate |

### Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

# Summary of findings

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

# Summary of findings

## Letter from the Chief Inspector of Hospitals

The BMI Fawkham Manor Hospital is an independent hospital located in Longfield, near Dartford, in Kent. It was originally established as a hospital in 1980 and has been part of BMI Healthcare Limited since 1989. The building itself dates back to the 19th century and is set within six acres of grounds. The hospital has 30 available beds with two theatres, one of which has laminar flow, and seven consulting rooms. The hospital sees both private patients and NHS patients through Choose and Book and views itself as a community hospital serving the local population. Surgical specialities include Orthopaedic, General Surgery, Gynaecology, Urology, Pain Management, Ophthalmics, ENT, Gastroenterology and Plastic Surgery. Outpatient services are provided to adults and children aged over three, and at the time of the inspection elective surgical procedures were provided to adults and children aged over 12.

We carried out a comprehensive inspection of BMI Fawkham Manor Hospital on 15,16 and 22 August and 01 November 2016 as part of our national programme to inspect and rate all independent hospitals. The inspection was brought forward because of information received which raised concerns about the standard of governance at the location. We inspected the core services of medical care, surgery, and outpatients and diagnostic imaging as these represented the activity undertaken by the provider, BMI Healthcare, at this location. Because the number of medical patients seen in the hospital was low (437 attending for colonoscopy and endoscopy), information on medical care has been included in the Surgery section of this report. Information on the care of children and young people is included in both the Surgery section (19 patients) and Outpatients section (769 attendances for first appointment and follow up).

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

Our key findings were as follows:

- The systems in place to keep patients safe and to allow staff to learn and improve following incidents and complaints were not effective.
- Parts of the hospital were visibly not clean and we saw evidence that staff were not complying with infection prevention and control policies, which put patients at risk of infection.
- The management of governance and risk was limited, with senior managers often making an assumption about the quality of care rather than actively seeking assurances.
- Patient records in outpatients were not always complete, as consultant notes were not always copied into them.
- Appointments were available so that patients could access care when they wanted it, both in the evenings and on Saturday mornings.
- Staff felt supported by their managers and there were arrangements to ensure that staff had the required training and skills to do their jobs.

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

Importantly, the provider must:

- Maintain securely an accurate, complete and contemporaneous record in respect of each patient.
- Ensure staff are trained to the required level in vulnerable adult and children's safeguarding and have adequate knowledge and understanding of safeguarding issues.
- Ensure the environment and facilities are suitable for children and young people.

# Summary of findings

- Ensure there is emergency and standard equipment available for children and young people.
- Ensure that care and treatment reflects current evidence-based guidance, standards and best practice.
- Ensure staff follow patient pathways and corporate policies and practices.
- Ensure appropriate documentation of controlled drugs is in line with hospital policy.
- Ensure infection control compliance and monitoring is given sufficient priority.
- Ensure the World Health Organisation 'five steps to safer surgery' is used appropriately and ensure staff engagement in the process.
- Assess medical patient outcomes.
- Ensure there is a robust system in place to ensure regular electrical testing and servicing of equipment.
- Assure themselves that risks are given sufficient priority, identified and lessened.
- Compile a hospital specific risk register and a process for monitoring this.

In addition the provider should:

- Put systems in place to fully support patients living with dementia.
- Ensure that privacy and confidentiality of patients is maintained at all times.
- Ensure lessons learnt from incidents are shared and embedded.
- Undertake a review of the facilities and identify areas where improvement is required.
- Ensure the difficult intubation trolley is fit for purpose.
- Ensure the anaesthetic machine checking log books are fully completed.

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

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Surgery** | **Inadequate**  | Surgery<br>Overall, we rated surgical services as inadequate. This was because:<br>• Patients were at high risk of avoidable harm, or abuse, as the hospital did not consistently follow safety systems, processes and standard operating procedures.<br>• Care premises, equipment and facilities were unsafe for children and young people. The service was not always responsive to children and young people, and did not enable patients to receive care or treatment that was appropriate to their needs.<br>• Staff did not assess, monitor or manage risks to patients who use their services.<br>• Infection control practices were not robust and hand hygiene practices placed an unacceptable risk to patient safety.<br>• Polices were not followed to ensure the maintenance, cleanliness and safety of equipment.<br>• The delivery of high quality care was not assured by the leadership, governance or culture in place.<br>• There was minimal evidence of learning and embedding new practices to ensure there was not a recurrence of incidents.<br>• The World Health Organisation “five steps to safer surgery” checklist was being undertaken in a way that did not ensure patients were protected from harm and staff lacked awareness regarding correct completion of this.<br>• The executive team demonstrated a lack of awareness of risks related to infection prevention and other clinical practice, and in relation to equipment used to deliver care.<br>However: |

# Summary of findings

- All staff had received annual appraisals. Other development and clinical training was accessible to staff and there was evidence of staff being supported and developed.
- Patients' pain was addressed and national nutritional tools were used to monitor those patients who may be at risk of malnutrition.
- Staff were caring and compassionate to patients' needs, and treated patients with dignity and respect.
- Patients were given enough information regarding their surgery and had enough time to ask questions.
- Feedback from people who used the service and those who were close to them was positive about the way staff treated people.

We returned on 01 November 2016 for an unannounced inspection and observed:

- A robust checking process which ensured the right patients were taken to theatre for the right operation.
- There had been an improvement in electrical testing of equipment.

## Outpatients and diagnostic imaging

Requires improvement 

Outpatients & diagnostic imaging
We rated the outpatient and diagnostic imaging department at BMI Fawkham Manor as requiring improvement. This was because:

- We found areas of concern related to infection prevention and control, including noncompliance with the Department of Health's Health Building Note 00.09: infection control in the built environment (HBN 00.09) in the diagnostics imaging department.
- In the diagnostic imaging department, we found concerns regarding compliance with the Ionising Radiation Regulations 1999 (IRR99).
- A full record of outpatient clinic notes was not kept at the hospital.
- There was a lack of secure storage of patient information and records in the diagnostic imaging department.
- Staff did not demonstrate adequate knowledge and understanding of safeguarding issues.

# Summary of findings

- We found instances where a patient's privacy and confidentiality was compromised.
- The facilities and surroundings were not tailored to the treatment of children and young people and we were not given assurance that a paediatric nurse, or other staff member with the appropriate level of safeguarding knowledge, was available on site when children were seen in the department.
- Staff did not have an adequate understanding of caring for patients living with dementia.
- Relatives and occasionally members of staff were used if translation was required rather than the interpreter service.
- We looked at several pieces of electrical equipment but could not find evidence of safety checks, which would indicate it was safe to use.
- Overall, we found that hospital management did not have oversight of the issues we identified during the inspection.

However,

- Staff mostly had a clear understanding of the paper-based incident reporting process and most were able to give examples of incident reporting. Incidents were discussed at team meetings and learning from incidents was demonstrated.
- Staff managed outpatient prescriptions and medicines in line with best practice and stored them securely.
- The outpatient and diagnostic imaging departments had sufficient numbers of appropriately trained staff to provide safe care to patients. The majority of staff had completed the hospital's mandatory training programme.
- The outpatients department had an ongoing audit programme which monitored areas for improvement.
- Policies and guidelines were based on National Institute for Health and Care Excellence (NICE) and other learned bodies guidance.
- Staff were competent to perform their roles.
- Health professionals worked together to provide services for patients.

# Summary of findings

- The diagnostic imaging and pharmacy departments provided on call services, 24 hours a day seven days a week.
- The service offered a variety of appointment times to suit the needs of the patients.
- Staff were proud of the work they did at the hospital.
- Staff were positive about their direct line management and felt senior management was visible and approachable.

# Summary of findings

## Contents

Inadequate

# BMI Fawkham Manor

**Services we looked at**

Surgery; Outpatients and diagnostic imaging;

# Summary of this inspection

## Background to BMI Fawkham Manor Hospital

The BMI Fawkham Manor Hospital is an independent hospital located in Longfield, near Dartford, in Kent. It was originally established as a hospital in 1980 and has been part of BMI Healthcare Limited since 1989. The building itself dates back to the 19th century and is set within six acres of grounds.

The hospital has 30 available beds with two theatres, one of which has laminar flow, and seven consulting rooms. The hospital sees both private patients and NHS patients through Choose and Book and views itself as a community hospital serving the local population. Surgical specialties include Orthopaedic, General Surgery, Gynaecology, Urology, Pain Management, Ophthalmics, ENT, Gastroenterology and Plastic Surgery.

Outpatient services are provided to adults and children aged over three, and elective surgical procedures are provided to adults and children aged over 12.

We inspected this hospital as part of our national programme to inspect and rate all independent healthcare providers. A planned inspection was brought forward because of information of concern which we had received regarding clinical and financial governance and patient safety. We inspected the core services which incorporated the activity undertaken at the hospital. These were surgery, outpatients and diagnostic imaging, medical care and children and young people's services.

## Our inspection team

Our inspection team was led by:

**Inspection Lead:** Elizabeth Kershaw, Care Quality Commission, Inspection Manager.

The team included four CQC inspectors and a variety of specialists:

- Three nurses, including an oncology nurse and leads in clinical governance and clinical effectiveness
- A senior radiographer
- A consultant general surgeon

## How we carried out this inspection

We reviewed a wide range of documents and data we requested from the provider. This included policies, minutes of meetings, staff records and results of surveys and audits. As it was an unannounced inspection, we did not gather comments from patients in advance of the inspection but we were able to speak to patients during the inspection.

We carried out an unannounced inspection on 15 and 16 August 2016 with further unannounced visits on 22 August and 01 November.

We interviewed the management team and spoke with a wide range of staff including nurses, the chair of the medical advisory committee, other doctors, radiographers, physiotherapists and administrative and support staff. In the surgery service, we spoke to 36 members of staff, five patients and one relative. In the outpatients service we spoke to 18 members of staff, five patients and two relatives.

We observed care in the outpatients and imaging departments, in operating theatres and on the wards. We reviewed 26 sets of patient records. We visited all the clinical areas of the hospital and reviewed the environment and equipment in use.

# Summary of this inspection

## Information about BMI Fawkham Manor Hospital

Between July 2015 – June 2016, BMI Fawkham Manor Hospital treated a total of 1,095 patients requiring overnight stays and 3,321 day cases. NHS funded patients represented 32% of inpatient stays and 50% of the day cases. The hospital also saw 25,785 new and follow up outpatient attendances, of which 33% were NHS funded.

The most common surgical procedures in this time period included cataract surgery (425 procedures), arthroscopic meniscectomy (285), diagnostic endoscopic examination of the bladder (162) and facet joint injection (139). In the same period, the most common surgical procedures for children and young people included diagnostic colonoscopy (2), correction of hydrocele (2) and circumcision (2).

Medical services over this time period were provided within the outpatients department and the hospital was in the process of building a general medical service. The most common medical procedures were diagnostic colonoscopy (249) and diagnostic oesophago-gastro-duodenoscopy (188).

Figures provided by the hospital showed that there were 177 doctors with practising privileges. Of these, 10% had carried out more than 100 episodes of care in the 12 month period, 25% between 10 – 99, 7% between one and nine and 14% provided no episodes of care. Twelve doctors had had their practicing privileges removed because they had retired, seven had been temporarily suspended for failing to supply evidence of the appropriate documentation and one was currently suspended pending investigation.

There were 20.29 whole time equivalent (WTE) registered staff employed (including nurses) and 10.46 WTE health care assistants. From July 2015 – June 2016, bank and agency staff had been used to fill 19% of nursing shifts and 26.7% of operating department practitioner and health care assistant shifts.

There were 43 complaints received, one of which was referred to either the Parliamentary and Health Service Ombudsman or the Independent Healthcare Sector Complaints Adjudication Service (ISCAS). This was a decrease from the previous year when there had been 45 complaints received.

There was one serious injury, no patient deaths and no never events in this time period. Never events are serious incidents which are wholly preventable and have the potential to cause serious patient harm or death. There were 191 clinical incidents reported, of which 92% were categorised as no harm and 8% as low or moderate harm. There were 20 non clinical incidents. There was one unplanned return to theatre and 12 unplanned transfers of inpatients to other hospitals. There were seven unplanned readmissions within 28 days of discharge. There were no reported hospital acquired infections such as Methicillin-resistant Staphylococcus aureus (MRSA), MSSA, Clostridium difficile (C. difficile) and E.coli.

The proportion of adults admitted as inpatients who were screened for venous thromboembolism (VTE) was 100%, which was better than the target for NHS patients of 95%, and there were no cases of hospital acquired VTE reported.

# 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 | Requires improvement | Inadequate | Inadequate |
| **Outpatients and diagnostic imaging** | Requires improvement | Not rated | Good | Requires improvement | Requires improvement | Requires improvement |
| **Overall** | Inadequate | Requires improvement | Good | Requires improvement | Inadequate | Inadequate |

Inadequate

# Surgery

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

## Information about the service

Surgical services at BMI Fawkham Manor Hospital cover a variety of specialties for adults. These include spinal procedures, urology, gynaecology, orthopaedics, ophthalmic, cosmetic, podiatry, ear nose and throat, dental, endoscopy and general surgery.

Pre-planned elective surgery services are also provided to children and young people between the age of 12 and 18. The hospital does not accept emergency children's admissions. Nineteen children and young people were seen as day cases between July 2015 and June 2016.

Between July 2015 and June 2016, there were 4,422 visits to theatre. Nearly 25% of these involved an inpatient stay but the majority (75%) were day case procedures. The most common procedure performed in the same period was Phacoemulsification (cataract surgery); this accounted for 4,422, or 10% of procedures. Arthroscopy (key hole surgery) of the knee, was the second most common procedure and accounted for 285, or 6% of procedures.

The NHS funded 32% of inpatient procedures and 68% were Non- NHS funded between July 2015 and June 2016. Day case procedures were 50% NHS funded and 50% Non-NHS funded.

The theatre suite has two operating theatres, two recovery bays and two anaesthetic rooms. Both theatres are used Monday to Friday between the hours of 7am and 8pm and between 7am and 6pm on Saturdays. There is a mixture of all day sessions or morning and afternoon sessions. Sessions within the theatres are set to regular times, but can be flexible if extra lists are scheduled. All orthopaedic operations are undertaken in theatre one which is equipped with a laminar flow (a system that circulates filtered air to reduce the risk of airborne contamination). In addition, other surgical specialities are undertaken in theatre one for example gynaecology, ophthalmic, dental and general surgery. Theatre two undertakes all the same surgical specialities as theatre one, with the exception of orthopaedics.

There are two surgical wards, Mulberry and Hawthorn. Both day case and inpatient patients are cared for on both wards. The overall total of rooms is 30, there are three double rooms (usually used by NHS patients) and the remaining are single rooms. All patient bedrooms have ensuite bathroom facilities, a television and free Wi-Fi.

This report will also include our findings of medical day cases and inpatients. This is due to the low number of medical patients seen at the hospital. As well as the two wards, medical patients were supported in an ambulatory lounge with six reclining chairs. The oncology suite has two chairs and has obtained the Macmillan Quality Environment Mark (a quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer).

The hospital provides day case and inpatient medical services to people 18 years and over. Services include; endoscopy and oncology, with oncology services including diagnostic, chemotherapy, monoclonal antibodies therapy (a form of immunotherapy that uses antibodies to bind to certain cells or proteins. This may then stimulate the patient's immune system to attack those cells), and supportive therapies such as blood transfusions. Between July 2015 and June 2016, the most common medical procedures undertaken at the hospital were colonoscopy (a test that allows your doctor to look at the inner lining of your large intestine, rectum and colon) which accounted

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# Surgery

for 249 of procedures and oesophago-gastro-duodenoscopy (OGD) (an examination of oesophagus, stomach and the first part of the bowel) with 188 procedures.

During our inspection of medical and surgical services, we spoke with 36 members of staff including doctors, nurses, operating department practitioners, administrative staff, housekeepers, health care assistants and the executive team. We spoke with five patients and one patient relative. We reviewed 16 sets of patient records and a variety of hospital data including meeting minutes, policies and performance data.

## Summary of findings

Overall, we rated surgical services as inadequate. This was because:

- Patients were at high risk of avoidable harm.
- The hospital did not follow safety systems, processes and standard operating procedures.
- Care premises, equipment and facilities were unsafe for children and young people.
- Staff did not assess, monitor or manage risks to patients who use their services.
- Infection control practices were not robust and hand hygiene practices placed an unacceptable risk to patient safety.
- The service was not always responsive to children and young people, and did not enable patients to receive care or treatment that was appropriate to their needs.
- The hospital did not provide treatment and care in accordance with the National Institute for Health and Care Excellence (NICE) evidence-based national guidelines.
- There were not systems in place to ensure the maintenance, cleanliness and safety of equipment.
- Controlled drug record keeping was poor.
- The hospital did not have a specific local risk register; there was a BMI corporate risk register.
- The delivery of high quality care was not assured by the leadership, governance or culture in place.
- There was minimal evidence of learning and embedding new practices to ensure there was not a recurrence of incidents.
- There was an over reliance on patient satisfaction survey results as a measure of good patient outcomes.

We returned on 1 November 2016 for an unannounced inspection and found:

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# Surgery

- The World Health Organisation “five steps to safer surgery” checklist was being undertaken in a way that did not ensure patients were protected from harm.
- Staff lacked awareness regarding correct completion of the World Organisation “five steps to safer surgery” checklist.
- The electrical cupboard which we identified previously on our inspection as being unlocked was again unlocked.
- The infection control and prevention were still not robust and hand hygiene practices, placed an unacceptable risk to patient safety.
- The executive team demonstrated a lack of awareness of risks related to infection prevention and other clinical practice, and in relation to equipment used to deliver care.
- Polices were not followed to ensure the maintenance, cleanliness and safety of equipment.

However:

- All staff had received annual appraisals. Other development and clinical training was accessible to staff and there was evidence of staff being supported and developed.
- Patients’ pain was addressed and national nutritional tools were used to monitor those patients who may be at risk of malnutrition.
- Staff were caring and compassionate to patients’ needs, and treated patients with dignity and respect.
- Patients were given enough information regarding their surgery and had enough time to ask questions.
- Feedback from people who used the service and those who were close to them was positive about the way staff treated people.

We returned on 1 November 2016 for an unannounced inspection and observed:

- A robust checking process which ensured the right patients were taken to theatre for the right operation.
- There had been an improvement in electrical testing of equipment.

Inadequate

# Surgery

## Are surgery services safe?

Inadequate

We rated safe as inadequate because:

- Infection control practices were not robust and hand hygiene practices placed an unacceptable risk on patient safety.
- Safety systems, processes and standard operating procedures were not followed.
- Care premises, equipment and facilities were unsafe for children and young people.
- Staff did not assess, monitor or manage risks to patients who use their services.
- The World Health Organisation 'five steps to safer surgery' was not consistently used and there was poor staff engagement.
- Policies were not followed to ensure the maintenance, cleanliness and safety of equipment.
- The equipment and environment were not clean and tidy.
- Substances that could cause harm were not secured.
- Controlled drug record keeping was poor.
- When concerns were raised or things went wrong, the approach to reviewing and investigating causes was insufficient. There was little evidence of learning from events or action taken to improve safety and missed opportunities to prevent harm.
- There was insufficient attention to safeguarding children and adults.

We returned on 1 November 2016 for an unannounced inspection and found:

- The World Health Organisation "five steps to safer surgery" checklist was being undertaken in a way that did not ensure patients were protected from harm.
- Staff lacked awareness regarding the correct completion of the World Health Organisation "five steps to safer surgery" checklist.
- The electrical cupboard which we identified previously on our inspection as being unlocked was again unlocked.
- The infection control and prevention were still not robust and hand hygiene practices placed an unacceptable risk to patient safety.
- We were not assured that there were robust processes to ensure the security of patient records.
- Policies were not followed to ensure the maintenance, cleanliness and safety of equipment.
- There was still not adequate documentation of anaesthetic machines safety checks in accordance with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines.

However;

- Decision making about the care and treatment of a patient was clearly documented.
- There was good practice, for example, assessments of patient needs and falls risk assessments.
- There were examples of effective multidisciplinary working.
- Other development and clinical training was accessible to staff and there was evidence of staff being supported and developed.

We returned on 01 November 2016 for an unannounced inspection and observed:

- A robust checking process which ensured the right patients was taken to theatre for the right operation.
- There had been an improvement in electrical testing of equipment.

### Incidents

- The hospital reported no never events from July 2015 to June 2016. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The hospital reported no expected or unexpected deaths from July 2015 to June 2016.

- The hospital reported one serious injury between July 2015 and June 2016.
- The hospital reported no serious incidents between July 2015 and June 2016. During the same period, the hospital reported 191 clinical incidents. Of these, 168 (87.9%) related to surgery. However, during our inspection we identified an incident regarding a patient who went to theatre with the wrong identity wristband. This should have been categorised as a serious incident. It demonstrated a lack of understanding of what serious incidents were and may have meant serious incidents were under reported.
- Of the incidents 92.1% resulted in no harm to the patient, 7.3% resulted in low harm and 1.0% resulted in moderate harm.
- Staff completed a paper clinical incident form, which they submitted to the appropriate ward or theatre manager. The personal assistant to the Executive Director entered data from the form onto the risk management system. The paper copy was reviewed by the Director of Clinical Services and then actions required were communicated to the relevant head of department.
- Staff could all describe the process for reporting incidents, and gave examples of times they had done this.
- The PA to the Executive Director enters data from the form onto the risk management system.
- Heads of departments investigated incidents with oversight by the clinical governance committee. Staff told us the relevant ward or theatre manager fed back to the team with learning from incidents at monthly ward or theatre team meetings.
- We saw that the review of incidents was a standard agenda item on a variety of meetings, for example head of departments and the medical advisory committee. The management team told us that minutes from all hospital meetings are saved on the shared drive and all staff have access to all minutes. However, staff reported they got little feedback from incident outcomes.
- Staff showed us BMI Healthcare incident forms, which were classified as either clinical or non-clinical incidents. National Reporting and Recording Systems state a clinical incident should include any incident that affects a patient. Therefore, a slip, trip or fall is a clinical incident, whereas on the BMI Healthcare forms it was classified as a non-clinical incident. We saw examples where clinical and non-clinical incidents had correctly been identified by staff. However, one incident form regarding a needle stick was classified as non-clinical instead of as a clinical incident.
- We saw clinical governance meeting minutes where incidents were discussed. However, many of the 'actions taken' were not specific and did not describe what systems were put in place to prevent the incident occurring again.
- Staff we spoke with were aware of the duty of candour (DoC) under the Health and Social Care Act (Regulated Activities Regulations) 2014. The DoC is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of "certain notifiable safety incidents" and provide them with reasonable support. Staff knew what DoC meant, could describe their responsibilities relating to it, and gave examples. We also reviewed a sample of clinical incidents, patient notes and root cause analysis (RCA)'s and saw evidence that staff had applied DoC appropriately. For example, when a patient suffered a complication during surgery we saw in the RCA that the patient received an apology and contact had been maintained.

### Safety thermometer or equivalent (how does the service monitor safety and use results)

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient 'harm or harm free' care. The hospital collects data for the NHS patients, which the hospital are caring for on the day of the data input. The submission included data on patient falls, pressure ulcers, catheter and urinary tract infections.
- The hospital reported zero cases of venous thromboembolism (VTE) for surgical inpatients between July 2015 and June 2016.
- However, due to a lack of data regarding the safety thermometer we are unable to comment further.

### Cleanliness, infection control and hygiene

Inadequate

# Surgery

- We saw staff were not compliant with infection prevention and control (IPC) policies. We saw six members of staff enter the theatre department without cleaning their hands with alcohol hand gel. On Mulberry ward we saw four consultants enter patient rooms without using alcohol hand gel and were wearing suit jackets so were not bare below the elbows. In addition, we saw three members of staff either enter or exit patients' rooms without using alcohol hand gel or washing their hands.
- Bacteria and viruses can easily be spread by touch. They may be picked up from contaminated surfaces, objects or people, and then passed on to others. Effective hand cleaning, either by washing with soap and water or with an alcohol-based hand rub, is recognised as crucial in reducing avoidable infection. The breaches in IPC hand hygiene and bare below the elbow practices we observed meant patients were at higher and avoidable risk of developing an infection.
- Staff did not consistently adhere to or enforce the BMI Healthcare clinical uniform policy and national guidance 'bare below the elbows' policy. We observed nine members of staff who visited Mulberry ward, who were not bare below the elbows, for example wearing watches and long sleeves.
- There were hand sanitiser bottles readily available throughout clinical areas in theatres and on the wards.
- Equipment was not marked with a sticker when it had been cleaned and ready for use, this meant staff could not be sure if a piece of equipment was clean prior to use.
- We saw the skirting had become unstuck from the wall in the scrub room of theatre one. The Department of Health (DOH) HBN 26 Facilities for surgical procedures, Volume 1 paragraph 6.23 states: "There should be a continuous return between the floor and the wall, for example coved skirting's returned a minimum of 100mm, which allow easy cleaning and avoid microbial colonisation. The skirting material used should be integral with, and have properties similar to, the floor finish." This meant it could not be cleaned effectively and there was a risk harmful bacteria could collect here.
- We saw in the sluice room (a sluice room is where used disposables such as incontinence pads and bedpans are dealt with, and reusable products are cleaned and disinfected) the hand soap dispenser was dusty and empty which meant staff were unable to wash their hands. It also indicated that it had not recently been cleaned or used. In addition, the sink was rusty and had visible lime scale, which meant it could not be cleaned effectively, and the footstools used to stand on whilst operating were also rusty.
- We saw a limb positioner, which was made of foam that was covered in sticky tape. This tape was peeling off, allowing the foam underneath to absorb fluids or blood, which could pose an infection control risk.
- The Department of Health HBN 26 Facilities for surgical procedures Volume 1 states: "In theatres with ultra-clean ventilation the floor area enclosed by the hood should be marked with lines or a contrasting coloured area of flooring." We saw staff setting up their instruments within theatre, but without the markings on the floor staff could not ensure they were under the ultra-clean ventilation. This could increase the risk of the instruments becoming contaminated and increase the risk of infection.
- Tourniquet cuffs (a device for stopping the flow of blood through a vein or artery, typically by compressing a limb with a cord or tight bandage cuffs) were stored in bag on the floor meaning they could become contaminated with bacteria which could be passed on to a patient.
- The computer screens and keyboards in theatres were dusty, this meant there was a risk that the dust may accumulate and contain harmful bacteria, which could pose an infection risk.
- In theatre one there was a poster on the wall, it was stuck to the wall with putty-like adhesive, which could pose an infection risk.
- In theatre two, we saw there was an intravenous fluid warming device cartridge left in the machine. This meant there was no way of knowing if this cartridge had already been used on a different patient. A contaminated intravenous device could potentially be connected to a patient, which posed a risk of cross contamination.

- We saw equipment in theatre that was covered with dust and some machines had labels stuck to them with sticky tape, which posed an infection risk. In addition some of the trolleys and drip stands were rusty which meant they could not be cleaned effectively.
- We saw that the anaesthetic machine in theatre one had blood on it meaning it had not been cleaned effectively and could be an infection risk.
- We saw the operating table in theatre one had blood splatters and dust on it. This meant it had not been cleaned adequately and posed an avoidable infection control risk.
- On the difficult intubation trolley, there were unsterile items. This contravened the Association of Anaesthetists of Great Britain and Ireland (AAGBI) Safety Guideline, which states: "Packaging should not be removed until the point of use for infection control, identification, traceability in the case of a manufacturer's recall, and safety". This meant the items could be contaminated either by direct contact with patients, or indirectly via splashing, by secretions or from handling by staff, which would not be visible.
- In theatre one, we saw peeling paint on the ceiling the Department of Health HBN 26 Facilities for surgical procedures, Volume 1 states: "The ceiling in the operating theatre should also be able to withstand an occasional wash and have a completely sealed finish to maintain microbiological standards." In addition, there was a risk that paint could peel off and fall into an open wound during surgery, which could cause an infection.
- We saw there was no dedicated hand hygiene sinks in patient bedrooms. This was contrary to the BMI Healthcare policy which states in each single bed/ ensuite there should be one dedicated hand hygiene sink in addition and separate to the patients' washbasin.
- The ward sister explained that the hospital knew the sinks in patient rooms were not suitable for hand hygiene and a dedicated hand hygiene sink had been installed on the ward. This meant staff could wash their hands when they exited patient rooms and we saw staff using the sink to wash their hands. However, if staff contaminated their hands whilst in a patient it meant they had to exit the patients' room and walk to the dedicated hand hygiene sink.
- On Mulberry ward, we found disposable curtains that were not compliant with The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance. The code of practice states curtains should be changed every six months. However, during the inspection we found three curtains dated 15 July 2015.
- The hospital reported no infections of Methicillin Resistant Staphylococcus Aureus (MRSA), Clostridium Difficile or Methicillin Sensitive Staphylococcus Aureus (MSSA) between June 2015 and July 2016. We spoke to a pre-assessment nurse, who told us the hospital screened patients at risk of carrying MRSA, for example patients recently admitted to an NHS hospital, at the pre-assessment clinic.
- The hospital reported zero surgical site infections (SSI's) between June 2015 and July 2016.
- Sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We checked 15 sharp bin containers and all were clearly labelled to ensure appropriate disposal and traceability.
- We saw posters displayed which outlined what action must be taken if a member of staff sustained a sharps injury; this information was also in departmental resource folders.
- Personal protective equipment (PPE), such as gloves and aprons were generally used appropriately and were available in sufficient quantities. However, we observed one staff member assisting with an operation without wearing eye protection, this meant there was a risk of body fluid entering the eyes.
- We observed that the NICE guideline CG74, Surgical site infection: prevention and treatment of surgical site infections (2008) was followed by staff in the theatre environment. This included skin preparation and management of the post-operative wound.
- The decontamination of surgical instrumentation was managed offsite. Procedures were in place for storage of dirty and clean instrumentation.

We returned on 1 November 2016 for an unannounced inspection and found:

- Staff were still not consistently adhering to the BMI Healthcare clinical uniform policy and national

guidance 'bare below the elbows' policy. For example we observed a member of staff in theatres wearing a long sleeved top and staff on Mulberry ward were not bare below the elbows,

- Tourniquet cuffs (a device for stopping the flow of blood through a vein or artery, typically by compressing a limb with a cord or tight bandage cuffs) were stored in a bowl on the floor meaning they could become contaminated with bacteria which could be passed on to a patient. We saw the tourniquet cuffs had cotton wool from previous patients stuck on them; this meant they had not been adequately cleaned after use and could be contaminated with bacteria which could be passed onto patients.
- The computer screens and keyboards in theatres were still dusty and dirty, this meant there was a risk that the dust may accumulate and contain harmful germs, which could pose an infection risk.
- We saw what looked like blood on a foot pedal in theatres. We asked staff what they thought the substance was and they confirmed that it "was probably blood". This showed that the cleaning processes in theatres were insufficient and put patients at an increased risk of infection.
- In theatre one, there was still peeling paint on the ceiling. The Department of Health HBN 26 Facilities for surgical procedures, Volume 1, states: "The ceiling in the operating theatre should also be able to withstand an occasional wash and have a completely sealed finish to maintain microbiological standards." In addition, there was a risk that paint could peel off and fall into an open wound during surgery, which could cause an infection.
- We saw that recent plastering had been undertaken on theatre one's ceiling. This also contravened the Department of Health HBN 26 guideline.
- We saw several wooden shelves in theatre had exposed wood where the protective coating had worn away. This meant they could not be cleaned effectively and germs could accumulate within the exposed wood.
- There were posters stuck to walls with adhesive tape in theatres, this meant germs could stick to the tape and could be an infection control risk.
- Theatres and theatre equipment were dusty, for example anaesthetic machines and on top of door frames, ledges, and operating tables. This meant dirt could accumulate in the dust.
- We did not witness staff cleaning their hands when they entered the operating department. This meant that bacteria and viruses could be spread.

### Environment and equipment

- We undertook a review of the theatre operating registers, which demonstrated that 31 children aged between 13 and17 years old, had undergone operations between January 2015 and August 2016.
- We observed there was not a specific paediatric area in recovery. This is contrary to the Association of Anaesthetists Great Britain and Ireland (AAGBI) Safety Immediate Post-anaesthesia Recovery 2013, which states: "There should be a specially designated area for the recovery of children that is appropriately equipped and staffed."
- In addition, there was not a full range of paediatric equipment available in-line with AAGBI guidelines.
- It was also contrary to The Royal College of Anaesthetists Guidelines for the Provision of Anaesthetic Services 2010, which states: "Resuscitation drugs and equipment, including an appropriate defibrillator, should be routinely available at all sites where children are to be anaesthetised." It was also in breach of The BMI Children Resuscitation policy.
- Children undergoing operations at the hospital were at an increased risk of harm because of a lack of suitable standard and emergency equipment.
- We saw that the defibrillator in recovery was due to be serviced on 12 July 2016, we asked the theatre manager why this had not been done and they said it had been missed. This meant the safety and effectiveness of the defibrillator could not be assured. When we returned the next day, we saw the engineer was servicing the defibrillator.
- The general environment within was tired, dated and in need of refurbishment. For example, there were storage cupboards with missing handles, flooring was stained and walls were in need of redecoration.

- The cupboard doors containing the electrical circuit board for theatres were labelled “fire door keep locked danger 415 volts.” This door was not locked, increasing the risk of injury should anyone enter the cupboard. In addition, anyone could turn the electrical supply off to theatres, which could cut the power to life saving equipment. We alerted the theatre manager to the unlocked door who said they would contact the maintenance department immediately. When we returned for an unannounced inspection six days later we found the door was locked.
- Four anaesthetic vaporisers (a device used to deliver anaesthetic gas) should have been serviced in January 2016. This meant the quantity of gas delivered could not be assured and could result in harm to patients. We asked a senior operating department practitioner why they had not been serviced and they said the department was awaiting replacements from the company.
- Portable appliance testing (PAT) labels were attached to electrical items showing that they had been inspected and were safe to use. However, we checked 34 pieces of electrical equipment; 17 of these (50%) were compliant with electrical testing within last 12 months, 10 (29.5%) were non-compliant with electrical testing within last 12 months and for seven (20.5%) we could not find evidence of a PAT label. This meant 50% electrical equipment we checked might not be safe.
- Staff documented daily checks on resuscitation trolleys and defibrillators. However, this was inconsistent, for example, between 3 August and 14 August 2016 there were six occasions when the recovery resuscitation trolley checklist was not marked as either completed or not done because the unit was not open.
- There was an emergency difficult intubation trolley. However, the trolley did not meet AAGBI standards. This was because there was no checklist to provide assurance of regular safety checks. The AAGBI guidelines, “checking anaesthetic equipment” (2012) states, “equipment for the management of the anticipated or unexpected difficult airway must be available and checked. Regularly.” In addition, the trolley was extremely untidy which meant it would be difficult to locate equipment in an emergency. We checked 28 items on the trolley and three were out of date.
- Both the Control of Substances Hazardous to Health (COSHH) cupboards within theatres were unlocked and contained hazardous chemicals. This contravened the national requirements for the Control of Substances Hazardous to Health Safety Executive guideline SR24.
- We saw the theatre microscope was obstructing the fire escape; this could hinder escape via the fire exit.
- In theatres, we checked the anaesthetic machine logbooks for both the anaesthetic machines. We saw staff had not fully completed both logbooks with evidence of daily pre-use checks in accordance with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines. For example, the last documented check of the anaesthetic machine in theatre two was two days prior to our inspection and between 4 July 2016 and 15 July 2016 there were six occasions when checks had not been documented. This did not provide assurance that the anaesthetic machines worked safely. We spoke to one of the senior operating department practitioners regarding the lapses in the checking process; they said this was because the anaesthetic machine was not used on that day. Logbooks should be documented concurrently and on days when the machine was not used it must be documented in the logbook. This ensured an accurate record of checks was maintained.
- In theatres, staff told us that equipment was poorly maintained and invested in. For example, the drills used for orthopaedic (bone) surgery were not standardised or complete; sometimes staff had to open multiple drills in order to obtain all the pieces required.
- There was good management and segregation of waste. All bins were labelled to indicate the type of waste to be disposed and were emptied regularly.
- In theatres, we observed staff checked all surgical instruments and gauze swabs before, during and at the end of patients’ operations. This was in line with the Association for Perioperative Practice (AfPP) guidelines.
- We saw that there was an adequate number of portable oxygen cylinders; we checked 10 cylinders, which were in date and labelled correctly.
- Theatres were fitted with an uninterrupted power supply (UPS) which meant lifesaving equipment would continue to operate in the event of a power cut.

- There was a hospital generator that was tested monthly, this ensures a backup supply of electricity if the main electricity supply failed.

We returned on 1 November 2016 for an unannounced inspection and found:

- The cupboard doors containing the electrical circuit board for theatres were labelled "fire door keep locked danger 415 volts." This door was not locked, increasing the risk of injury should anyone enter the cupboard. In addition, anyone could turn the electrical supply off to theatres, which could cut the power to life saving equipment. We had highlighted this to the theatre manager and executive team on our last inspection visit in August, who assured us it would be addressed. This showed there was not a robust system in place to ensure the security of the electrical circuit boards.
- The theatre manager was unable to provide assurances of electrical safety testing on two electrical items. However, we noted that the majority of electrical equipment had undergone electrical testing since our last inspection.
- We saw operating table attachments which supported patients during operations and provided essential padding to avoid injury were not fit for purpose. The attachments were split and torn and some had adhesive tape on them covering the splits. This meant the attachments could not be cleaned adequately and germs could accumulate. In addition, they did not provide adequate padding protection for patients.
- There were stirrups used to position patients in theatre stored by the scrub sink. We saw that when staff washed their hands, they were splattered with dirty water and soap. This meant that the stirrups could be covered with germs.
- We saw that several trolleys and stools in theatres had rusty wheels and bars. This meant that they could not be cleaned effectively and germs could accumulate. We raised this issue with the theatre staff who said "you should see some of the others". This showed that staff were aware of the issue however the equipment had not been replaced.
- We saw the anaesthetic machine logbook in theatre two had not been completed on the day of our inspection or the previous day, this meant there was no assurances that the correct safety checks had been undertaken. We raised this with the anaesthetic practitioner working in theatre two who said they had forgotten to sign it today and "I didn't work in here yesterday". We reviewed the contents of the logbook and identified several occasions when it was not completed to confirm the safety checks had been undertaken. This was against the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines.

### Medicines

- We checked the controlled drugs (CD) book in theatre one, two and recovery and saw incomplete records of the CD's. This was because staff block-signed for the drugs rather than signing individually at each stage of the dispensary process. This issue had been identified by the pharmacy department and action was being undertaken to address the issue. The daily checking process of CDs in theatres was otherwise robust.

However we also found:

- On both wards, medicines were stored safely and securely in line with relevant legislation for the safe storage of medicines.
- We checked the controlled drugs (CD) cupboard on both wards. Controlled drugs are medicines liable for misuse that required special management. We saw the CD cupboard was locked, and only authorised staff with a key could access them. We checked the stock levels of two CDs and found the correct quantities in stock according to the stock list, and that all were in-date.
- We checked temperature monitoring charts for the drug fridges and ambient room temperature in anaesthetic room one, two and recovery. The records showed staff had monitored the temperature of both fridges daily in the last month. This provided assurances the theatre team stored refrigerated drugs within the correct temperature range to maintain their function and safety.
- The temperature of the drugs fridge on Mulberry ward was within the expected range. We asked two members of staff, and both knew the safe temperature ranges for the fridge and at what temperatures they should take action.

- There was a checklist for monitoring the ambient temperature of the medicines storage room. This was to ensure that drugs stored at room temperature remained within the manufacturer's indicated temperature range.
- We reviewed ten prescription charts, and found them to be legible, and completed appropriately. Patient allergies had been clearly noted on the chart and on their identity band, which alerted staff to their allergy. The ten charts we reviewed demonstrated that prescribing was in line with national guidance and that all were compliant with (NICE) VTE guidance. A section in the front of this chart confirmed a completed VTE assessment had taken place and that prophylaxis had been prescribed and administered.
- Medicines were checked and reconciled by pharmacy staff on a daily basis in theatres and on a weekly basis on the wards.
- There was one pharmacist at the hospital, a pharmacy technician and a bank pharmacist who worked one day a week.
- An experienced pharmacist was available at all times, delegating responsibility to the registered medical officer (RMO) out of hours. There was a pharmacist on-call and details were left at switchboard and in the pharmacy out of hours folder located in the pharmacy. The on call pharmacist was available for the dispensing of controlled drugs and advice for the RMO and nurses.

## Records

- We saw there was a BMI Healthcare Group Policy for the retention of records, which was in date.
- Staff adhered to this policy, for example, staff stored notes securely in the nurses' office to prevent unauthorised access to confidential patient data.
- Patients' records were kept on site. During our inspection we requested several patients' records and these were obtained quickly.
- We examined 14 sets of surgical patients' records; there was a good standard of documentation in all areas. For example, patients had care plans, which identified all their care needs, and were fully completed.
- Patients followed standardised pathways, for example endoscopy, minor procedure under local anaesthetic and day case procedures. This was personalised through individual risk assessments and notes made in the care plans.
- A variety of risk assessments were used, for example infection control risk assessments and patient pressure area assessments.
- Oncology patients were provided with a chemotherapy book for each cycle of chemotherapy, which contained medical information. However, we saw that information, for example medication, was not being transferred from one book to the next. Therefore, staff may not have had access to important patient information.
- The hospital had changed the layout of oncology notes, which hindered flow and understanding in patient notes where the layout was changed half way through treatment.
- Information Governance training was mandatory for all staff. There was an information governance lead as well as information governance meetings on a quarterly basis.
- We checked all recent records for medical patients in the Mulberry Suite (two in total) and found they were contemporaneous, legible, dated and signed and contained full clinical details in line with the Royal College of Physicians Standards for the clinical structure and content of patient records 2013.

## Safeguarding

- There was a BMI Healthcare Group Safeguarding Children policy and a Safeguarding Adults policy.
- The Director of Clinical Services had overall safeguarding responsibility for adults and children and had undertaken the relevant training.
- The intercollegiate document Safeguarding children and young people 2014 states clinical staff who could potentially contribute to assessing, planning, intervening or evaluating the needs of a child or young person must be trained to safeguarding level 3, with the safeguarding lead trained to level 4. Nursing staff were trained to level 2, with only the safeguarding lead trained to level 3. Therefore, the hospital did not have

adequately trained staff in safeguarding and staff we spoke with could not all demonstrate knowledge and understanding of how safeguarding issues applied to their work.

- Staff received paediatric safeguarding training; however staff on Mulberry ward were unable to explain any specific differences between safeguarding children and adults.
- On Mulberry ward, staff knowledge of female genital mutilation (FGM) was poor, with many not knowing what it was or correct procedures to follow if it was identified. For example, the NMC code of conduct 2016 states healthcare professionals who suspect FGM must report the incident immediately to the local authority. Staff we spoke with were unaware of this process. Therefore, patients presenting at the hospital with female genital mutilation may be at risk of not being reported or given access to help if needed.
- Ninety five percent of staff had completed level 2 adult safeguarding training. This was better than the BMI target of 90%. Ninety-three percent of staff had completed level 2 safeguarding children training which was better than the BMI target of 90%.
- One hundred percent of staff had undertaken protecting people at risk of radicalisation (PREVENT) training.

### Mandatory training

- Overall mandatory training rates for theatre staff was 97%, which was better than the BMI target of 90%.The overall training rates for the ward staff was 91%, which was better than the BMI target of 90%.
- There were 51 mandatory training courses for staff. This was a combination of online and classroom-based training. Staff completed the appropriate number and type of courses from this list relevant to their role. This was monitored through the staff member's appraisals and in addition, managers received notification when a staff member's mandatory training had lapsed.
- Staff completion rates for mandatory training were 83% for the Mulberry Suite. The BMI Healthcare benchmark completion rate was 90%, therefore staff on Mulberry Suite were not meeting this target.
- Nursing staff and operating department practitioners received paediatric immediate life support training and were therefore qualified to support children in arrest.

### Assessing and responding to patient risk

- We observed theatre staff carrying out the World Health Organisation "Five steps to safer surgery" (WHO) checklist for five procedures. The "Five steps to safer surgery" checklist is a national core set of safety checks for use in any operating theatre environment. The checklist consists of five steps to safer surgery. These are team-briefing, sign in (before anaesthesia), time out (before surgery starts) and sign out (before any member of staff left the theatre) and debriefing. We saw staff did not complete all of these steps, for example: -
- Prior to the start of the endoscopy list a 'team briefing' (step one) did not occur, this meant any potential risks or issues such as, equipment requirements, were not discussed and could result in harm to patients.
- We saw two other 'team briefings' (step one) but not all the team members were present, this meant vital safety information was not shared with the whole team.
- We saw patients undergoing operations under local anaesthetic were not asked to confirm their identity, date of birth, allergy status or operation undertaken at the 'sign in' stage (step two). It is best practice where possible for the patients to be involved in the "Five steps to safer surgery" checklist, as they can confirm their details.
- We saw the different stages were undertaken, however the actual checklist was completed retrospectively and not at the time of completion. There was a risk that important information may have been missed or forgotten if the documentation was undertaken retrospectively.
- We saw in one instance the 'sign out' stage (step four) had been documented on the checklist before it had been undertaken. This meant that the documentation may have been inaccurate and contradicts the purpose of the checklist.
- We observed on one occasion when the site marking of the leg was not confirmed with the patient. This contravened the BMI Healthcare Surgical Site Marking

policy, which states: 'The planned procedure must be confirmed and the surgical site marking checked at both 'sign in' and 'time out''. This meant there was a risk that the operation could be carried out on the wrong limb.

- Staff engagement was poor when the safety checks were undertaken, for example, staff were still moving objects around and did not stop, listen and pay attention. This made it difficult for staff to concentrate and pay attention to the safety checks.
- During our inspection, we witnessed an incident where the wrong patient was taken to theatre. The operating department practitioner (ODP) gave the porter the notification containing the correct details for the patient due for collection from Mulberry ward. The ward sister explained that the nurse took the patient to theatre without performing any checks to confirm identity. This contravened the BMI Healthcare Standard Operating Procedure for Patient Transfer: Ward to Operating Theatre, which states: "The staff member escorting the patient to theatre must ask the patient to confirm their name and date of birth prior to leaving the ward."
- On arrival in the anaesthetic room the sign in stage (step two) of the 'five steps to safer surgery' was performed. It was identified the correct patient had not been brought. We saw that a clinical incident form had been completed and the incident had been escalated to the Director of Clinical Services. The ward sister told us that statements would be obtained from all staff members involved and an investigation undertaken to prevent recurrence. The staff member involved was asked to write a reflection of the incident in order to identify any learning needs.
- Staff told us of a similar incident that occurred a few months previously when a patient was taken to theatre with the incorrect identity wristband on, it was the wristband of another patient. This error was not identified until the 'time out' (step three) of the "Five steps to safer surgery" checklist was performed. This meant that the' sign in' (step two) stage of the "Five steps to safer surgery" checklist was not performed correctly or the error would have been identified at this stage. However, this was not identified as a serious incident. This demonstrated a lack of awareness of the seriousness of the incident.
- These two incidents demonstrated that the BMI Healthcare Standard Operating Procedure for Patient Transfer: Ward to Operating Theatre and the "Five steps to safer surgery" checklist were not consistently adhered to. This meant there was a risk to patients as hospital and national policies were not complied with.
- The hospital assessed all patients prior to admission using the BMI Healthcare pre admission medical screening form, which detailed inclusion and exclusion criteria. Exclusion criteria included a body mass index of over 40, alcohol/drug dependency and stroke.
- The hospital used the National Early Warning System (NEWS) track and trigger flow charts. NEWS was a simple scoring system of physiological measurements (for example blood pressure and pulse) for patient monitoring. This enabled staff to identify deteriorating patients and provide them with additional support. We reviewed ten patients' NEWS charts. We saw evidence of increased monitoring and intervention when clinically indicated in line with national guidance.
- The hospital had a service-level agreement with a local NHS hospital for the retrieval of paediatric patients. This enabled them to transfer any children who became unwell and needed critical care support.
- The hospital had a standard operating procedure (SOP) regarding the emergency transfer of deteriorating patients. The SOP was in date and set out actions and responsibilities, should a patient become unwell and required transfer to an acute NHS hospital. This meant there was a process in place to ensure patients who became unwell were transferred to an acute hospital for assessment and treatment.
- Pre assessment of patients was undertaken either by telephone or face-to-face by a pre assessment nurse. The nurse had access to anaesthetists should they have any concerns or questions.
- The hospital did not have any level two or three critical care beds. To mitigate this risk, the hospital only operated on patients pre-assessed as grade one or two under The American Society of Anaesthesiologists (ASA) grading system. Grade one patients were normal healthy patients, and grade two patients had mild disease, for example well controlled mild asthma.

- Risk assessments were undertaken in areas such as venous thromboembolism (VTE), falls, and pressure sores. These were documented in the patient's records and included actions to mitigate the risks identified.
- Nursing staff told us medical support was readily available when required as the RMO attended to patients quickly.
- The hospital's RMOs provided medical cover 24 hours a day, seven days a week. This ensured nurses could always quickly escalate any issues concerning a deteriorating patient. The RMO also informed the patient's consultant in an emergency so that they could provide consultant-level care.
- A RMO told us that there was a robust support process in place should they require support or advice quickly, initially via telephone and consultants would attend the hospital if needed.
- A report on patient transfers to the local NHS hospital showed the hospital had transferred nine surgical patients to the local NHS hospital between June 2015 and July 2016.
- The service used a communication tool called Situation Background Assessment Recommendations (SBAR) for both medical and nursing staff to use when escalating concerns about a patient's condition to their seniors. Staff confirmed they had received training on using this tool.
- Staff told us any patients who developed complications following discharge could contact the nurses on the wards at any time, day or night. We saw staff provide patients with contact numbers of who to contact when discharged.
- Staff told us they checked the pregnancy status of female patients of potential childbearing age on the day of planned surgery by undertaking a pregnancy test. We saw theatre staff checked that a pregnancy test had been performed and the result was available prior to the induction of anaesthesia.

We returned on 1 November 2016 for an unannounced inspection and found:

- During our last inspection we found that the World Health Organisation (WHO) "five steps to safer surgery" checklist was not undertaken correctly which placed patients at an increased risk. We asked the provider to provide us with assurances that these checks were being undertaken correctly. The provider undertook 10 WHO checklist audits per week to monitor WHO checklist compliance, and these demonstrated 100% compliance. However, this did not reflect what we observed. We saw that the staff were undertaking the WHO checklist without using the actual WHO checklist and then completed the checklist retrospectively.
- The WHO checklist was designed to be used when the safety checks were undertaken to follow a systematic approach to the checks and ensure each one was undertaken. We saw that staff asked some of the questions at the various stages of the "five steps to safer surgery" but not all. This meant important safety checks could be missed and could result in harm to patients. In addition, we saw one member of staff sign the WHO checklist to confirm the checks were undertaken, however, it was another member of staff that had undertaken the checks.
- We asked a staff member why they had not asked all the questions on the WHO checklist and their response was "I know the answers to all the other checks already". This demonstrated a lack of knowledge of the correct way to undertake the "five steps to safer surgery". During the "time out" stage of the WHO checklist we saw that staff were still talking and doing things, for example one of the surgeons said "we need to move the patient down the table a foot". The "time out" stage of the WHO checklist is the final stage of checks to prevent severe harm being done to the patient, for example doing an operation on the wrong arm. At the "time out" stage, all staff need to stop and listen whilst the relevant checks are undertaken before starting the operation.
- We spoke to the theatre manager and confirmed that their expectation was that the WHO checklist should be undertaken contemporaneously and with the WHO checklist to ensure all the checks were completed. The theatre manager and head of clinical services confirmed that this was their expectation.

### Nursing staffing

- The surgical services department had 29.07 whole time equivalent (WTE) staff. At the time of inspection, there were three WTE ward nurse vacancies. Staff told us that they were actively trying to recruit into these roles.

Inadequate

# Surgery

- On the day of our visit, we saw staffing levels met the AfPP guidelines on staffing for patients in the perioperative setting. The guidelines suggested a minimum of two scrub practitioners, one circulating staff member, one anaesthetic assistant practitioner and one recovery practitioner for each operating list.
- There were a total number of 323 shifts covered by bank or agency staff between July 2015 and June 2016.The highest bank or agency was for theatre nurses (115) and the lowest rate was for ward health care assistants (34).
- There was an unfilled agency or bank shift rate of 1.0% between June 2015 and July 2016.
- The hospital used the BMI staff planning tool. The planning tool calculated the nursing hours and skill mix needed for the planned patient numbers and acuity levels. The hospital told us they used the tool to plan the appropriate number of hours and skill mix needed to meet demand five days in advance, with continuous review on a daily basis. The hospital told us they also entered the actual hours staff worked retrospectively to understand any variances from the planned hours and the reasons for these.
- We saw that the daily actual versus planned staffing levels were displayed on the 'ward boards.' Actual staffing levels met the expected numbers on all shifts.
- At the time of inspection, there were no nursing vacancies on Mulberry Suite and staff advised us there were adequate staffing levels for the number of patients seen.

### Surgical and medical staffing

- There were 168 consultants who had practising privileges at the hospital, of whom 48% had not undertaken work at the hospital between April 2015 and March 2016. Practising privileges is a term, which means consultants have been granted the right to practise in an independent hospital.
- The hospital used an agency to provide 24-hour, seven days a week RMO cover on a rotational basis. This ensured a doctor was on-site at all times of the day and night should an emergency arise. The RMO conducted regular ward rounds to ensure patients were safe. The RMO reported any changes in a patient's condition to their consultant and followed the consultant's advice regarding further treatment.
- The RMO told us the consultants were approachable, reacted quickly in emergencies and were easily contactable. The nurses and the RMO told us that consultant lead care was available out of hours and at weekends.
- Staff told us RMOs carried out a formal handover. However, we did not see this as there was no change over during our visit.

### Major incident awareness and training

- The hospital provided scenario-based training exercises, which included resuscitation exercises.
- We saw the hospital's business continuity policy. The policy was in-date and produced with reference to the NHS England Core Standards for Emergency Preparedness, Resilience and Response (May 2015) and ISO 22301 Business Continuity Management Systems Requirements. The policy set out clear roles and responsibilities to ensure service continuity in the event of a business continuity incident.
- The hospital had a back-up generator to ensure services could continue in the event of a disruption to the main power supply. Maintenance staff told us the generator was checked on a monthly basis. Generator testing provided the hospital with assurance that the generator would provide back-up power and enable services to continue in the event of a power failure.

## Are surgery services effective?

Requires improvement

We rated effective as requires improvement because:

- Care and treatment did not always reflect current evidence-based guidance, the National Institute for Health and Care Excellence (NICE) guidelines, and best practice.
- Treatment and care was not always provided in accordance with evidence-based national guidelines.
- The outcomes of patients' care and treatment was not always monitored regularly or robustly.

- Participation in external audits and benchmarking was limited. The results of monitoring were not always used effectively to improve quality.
- Staff failed to comply with the Mental Capacity Act.

However;

- Staff obtained and recorded consent for surgery in line with relevant guidance and legislation.
- Patients' pain was addressed and national nutritional tools were used to monitor those patients who may be at risk of malnutrition.
- The hospital submitted some national data, for example the National Joint Registry.

We returned on 1 November 2016 for an unannounced inspection and:

- We saw that patients' temperatures were being monitored in theatres in line with NICE guidelines [CG65].

### Evidence-based care and treatment

- We observed how patient care and treatment did not always reflect current legislation and nationally recognised evidence-based guidance.
- During the inspection visits in August, in theatres, we saw four occasions during one operating list when the patient's temperature was not measured and documented before induction of anaesthesia and then every 30 minutes until the end of surgery. This contravened: Hypothermia: prevention and management in adults having surgery NICE guidelines [CG65].This meant there was a risk that patient could become hypothermic (low body temperature) as their temperature was not monitored.
- In the theatre rest room there was a resource folder, which contained a variety of risk assessments. Staff were meant to sign a register to confirm they had read these. We saw that there was a minimal amount of staff signatures which meant the hospital could not be assured that staff were aware of the risks associated with their area of work.
- The hospital provided data to the National Joint Registry (NJR). The NJR collected information on all hip, knee, ankle, elbow and shoulder replacement operations to monitor the performance of joint replacement implants. However, it was not clear how this information was reviewed and benchmarked in order to improve patient care.
- At the time of inspection, the oncology department was not taking part in any clinical trials.
- In theatres, and in the patient notes, we saw evidence of the hospital providing surgery in line with local policies and national guidelines such as NICE guideline CG74: Surgical site infections: prevention and treatment. For example, in theatre we saw that the patient's skin was prepared at the surgical site immediately before incision using an antiseptic (aqueous or alcohol-based) preparation: povidone-iodine or chlorhexidine.
- We observed patients receiving regular observations, for example, blood pressure and oxygen saturation, to monitor their health post-surgery. This was in line with NICE guideline CG50: Acutely ill patients in hospital - recognising and responding to deterioration.
- There were specialist clinical pathways and protocols for the care of patients undergoing different surgical procedures, for example, the hip and knee replacement pathway. These were designed to specifically assess risks associated with these procedures.
- Endoscopy policies and procedures such as colonoscopy and upper gastrointestinal endoscopy (the scope is inserted through your mouth to examine the oesophagus and upper intestinal tract) followed National Institute for Health and Care Excellence guidance.
- The endoscopy service was working towards Joint Advisory Group (JAG) accreditation. The service had registered with JAG and had completed an endoscopy global rating scale (GRS) self-assessment. JAG had not yet formally reviewed the hospital. The GRS is a quality improvement system designed to provide a framework for continuous improvement for endoscopy services to achieve and maintain accreditation.
- The hospital was BUPA accredited and therefore recognised by BUPA to treat its customers in breast care and bowel care.
- The hospital director stated end of life care was not provided at the hospital, and staff echoed this. The National Council for Palliative Care describes anyone as

approaching the end of life when they are likely to die within the next 12 months. Oncology patients treated at the hospital fell into this category. Therefore, the hospital was providing end of life care without fully completing the required care assessments and plans.

We returned on 1 November 2016 for an unannounced inspection and:

- We saw that patients' temperatures were being monitored in theatres in line with NICE guidelines [CG65].

### Pain relief

- Pre-assessment provided advice booklets on pain to patients pre-operatively, with any issues discussed and existing issues documented and highlighted. This was also discussed verbally with any patients having a phone call pre-assessment. Pain scores were documented on the Adult National Early Warning Scoring Chart (NEWS) observation chart and responded to accordingly.
- We saw the use of a pain assessment tool, where patients were asked to rate their pain between one and 10, one meaning no pain and 10 being extreme pain. Pain scores were recorded along with clinical observations following surgery. There was not a recognised pain score tool in use for children.
- Nurses on the medication ward rounds asked each patent if they were in any pain and gave prescribed analgesia if necessary. Patients were also asked whether they were experiencing pain as part of the hourly ward rounds. We saw evidence of pain assessment as part of hourly ward rounds within the patient's notes.
- We observed pain relief administration on Mulberry ward, which included a reassessment of pain to monitor if the pain relief had been effective.
- The hospital monitored the results of the patient Corporate Quality Health questionnaire as to whether the patient was assessed for their level of pain and this was discussed at the Medicine Management Committee.
- However, the second most common complaint on Mulberry Suite was related to pain relief. Patients stated there was a disconnect between analgesia provided pre and post procedure, with patients waiting too long post procedure due to medication prescription waiting times.

### Nutrition and hydration

- The hospital used the Malnutrition Universal Screening Tool (MUST) as part of pre-assessment screening. The MUST tool enabled staff to identify patients at risk of malnutrition and make adjustments to mitigate any risk where appropriate. We reviewed ten sets of patients notes, which all provided evidence of MUST assessment.
- On the hospital admission letter, fasting advice was given which informed the patient when to stop eating and drinking, and the pre-assessment team also discussed this. The hospital followed the national guidelines for fasting prior to surgery. Also included in the admission pack was an information letter requesting any dietary advice for the patient, which they returned prior to admission to ensure the catering department could prepare in advance for any requirements.
- Patients told us nurses offered them drinks as part of their hourly ward rounds. We also saw patients had access to a water jug at their bedside to enable them to stay hydrated.
- Food was delivered to the patient's bedside and patients generally gave us positive feedback regarding the food.
- Patients received advice on how to prepare for endoscopic procedures and were given general guidance regarding pre-operative dietary and fluid intake. Patients having a procedure that looked into their stomach were advised not to eat or drink anything for at least six hours prior to their appointment to enable good images of the stomach. We also saw information leaflets advising patients of this.
- Patients were offered a drink and light snack prior to discharge following an endoscopic procedure.
- Patients with swallowing difficulties had access to a speech and language therapist who regularly attended Mulberry ward. The hospital also supported patients by providing soft menu options. Patients requiring a puree diet were not admitted to the hospital as they were deemed high risk, which would be picked up at pre-assessment.

Inadequate

# Surgery

## Patient outcomes

- There was a range of BMI dashboards that were used to monitor performance, for example, it monitored clinical quality and risk, safety, health and environment and complaints.
- Integrated audits were completed by the BMI Corporate team, which included areas such as clinical, financial, health, safety and information security. Results and action trackers were discussed at the relevant hospital meetings.
- In addition, monthly audits were undertaken which included for example 'Five Steps to Safer Surgery', infection control, and clinical care bundles such as urinary catheter care.
- There were one case of unplanned readmission within 28 days of discharge between July 2015 and June 2016.
- The hospital reported one unplanned return to theatre between July 2015 and June 2016.
- The hospital provided data to national Patient Reportable Outcomes Measures (PROMS) for NHS patients. PROMS use patient questionnaires to assess the quality of care and outcome measures following surgery.
- The hospital had submitted data for patients undergoing hip replacements, knee replacements, varicose vein surgery and hernia surgery. The provider reported having achieved similar outcomes to the national and BMI average scores.
- BMI were going to introduce PROMS for all private patients, in-line with specialties already captured for NHS patients. The hospital will also be capturing data for all patients undergoing cataract surgery.
- The BMI Fawkham Manor Hospital also participated in National Joint Registry (NJR) and Patient Led Assessment of the Clinical Environment (PLACE) audits.
- We reviewed a variety of meeting minutes, which included the medical advisory committee (MAC), heads of departments meeting and senior staff meetings. Patient outcomes were not itemised as a standard agenda item at any of these meetings. Therefore, there was no assurance that patient outcomes were regularly benchmarked, monitored and discussed and areas of improvement identified.

## Competent staff

- One hundred percent of staff working within surgical and medical services had undergone an appraisal within the last twelve months. This meant learning needs were addressed and objectives were set to ensure suitable training opportunities for staff development.
- All new staff were inducted using the BMI corporate policy and there was a hospital induction checklist and courses on BMI Learn (an electronic training system).
- We saw an induction check sheet in use on the wards and in theatres to demonstrate that staff had undergone an induction to the department and were aware of safety information such as the location of fire exits and emergency equipment.
- The hospital reported all ODP's and all registered nurses working in inpatient departments had validation of professional registration. The hospital had an active revalidation process in place.
- Practising privileges are granted to consultants, which gives them permission to practice as a medical practitioner at a specific hospital. The hospital had a practising privileges policy, which detailed roles and responsibilities, quality and safety and standards of practice. Before being able to practice at the hospital, consultants had to provide documentary evidence of their disclosure and barring service enhanced check. All consultants were registered with the General Medical Council.
- The hospital maintained a Medical Advisory Committee (MAC) whose role included ensuring that any new consultant was only granted practising privileges if deemed competent and safe to do so. The role of the MAC included periodically reviewing existing practising privileges and advising the hospital on their continuation. They gave examples where practising privileges had been suspended or withdrawn because of concerns raised. This demonstrated that the MAC was an effective body for monitoring the competence of the consultants working at the hospital.
- The agency provided Resident Medical Officers (RMO's) with up-to-date advanced life support training (ALS). We spoke to an RMO who confirmed they had ALS training every four years. This was in line with current guidance from the Resuscitation Council (UK).

- In addition, RMO's were required to undertake the BMI Healthcare RMO induction programme.
- The hospital had verification of registration status for 100% of doctors and dentists working under practising privileges who had worked at the hospital for more than six months.
- Staff were supported to develop and expand their knowledge and skills with study days.
- There were systems which alerted managers when staff professional registrations were due, and to ensure they were renewed. These were demonstrated to us.
- Staff advised us they had access to the internal BMI Learn system, which included a revalidation tool to support staff going through the revalidation process. Staff also advised they were allocated sufficient time and support to complete the revalidation process.
- Health care assistants were supported using a competency assessment where tasks were assessed and rated. Tasks included: catheter care, blood glucose testing and pressure area care. These assessments were also linked to appraisals and supervision.
- Bank staff had an induction to their area prior to starting work. We spoke with one bank nurse who told us she had been given an orientation.
- Theatres had trained their own staff to work as first assistants, the staff had all undergone accredited training.

### Multidisciplinary working

- We observed positive interactions and collaborative working between the ward and theatre staff and in theatres between the surgeons and theatre staff.
- Ward staff told us that they liaised with the district nursing and GP services prior to patients returning home to make sure that support mechanisms were in place once the patient returned home.
- The multidisciplinary theatre team had recently started undertaking meetings; there was one in August 2016 and we saw the minutes of this. It was acknowledged by the theatre manager that these had been slow to start and they had previously been given insufficient priority. The theatre manager explained they planned to have a meeting at least every three months moving forward.
- The integrated surgical care pathways incorporated space for the MDT to document; this ensured all relevant information was contained within one document. The records we reviewed contained details of all the MDT input, which included the medical, nursing and anaesthetic teams, recovery input and physiotherapy when back on the ward.
- There were physiotherapists based at the hospital and there was access to occupational therapists.
- Staff in oncology told us there was effective multidisciplinary working, within the hospital and externally. They worked closely with a local hospice to deliver services to patients.
- The hospital had service level agreements (SLA) with other service providers where needed, for example microbiology and infection prevention doctor at an NHS trust.

### Seven-day services

- The hospital provided elective surgery Monday to Friday each week from 8am to 8pm and between 7am and 6pm on Saturdays.
- An RMO provided a 24 hour seven days a week service on a rotational basis.
- There was always a senior nurse available at the hospital as a contact point for both staff and patients, including help to resolve patient queries and to accept out of hours admissions.
- It was a requirement of BMI Healthcare's practising privileges policy that consultants remained available at all times when they had inpatients in the hospital (both by phone and, if required, in person) or arranged appropriate alternative named cover if they were to be unavailable. This ensured inpatients recovering from surgery over the weekend had 24-hour access to a consultant if needed.
- The theatre staff operated an on-call rota, which covered the hours of 8pm to 8am on weekday nights, and 24 hours on Saturdays and Sundays. This ensured staff were available should a patient need to return to theatre out-of-hours.
- The management team was available 24 hours a day, seven days a week on a rotational basis.

Inadequate

# Surgery

- The pharmacy department was open Monday to Friday 8:30am until 5pm. There was an on call pharmacist outside these hours.
- Ward clerks provided a six day a week service with cover from 7am to 6pm Monday to Friday and 7am to 3pm on Saturdays.
- Patients receiving chemotherapy had access to telephone advice 24 hours a day, seven days a week.

### Access to information

- There were computers throughout individual ward areas to access information including test results, diagnostics and records systems. This ensured staff had easy access to patient information if required.
- All protocols we saw were in-date, for example we reviewed the BMI Healthcare document: 'Clinical Services Policies and Procedures: Policy statement '(2015). This document set out all clinical care must be underpinned by best practice and, where possible, evidence based practice. Its purpose was to ensure that all clinical practitioners were aware of where to locate the most up to date standard operating procedures (SOPs), and policies and procedures that underpin clinical practice.
- Patients receiving chemotherapy treatment carried their own records, which enabled other clinicians to see what treatment they had received. Details of blood test results were also kept in this record.
- Patients received a letter, which included the reason for the procedure, findings, medication and any changes, potential concerns and what to do alongside details of any follow up treatment. Staff sent copies of this letter to the GP and placed a copy in the patient's medical records, which were kept at the hospital.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed seven consent forms for surgery. These were mostly completed well, however we saw one consent form was illegible and another did not have the patient's name printed or dated. This meant it was not easy to read the exact procedure, and risks associated with the procedure.
- The consent forms did not contain any abbreviations that a patient may not have understood.
- We observed a consultant obtaining consent for a patient. The consultant detailed the potential risks of their surgery and the patient was happy to sign the consent form with full knowledge of the surgical risks.
- Surgical staff we spoke with were aware of Deprivation of Liberty Safeguarding (DoLS), and were able to describe the process of applying for a standard authorisation from the local authority. A standard authorisation enables hospital staff to restrict the wishes of a patient who lacks mental capacity, when it is deemed necessary and proportionate to keep the patient safe from avoidable harm.

## Are surgery services caring?

Good

We rated caring as good because:

- The service helped people and those close to them cope emotionally with their care and treatment.
- Staff took time to involve patients in their care. Patients told us staff involved them in all decisions about their care.
- Flexible visiting hours allowed patients to maintain supportive relationships with those close to them. Staff supported patients to keep their independence and connections with family and friends.

However;

- We saw an engineer undertaking maintenance on equipment when patients were present. This should have been undertaken when no patients were present.
- We saw that the doors were open in recovery, and other patients who walked past could see patients in there. This meant patients' dignity was not preserved.

### Compassionate care

- Between January 2016 and June 2016, the friends and family test (FFT) for NHS patients scored 99%. This showed that the vast majority of patients would recommend The BMI Fawkham Manor hospital to their family and friends.

- The response rate for patients who completed the FFT was varied in the same time period, with the lowest response rate (14%) in February 2016 and the highest response rate (49%) in June 2016.
- There were 'thank you' cards on Mulberry ward, which demonstrated positive feedback from patients and their relatives.
- We saw that staff generally respected patients' privacy and dignity. Theatre staff ensured doors were closed before transferring or exposing patients. However, we saw recovery doors were left open whilst patients were present. This meant other patients who were walking past could see into the room and unnecessarily compromised the confidentiality and dignity of these patients, some of whom were unaware as they were still unconscious from an anaesthetic.
- Patients told us they felt supported and well cared for. Staff treated them compassionately, responding to them in a timely and appropriate manner.
- Staff responded to call bells promptly and treated patients with dignity and respect when providing care.
- Patients told us they thought staff were excellent and could not praise them enough for their care and attention to detail. We saw staff spent time talking with patients and those people close to them.
- A light was used outside each room when a member of staff was providing care to a patient. This was a further measure to maintain patient's privacy and dignity and to inform other staff care was being carried out and they should not be disturbed.
- During the inspection there was an engineer testing the defibrillator in recovery whilst there was a patient recovering from their operation. The testing process included verbal commands for example "analysing heart rhythm" and "shock advised." If the patient was still drowsy or confused whilst waking up from anaesthetic, this could cause anxiety and confusion to the patient. The staff member did not explain to the patient what was happening. This showed a lack of compassion and insight into what effect this might have on the patient.

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

- We observed nurses, doctors and other professionals introducing themselves to patients at all times and explaining to patients and their relatives about their care and treatment options.
- We saw a surgeon explaining to a patient about the procedure they were about to perform and ensured that the patient understood what they had told them.
- The service involved patients' relatives and people close to them in their care. One patient was allowed to keep his young child with him whilst awaiting the operation, which was a positive distraction at a time of anxiety.
- We spoke to five patients, who all told us they had been kept well informed at every stage of their care.
- We observed staff providing patients' visitors with hot and cold drinks.
- In most cases, the hospital provided self-paying patients with a fixed price treatment package. This ensured patients had peace of mind and would not have unexpected costs to their bill.
- Written information given to self-paying patients was very clear of the requirement to pay their bill before treatment started.
- Discharge planning was considered pre-operatively and discussed with patients and relatives to ensure appropriate post-operative caring arrangements were in place.
- Medical patients were given a leaflet detailing when their consultant would discuss costs and the different payment options available. Staff provided information regarding a BMI credit card with a £20,000 limit, which patients could apply for. The one patient we spoke with said staff were very open and honest regarding the cost of treatment.

### Emotional support

- We saw staff in theatres providing emotional support to patients who were worried or anxious.
- Sufficient time was allocated for the pre assessment appointment to allow patients time to discuss any fears or anxieties.
- Ward staff demonstrated sensitivity towards the emotional needs of patients and their relatives.

Inadequate

# Surgery

- There was open visiting on the ward to allow patients to have emotional support from family and friends.
- The hospital provided counselling services for patients. We saw counselling leaflets and posters around the hospital, which contained details of how to book an appointment.
- All patients received a follow up phone call 48 hours after discharge from one of the nurses to check on their welfare and recovery. This enabled patients to continue to feel supported by staff after they left the hospital.
- An oncology patient advised us staff gave them all the time they needed and were there for them when they needed. They also advised us they had used the out of hours contact line and always received a prompt response.

## Are surgery services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Facilities, equipment and premises were not appropriate for children and young people.
- Mechanisms were not in place to ensure the service was able to meet the individual needs of children and young people.
- Although there were small numbers of patients cared for who had additional needs these were not planned for.
- Staff had a lack of knowledge and understanding of how they would address the needs of patients living with a learning difficulty or dementia.
- There was a lack of facilities and information for patients with additional needs.

However;

- The hospital dealt with complaints and concerns promptly and complaints were discussed at all staff monthly meetings. This highlighted any training needs and learning was identified as appropriate. The hospital stated there were “Please tell us” leaflets around the hospital of details of how to make a complaint, however we did not see these during our inspections.
- Staff provided care in a timely way and NHS and private patients experienced the same levels of care.
- Patients were asked to complete ‘your experience feedback cards’ which were used to monitor patient satisfaction and areas for improvement.

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

- We saw that the theatre and ward facilities were not appropriate for children and young people (CYP). For example, there was not a separate recovery area for CYP. This contravened the Health and Building Note 26 Facilities for surgical procedures Volume 1, which states: “A segregated area for children is essential in the recovery unit, with provision for parents to stay with them.”
- The surroundings were not child friendly and the needs of CYP had not been taken into consideration. The Royal College of Anaesthetists: Guidance on the provision of paediatric anaesthesia services 2015 states: “Wherever and whenever children and young people undergo anaesthesia and surgery, their particular needs must be recognised and they must be managed in appropriate facilities and looked after by staff with relevant experience and ongoing training.”
- Information was not tailored towards CYP, for example, child friendly hand hygiene leaflets should explain the importance of hand washing in an age appropriate format.
- There was no child friendly bed linen, artwork on walls or information leaflets, which would help CYP feel relaxed and informed.
- The theatre scheduler facilitated the booking of operations and co-ordinated with the theatre manager to ensure there were staff and resources available.
- The hospital used the BMI Healthcare staff planning tool to plan appropriate staffing ratios based on the planned number of patients. Staff reported that generally this tool worked well.
- Due to the elective nature of surgery at the hospital, service planning was relatively straightforward because the workload was predictable.

- Staff were aware of the patient lists in advance to enable appropriate staffing levels, equipment and rooms to be available.

### Access and flow

- Patients were generally booked two to three weeks in advance with a policy of not booking a patient within five days of surgery. This meant that all information, investigations and pre-assessment were carried out and results received in time for the date of operation.
- Once this information was taken, the booking was passed to pre-assessment and patient services made arrangements with the patients and pre-assessment clinic staff.
- All patients had pre-assessment before being admitted. Blood tests and other screening and investigations were done during this visit.
- The medical secretaries booked the operation dates on the hospital's electronic system. The list order was confirmed with the surgeon, theatre teams and ward staff the day before patients were admitted.
- On arrival at the hospital, staff showed surgical patients to either of the two wards.
- Patients got changed and prepared for surgery in their room. Staff then escorted patients to the theatre suite for their operation. The majority of patients walked to theatre rather than going on a trolley or wheelchair. Immediately after surgery, staff cared for patients in the recovery room.
- Once patients were stable and pain-free, staff took them back to the ward to continue recovering. Patients had a responsible adult to collect, escort and stay with them for 24 hours if they were a day case patient. Inpatients stayed on the ward for one or more nights after surgery.
- Throughout our inspection, theatre lists generally ran on time.
- The hospital used the BMI Referral to Treatment Access Policy to support patient waiting times based on clinical need, ensured appointments and admissions were acceptable to patients and referrers and ensured compliance with NHS waiting time standards. The referral to treatment waiting times (RTT) is the key access target for NHS - funded patients, stipulating that no patient should wait longer than 18 weeks from referral to the start of their treatment.
- The hospital monitored compliance regarding referrals to treatment timelines and patient listings on BMI's NHS Quality Dashboard and through the 18 week Referral to Treatment tool. We asked for the RTT data but the hospital did not provide this and so we are unable to comment further.
- There were three cancelled operations in the previous 12 months for non-medical reasons.
- Theatre staff participated in an on-call rota. Consultants were on-call whenever they had a patient in the hospital. Anaesthetists also participated in an on-call rota. This system ensured staff were available should a patient need to return to theatre at night or at the weekend.
- At discharge, nurses gave patients a direct telephone number to the ward in their discharge pack. Patients could call this number to speak to a nurse anytime of the day or night if they had any concerns.

### Meeting people's individual needs

- Staff told us the hospital could book interpreters for both NHS and private patients.
- One hundred percent of surgical staff had completed dementia awareness training; this was better than the BMI Healthcare target of 90%.However when questioned, staff had a lack of understanding regarding the specific needs of patients living with dementia.
- Staff promoted the 'Hello my name is' campaign. The aim of the campaign is to promote respect and preserve dignity, Staff knew to arrange extra staff if a patient required one to one support.
- However, rooms were not adapted to meet the needs of patients living with dementia. The NHS choices dementia guide states "Bed linen, towels, soft furnishings and wallpaper should be bold colours rather than pastels, which blend together easily." Living aids such as cups with two handles, clocks with large LCD displays, telephones with big buttons are also encouraged. The hospital did not provide these. Staff advised us they relied on carers and family to support

patients. Staff were unable to tell us how they provided extra support to this group and when asked if staff thought current systems were sufficient, several staff responded that patients were only at the hospital for short periods of time and therefore systems were sufficient.

- Patients told us that the hospital accommodated their dates for surgery and that there were no delays experienced. This included NHS patients.
- Rooms on the wards contained televisions, and access to the internet. There was also a welcome letter and general hospital information available.
- Patient baths and showers on Mulberry ward were accessible for wheelchair users. This was because there were level access showers.
- A hearing loop recorder was available at the hospital main reception to support patients who are hard of hearing.
- Reminder text messages were sent out to patients to remind them of their outpatient appointment.
- Patients had access to leaflets and information packs for a variety of different medical treatments and general hospital information in their rooms, in the ward corridor and in the main hospital reception. Leaflets and information packs were available in large print for patients with visual impairment.
- Patients had access to food, which ensured personal choice as well as cultural and religious beliefs could be maintained during their hospital stay, for example, vegetarian and kosher. Menus were available in a number of different languages including Polish, Iranian and Lithuanian as well as large print.
- Translation services were available from an external provider if required and staff knew how to access this.
- People with mobility problems were supported. There were disabled parking spaces next to the main reception and all corridors had ramps instead of steps with spacious lifts to the upper floors.
- Drinks machines were available in the reception area and outpatients for any patient who required hot or cold drinks.
- Staff advised us that NHS patients usually stayed in double rooms, however, if this was not suitable they moved the patient into a single bedded room. For example, a patient with Tourette's syndrome (a neurological condition affecting the brain and nervous system, characterised by a combination of involuntary noises and movements called tics) was moved to a single room as they stated they felt embarrassed by the noises they made.
- The service did not meet the needs of children and young people, due to a lack of facilities and information.

### Learning from complaints and concerns

- BMI Healthcare followed a three stage process in dealing with complaints, with clear timeframes set out in BMI Healthcare's complaints policy. The responsibility for all complaints rested with the Executive Director.
- An acknowledgment was sent out upon receipt of the complaint explaining the investigation process and timescales of the investigation. The details were then passed onto the relevant head of department(s) to start the investigation and produce a draft response.
- Responses were being provided to a complainant within 20 working days (in line with BMI complaints policy). If a response could not be provided within this timeframe, a holding letter was sent to the complainant so that they were kept fully informed of the progress of their complaint.
- The Executive Director was responsible for final verification of the response and sign-off.
- The hospital received 45 complaints between July 2015 and June 2016 but information regarding how many related specifically to surgical services was not available.
- Hospital managers told us they encouraged staff to identify and address any patient or relative concerns and issues whilst the patient was still in the hospital.
- Patients were invited into the hospital for a face to face meeting to discuss the investigation findings.
- Learnings and themes from complaints were shared at monthly head of department meetings, departmental meetings, clinical governance meetings and health and safety meetings.

Inadequate

# Surgery

- Staff were able to give examples of where complaints had resulted in a change of practice. For example, a patient had complained that staff did not spend enough time in their room with them and that they were left on their own for long periods of time. Staff now document each time they enter a patient's room and the duration.
- All patients were encouraged to complete a patient satisfaction survey during or after their admission which, alongside 'Friends and Family' postcard, allowed the service to evaluate the service being provided to patients. The surveys were analysed by a third party and the results communicated back to the hospital on a monthly basis.
- We did not see posters throughout the hospital to make patients and relatives aware of how they could highlight any concerns, however the hospital stated there were leaflets available.
- We saw minutes of a clinical governance meeting where complaints were discussed. However, they did not include any details of changes to policy or practice to ensure lessons were learned. One complaint showed 'actions taken' as "Investigated and responded," with no information regarding how it was responded to.

## Are surgery services well-led?

Inadequate

We rated well led as inadequate because:

- There was no effective and comprehensive process in place to identify, understand, monitor and address current and future risks.
- The leadership team did not understand these risks and therefore actions were not taken to address them.
- The delivery of high quality care was not assured by the leadership, governance or culture in place.
- There was minimal evidence of learning and embedding new practices to ensure there were no recurrences.
- There was an over reliance on patient satisfaction survey results as a measure of good patient outcomes.
- Staff satisfaction was mixed.
- Staff did not always feel actively engaged or empowered.
- Staff did not always feel they could raise concerns or have confidence that their concerns would be listened to.

We returned on 1 November 2016 for an unannounced inspection and found:

- The Executive Director and the Head of Clinical Services were aware of poor compliance with the World Health Organisation "five steps to safer surgery" but failed to take appropriate action to address the issue.
- The Executive Director and the Head of Clinical Services were not aware of all the infection prevention and control issues that we highlighted in theatres.

### Leadership / culture of service related to this core service

- The management team was led by the Executive Director who was supported by a personal assistant who was also the health and safety advisor, the Director of Clinical Services, and the Operations and Risk Manager. There were an additional eight managers who were part of the management team who managed individual departments.
- Some staff told us that meeting financial targets was seen as a priority at the expense of quality and safety. For example, a member of staff told us that the hospital was only concerned about the amount of patients they operate on and there was no investment in equipment.
- There was a culture of discontent amongst the theatre staff and the theatre meeting minutes of August 2016 confirmed this. It was not clear what action the management team was undertaking to address this issue.
- We saw from time sheets in the theatre rest room that theatre staff were working long hours and often going without a break. This meant there was a risk that the workforce would become tired and affect staff morale.
- There was a lack of overall responsibility for the maintenance of equipment within surgical services. In addition, there was not a robust system in place to

ensure regular maintenance and servicing of medical equipment, the service was reliant on the manufacturers contacting the hospital when servicing was due.

- The management team relied on patient satisfaction results as a measure of patient outcomes. There was a lack of understanding between the management team of risks and preventing recurrence. For example, two incidents involving the wrong patient in theatre happened within a short time of each other. This demonstrated that the first incident had not been fully investigated and understood and actions had not been put in place to prevent recurrence.
- Staff did not always feel they could raise concerns or have confidence that their concerns would be listened to. We were given examples of when this had occurred.
- There was a presumption from the management team that risk and safety measures were in place, rather than having evidence based assurances.
- All staff we spoke with knew the members of the senior management and said they were very visible within the hospital.
- A staff survey from February 2016 showed staff felt valued in their role.
- The Executive Director operated an "open door" policy for staff and consultants.
- Staff told us about being supported and enjoyed being part of a team.
- There was a culture of transparency and honesty amongst junior staff. Staff told us managers encouraged and supported them to report incidents.
- We found throughout the hospital staff worked collaboratively to promote the health and well-being of the patients, it was a small hospital and all staff groups knew each other.
- There was a staff turnover of 4% for all surgical services staff theatre nurses between July 2015 and June 2016.

### Governance, risk management and quality measurement

- The risk register was generally used for issues when control lay outside the hospital. This meant there was not adequate assurance of the assessment of risks pertinent to The BMI Fawkham Manor hospital and there were not processes in place to mitigate these risks.
- We found management lacked understanding around patient outcomes, for example, one senior manager was unable to describe what constituted patient outcomes. We also found no evidence that medical patient outcomes were monitored. Therefore, there was no assurance that management was providing an effective governance or risk management strategy.
- The Executive Director and the Head of Clinical Services were not aware of the infection prevention and control issues that we highlighted in theatres.
- The hospital worked within the BMI Hospital Committee Terms of Reference. This structure allowed for the cascade of information from the Heads of Department meetings (HOD), which were held monthly, and the regular “huddle", through departmental team meetings, to all members of the team at the hospital.
- Clinical quality and governance matters were reviewed by the medical advisory committee (MAC) which met quarterly. The minutes and actions from these governance meetings were circulated to all consultants, however the chair of the MAC did not attend the meetings. The Clinical Governance Meeting and the various sub-committees for example health and safety and infection prevention were reported to the MAC, and to the management team through the HODs meeting. Minutes of all meetings were held on the shared drive for all staff to be able to access. A standard agenda template was used to ensure a coordinated approach to each meeting.
- The Chair of the MAC was closely involved with the day to day activity of the hospital, meeting with consultant representatives formally on a quarterly basis. Consultant surgeons, anaesthetists, the ward manager and theatre manager represented surgery on the medical advisory committee (MAC).
- The hospital’s MAC provided the formal organisational structure through which consultants communicated. The MAC advised the executive team and worked to maintain high standards and improve the quality of services.

- We saw from the MAC minutes that the committee reviewed consultant's practising privileges. This provided the executive team with assurance that consultants were competent to perform surgery at the hospital.
- Heads of departments (HOD's), senior staff and management team met monthly and we saw minutes from these meetings.
- The Hospital Infection Prevention & Control Committee (IPCC) met every three months and we saw from the meeting minutes that a variety of the multi-disciplinary team (MDT) attended these meetings. For example, the housekeeping lead attended this, which ensured a holistic approach to infection control and prevention.
- There was a monthly corporate clinical governance bulletin. The bulletin identified changes in legislation relating to publications and alerts for example (drugs, equipment). It also provided details of issues and best practice at other sites so that shared learning could be applied locally.
- Surgery staff reported to either the ward manager or theatre manager. Managers met on a monthly basis and reported to the director of clinical services.
- The BMI Healthcare group produced a monthly group clinical governance bulletin. This contained details of incidents, never events, and internal quality inspection visits from hospitals across the BMI Healthcare group. The purpose of the newsletter was to share learning from governance issues in all hospitals across the group.

We returned on 1 November 2016 for an unannounced inspection and found:

- The Executive Director and the Head of Clinical Services were aware of poor compliance with the World Health Organisation "five steps to safer surgery". We had highlighted this issue to them during our last inspection, however the action taken failed to address the issue.

## Vision and strategy for this core service

- The service shared the BMI Healthcare vision. This was to provide the best outcomes, the best patient experience and the most cost-effective care.
- The hospital also had its own vision, which was to continuously improve the health of the local community by providing accessible, compassionate, quality healthcare. The Business Plan for 2016 identified key strategic priorities as ensuring an effective organisational structure, providing superior patient care, striving to attract the best consultants and staff, achieving business growth, maximising the efficiency of service delivery and improving facilities and develop new services.
- There were information boards along the corridor in the Mulberry Suite which detailed the ward values including: 'Innovate, adapt and change', 'Be one team', 'Leadership', 'Think customer', 'Impact and influencing' and 'Own your part in delivering results'. Staff knew the contents of these information boards.

## Public and staff engagement

- Staff were recognised for their outstanding contribution through the BMI "Above & Beyond" awards. Managers met monthly and shared information with their teams at monthly departmental meetings.
- The hospital implemented the BMI appraisal policy to ensure that all staff understood their personal objectives.
- Opportunities for staff to engage with the management team occurred daily informally or through department meetings and staff forums.
- The hospital held a bi-monthly staff forum for staff to come and discuss complaints/incidents that they may have been involved with, this was to share the learning.
- The hospital valued staff social activities and regularly organised events where staff, family and friends could come together.
- The hospital also sought feedback through the NHS choices website and the NHS friends and family test.
- The hospital's website provided a range of information about the services provided. It also provided details of consultants who worked at the hospital and their credentials. Members of the public could use this information to help them decide whether they wanted to receive treatment at the hospital.
- Staff regularly met up at hospital-organised events. All staff we spoke with said they enjoyed these events and thought it enabled the team to work well together.

Inadequate

# Surgery

- Patients were provided with feedback forms. A patient we spoke with said they felt very listened to by all staff.

### Innovation, improvement and sustainability

- The hospital took part in BMI Healthcare provider visits. This was where staff from other BMI Healthcare hospitals carried out internal quality inspections. Provider visits gave the hospital feedback to enable a continuous cycle of improvement.
- Discussions were being held with the local trust to enhance the contribution The BMI Fawkham Manor Hospital could provide in the event of an emergency.

Requires improvement

# Outpatients and diagnostic imaging

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

## Information about the service

Outpatient services at BMI Fawkham Manor cover twenty specialties, including orthopaedics, gynaecology and ophthalmology. From July 2015 to June 2016, the outpatient department provided 4,418 new patient appointments and 4,185 follow up appointments for NHS patients. They provided 6,729 new patient appointments and 10,453 follow up appointments for patients with insurance or paying for themselves. From July 2015 to June 2016, the hospital provided 769 outpatient appointments to children aged three to seventeen.

The outpatient department consists of seven consulting rooms, a minor procedures room, and a plaster room. Phlebotomy is located in the outpatients department. There is a registration desk and two waiting areas for patients.

The outpatient department runs clinics between 9am and 8pm Monday to Friday and 8.30am to 12pm on Saturday.

The imaging department provides a range of diagnostic imaging services including non-obstetric ultrasound, plain x-rays, bone densitometry, and fluoroscopy. A service level agreement was in place with an external provider for magnetic resonance imaging (MRI) and computed tomography (CT).

The hospital has an on-site pharmacy, which is open on Monday to Friday from 8am to 4pm.

The physiotherapy department is open from 8am to 4pm Monday to Friday; with late clinics on Tuesday and Thursday running until 8pm. Clinics are available on Saturdays when required. Physiotherapy is in a dedicated location next to the outpatients department, it consists of three individual bays with access to gym equipment. The physiotherapists also use a designated inpatient room on the ward, if a fourth physiotherapist is available to provide treatment.

During our inspection, we spoke to 18 members of staff including nurses, radiographers, physiotherapists, administrative staff and managers. We spoke with five patients and two relatives. We reviewed 10 sets of patient records and we looked at policies and procedures, staff training records, audits and the environment and equipment.

Requires improvement

# Outpatients and diagnostic imaging

## Summary of findings

We rated the outpatient and diagnostic imaging department at BMI Fawkham Manor as requiring improvement. This was because:

- We found areas of concern related to infection prevention and control, including noncompliance with the Department of Health's Health Building Note 00.09: infection control in the built environment (HBN 00.09) in the diagnostics imaging department.
- In the diagnostic imaging department, we found concerns regarding compliance with the Ionising Radiation Regulations 1999 (IRR99).
- A full record of outpatient clinic notes was not kept at the hospital.
- There was a lack of secure storage of patient information and records in the diagnostic imaging department.
- Staff did not have the required level of safeguarding training. Therefore, the hospital did not have adequately trained staff in safeguarding and staff we spoke with could not all demonstrate knowledge and understanding of how safeguarding issues applied to their work.
- We found instances where patient's privacy and confidentiality was compromised.
- The facilities and surroundings were not tailored to the treatment of children and young people and we were not given assurance that a paediatric nurse was available on site when children were seen in the department.
- Staff did not have an adequate understanding of caring for patients living with dementia.
- Relatives and occasionally members of staff were used if translation was required rather than the interpreter service.
- We looked at several pieces of electrical equipment but could not find evidence of safety checks, which would indicate it was safe to use.
- Overall, we found that hospital management did not have oversight of the issues we identified during the inspection.

However,

- Staff managed outpatient prescriptions and medicines in line with best practice and stored them securely.
- The outpatient and diagnostic imaging departments had sufficient numbers of appropriately trained staff to provide safe care to patients. The majority of staff had completed the hospital's mandatory training programme.
- The outpatients department had an ongoing audit programme which monitored areas for improvement.
- Policies and guidelines were based on National Institute for Health and Care Excellence (NICE) and other learned bodies guidance.
- Staff were competent to perform their roles.
- Health professionals worked together to provide services for patients.
- The diagnostic imaging and pharmacy departments provided on call services, 24 hours a day seven days a week.
- The service offered a variety of appointment times to suit the needs of the patients.
- Staff were proud of the work they did at the hospital.
- Staff were positive about their direct line management and felt senior management was visible and approachable.

Requires improvement

# Outpatients and diagnostic imaging

## Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated safety as requires improvement for the outpatient and diagnostic imaging service. This was because:

- The hospital had identified areas of noncompliance with HBN 00.09 such as carpet or non-compliant flooring in clinical areas and non-compliant hand washbasins but there were no known dates for proposed improvements. Clinical areas were cluttered and used for storage of equipment.
- In the diagnostic imaging department, we found concerns regarding compliance with the Ionising Radiation Regulations 1999 (IRR99). Discussions with staff and documentation provided by the hospital were not adequate to give us assurance that the department met standards set out by the regulations. There was a sign on one wall of Room 1 (fluoroscopy) that stated "Do not point x-ray tube at this wall" but there was no mention of this wall in the Local Rules and we did not see any risk assessment undertaken in relation to this sign. In addition, the manager's office led directly off Room 1 and there were no radiation warning lights in the office, to indicate the risk of radiation exposure if staff working in the office entered Room 1 when it was in use.
- Consultants carried their own outpatient records, and copies were only filed in patient notes if the patient was later attending the hospital for a procedure. There was no plan in place to change the procedure for holding outpatient records at the hospital.
- We found a lack of secure storage for records in the diagnostic imaging department. On two occasions, we observed that patient information was accessible when the reception was not staffed. We found two filing cabinets containing patient information that were not locked and left unattended.
- Although the outpatient and diagnostic imaging departments treated children, there were no designated waiting areas or seating for children.
- The intercollegiate document, safeguarding children and young people: role and competences for health care staff, March 2014 states clinical staff must be trained to safeguarding level three, with the safeguarding lead trained to level four. Nursing staff and physiotherapists were only trained to level two and the safeguarding lead trained to level three. Therefore, the hospital did not have adequately trained staff in safeguarding children, and staff we spoke with could not all demonstrate knowledge and understanding of how safeguarding issues applied to their work.
- We looked at several pieces of electrical equipment but could not find evidence of electrical safety tests, which would indicate it was safe to use. We were informed that there had been a problem with labels; however, the hospital did not provide us with further evidence to support that electrical safety tests had been completed.
- We found a number of printed copies of out of date and obsolete versions of medicines management policies and procedure, this meant staff may not be using the most up to date information when treating patients.

However,

- Staff managed outpatient prescriptions and medicines in line with best practice and stored them securely.
- The outpatient and diagnostic imaging departments had sufficient numbers of appropriately trained staff to provide safe care to patients. The majority of staff had completed the hospital's mandatory training programme.

### Incidents

- Staff mostly had a clear understanding of the paper-based incident reporting process and most were able to give examples of incident reporting. However, there was scope for uncertainty because of the way the incident forms were separated into clinical and non-clinical and we saw two occasions where a patient collapsing in outpatients had been incorrectly classified as a non-clinical incident.
- There were no never events reported by the hospital between June 2015 and July 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide

strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. The occurrence of a never event could indicate unsafe practice.

- BMI, the provider company, sent examples of any never events that occurred at any of their hospitals to all hospitals for discussion and action where relevant. We saw the BMI "Stop and Check" signage in the ultrasound room as part of organisation wide learning.
- From July 2015 to June 2016, the outpatient and diagnostic imaging departments reported 35 incidents, which were a mixture of clinical and non-clinical incidents.
- An up-to-date BMI policy related to incident reporting and management was in place.
- Staff told us that actions and learning were discussed with individual members of staff as well as at team meetings and in the monthly team brief. We saw the minutes from the January 2016 team brief. A hospital memo with learning following a reportable post-surgical site infection, and a BMI memo regarding changes to the reference range of the medication digoxin following an incident, had been discussed. All staff met to develop an action plan that was followed up until completed. We saw evidence of action plans recorded on the shared drive.
- The manager investigated incidents and all incidents were reviewed at the clinical governance meetings. We saw minutes of these meetings where incidents were discussed and action plans monitored which indicated that this was occurring regularly.
- There were no reported incidents under the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) during the last 12 months. Incidents would be reported if patients were exposed to much greater than intended doses of radiation.
- The duty of candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient's safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred. Staff described examples of adherence to duty of candour and the importance of keeping the patient fully informed.

### Cleanliness, infection control and hygiene

- An up-to-date BMI policy for hand hygiene was in place. Minutes from the June 2016 hospital infection prevention and control committee showed 100% compliance on hand hygiene audit within the outpatients and diagnostic imaging departments. We saw appropriately located hand hygiene points with hand sanitising gel and posters were positioned near hand washing basins, which explained "5 moments for hand hygiene" in line with World Health Organisation guidance. However, within the diagnostic imaging department and physiotherapy department, we found that only one hand washbasin was compliant with HBN 00.09 and that was in the ultrasound room. The other, non-compliant, hand washbasins were on risk assessments but there was no date for completion. For example, the sink in the physiotherapy department was not compliant because it was not a standalone sink, resulting in a risk of contamination. The risk assessment included instructions on how to minimise the risk of contamination and to consider replacing the sinks if there was planned refurbishment.
- The hospital provided three training packages related to infection prevention and control (IPC); IPC high impact, care bundles and aseptic non-touch technique, IPC in Healthcare and IPC awareness, Completion rates for each module respectively were 83%, 87% and 100%, two of which were below the hospital's target of 90%.
- A Dual Energy X-ray Absorptiometry (DEXA) scan is a special type of X-ray that measures bone mineral density. The diagnostic imaging department identified the carpet in the DEXA scan room, poor cover for the television monitor cables and other infection control concerns in an environmental audit on 29 July 2015. We saw the maintenance management system dated 08 July 2016 that highlighted these and other issues. However, there were no known dates for the proposed improvements.

Requires improvement

# Outpatients and diagnostic imaging

- Interventional procedures were carried out in Room 1, making it a higher risk clinical area and we found that the room was not compliant with HBN 00-09. The room was generally cluttered and used for storage of other equipment.
- The flooring was easy to clean but there was intermittent/broken taping across the doorway and around some equipment. The flooring was not level or continuous in the doorway between the waiting area and Room 1. We found dust trapped in the gap. HBN 00-09 states that flooring should be seamless and smooth.
- HBN 00-09 states that there should be coving between the floor and the wall to prevent accumulation of dust and dirt in corners and crevices. Room 1 had rubber fittings between the floor and the walls, which was not seamless and smooth and had many places where it was not fixed properly to the wall. We found dust in the gaps.
- The concertinaed cover for the TV monitor cables was damaged and taped over in several places and we saw it was not clean.
- We found other areas non-compliant with HBN 00-09. The ultrasound room had suitable flooring but no coving between floor and walls with wooden skirting boards and an open fireplace.
- The most recent patient led assessment of the care environment (PLACE) score, completed in 2015 scored 98% for cleanliness, which was equal to the England national average of 98%.
- We saw evidence of completed and signed daily cleaning checklists in the outpatients, physiotherapy, and diagnostic imaging departments.
- There were appropriate waste bins for clinical and non-clinical waste within the outpatient and diagnostic imaging department.
- We saw that sharps bins were available in the department and were used in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Biohazard spill kits with instructions were available in appropriate areas of the diagnostic imaging department.
- Cleaning wipes for equipment and surfaces were available in all rooms we looked at.
- There were good supplies of personal protection equipment such as gloves available in all clinical areas we visited and we observed staff using them correctly.
- The areas we visited within the outpatients department including the physiotherapy department were visibly clean.
- We inspected two recently refurbished consulting rooms within the outpatients department and found them overall compliant with the HBN 00-09.

## Environment and equipment

- The outpatient department had seven consulting rooms, a minor procedures room, a plaster room, and two waiting areas for patients. Due to ongoing refurbishment, not all of these were operational at the time of the inspection.
- The two outpatient consulting rooms we inspected were tidy and free from clutter. Equipment was visibly clean; however, there was no indication on the equipment to indicate when it had last been cleaned.
- Waiting areas were tidy with limited seating available. There was no designated seating or waiting area for children.
- We saw evidence that equipment within the diagnostic imaging and physiotherapy departments was regularly serviced and maintained correctly. However, we saw equipment within the outpatients department that was overdue for maintenance. In Room 1 in the diagnostic imaging department, a radiographer had not signed the last three equipment faults noted, nor were there handover forms for two of the faults dated 14 January 2016 and 21 August 2016. The requirement is for the engineer dealing with the fault to complete the handover form and a radiographer to sign the form once the fault has been fixed.
- We looked at several pieces of electrical equipment but could not find evidence of electrical safety checks, which would indicate it was safe to use. We were informed that there had been a problem with labels; however, the hospital did not provide us with further evidence to support that safety tests had been completed.

Requires improvement

# Outpatients and diagnostic imaging

- In the diagnostic imaging department, we found concerns regarding compliance with the Ionising Radiation Regulations 1999. (IRR99). Discussions with staff and documentation provided by the hospital were not adequate to give us assurance that the department met standards set out by the regulations.
- There was a sign on one wall of Room 1 (fluoroscopy) that stated, "Do not point x-ray tube at this wall". Staff were not able to explain the reason for this sign and there was no mention of this in the Local Rules issued 24 March 2016. One member of staff thought the wall may not be lead lined, however the manager stated that all walls were lead lined. We did not see any risk assessment undertaken in relation to this sign. There was a room for staff to view x-rays on the other side of the wall and we were not shown any risk assessment for that area. This meant that staff could be at risk if viewing x-rays while there was radiation exposure in Room 1.
- In addition, the manager's office led directly off Room 1. Local Rules issued 24 March 2016 stated when using Room 1 could not be avoided when people are in the manager's office, people exiting the office must bang loudly on the door before opening it to warn of their exit and must await a verbal indication that it is safe to exit. There were no radiation warning lights in the office to indicate the risk of radiation exposure if staff working in the office entered Room 1 when it was in use.
- The most recent PLACE score in 2015 for condition, appearance, and maintenance scored 95%, which was better than the England national average of 92%.
- Rooms within the outpatient and diagnostic imaging departments were temperature controlled. The thermometers were checked daily and fitted with alarms.
- The resuscitation trolley was shared between the diagnostic imaging and Mulberry Suite, which were both on the ground floor. It was tamper proof and all consumables were in date. Staff checked the trolley daily; we saw complete checklists to confirm this was done. A further more thorough check was completed weekly
- We saw an audit of radiation warning lights completed in July 2016 indicating that lights outside Room 1, Room 2 and the mammography room were in appropriate working order. We observed the light next to Room 2 working on the day of inspection and saw clear signs on all doors regarding controlled areas.
- Radiation protection aprons were readily available and we saw an audit undertaken in the radiology department on 12 August 2016, which found no issues related to this.
- There was no wheelchair access to toilet facilities within the department, including the toilet in Room 1 and we were told that no wheelchair users were offered fluoroscopy treatment here. Wheelchair users for other procedures such as mammography or plain x-rays would be accompanied to the disabled toilet in the outpatient department.

## Medicines

- There was an up-to-date BMI policy related to the safe management of medicines in place.
- At the hospital, 100% of required staff had completed medicines management mandatory training.
- Medicines were stored in a locked cupboard within a temperature-controlled room and medicines requiring refrigeration were stored in an appropriate locked fridge within the outpatients department. We saw examples of in date contrast materials stored in a locked cabinet in Room 1 in the diagnostic imaging department. There were no controlled drugs stored within the outpatients department.
- Staff monitored and recorded the refrigerator and room temperatures where medicines were stored, we saw records, which indicated this was done regularly. We saw evidence of the correct procedure being followed, as per BMI policy, on one occasion in July 2016 when the temperature was out of range in the room where medicines were stored.
- Staff stored private prescription pads in a locked cupboard and a registered nurse held the key. We saw a log which indicated when a prescription had been issued and to whom. This is in line with NHS Protect, security of prescription forms guidance 2013.
- Private outpatient prescriptions could be dispensed at the hospital pharmacy or taken to the local chemist.

Requires improvement

# Outpatients and diagnostic imaging

- Up to date copies of the British National Formulary (BNF) and BNF for Children were available in hard copy throughout the outpatients department.
- We saw a medicines management folder in the outpatients nurses office; it contained eighteen medicine related policies, eight of which were past their review date.

## Records

- Consultants carried their own outpatient records, and copies were only filed in patient records if the patient was later attending the hospital for a procedure. There was no plan in place to change the procedure for holding outpatient records at the hospital. However, BMI had written to all MAC chairs alerting them to the need to review this.
- Information provided by the hospital showed over the last three months, no patients were seen in outpatients without the full medical record being available. However, we looked in 10 sets of patient records and saw no evidence of outpatient clinic notes.
- We found a lack of secure storage for records in the diagnostic imaging department.
- There was an unlocked filing cabinet containing patient referrals and radiology lists and a theatre referrals document containing patient information in the radiology reception area.
- On 16 August 2016 we observed two occasions when the reception area was left unattended. Once was during the lunch period and the other occasion was when the member of staff left to find something requested by a patient present in reception. This meant the area was left unattended with personal patient information not secured safely.
- On the 22 August 2016 visit we found an unlocked filing cabinet in the mammography room with 11 patient request forms inside.
- The quality audit trail for the three-part decontamination system register in the ultrasound room was incomplete. We looked at the whole register from 10 June 2016 to 15 August 2016. The patient detail box was not completed in 65% of the entries (30 out of 46). Other details were completed such as the item and serial number. This may mean that in the event of an issue it would be difficult to track the patient.
- However, we saw records were legible and signed. They contained completed patient registration forms, GP or consultant referral letters and other documentation such as pain relief assessments.
- We saw the results of the nursing documentation audit completed in the outpatients department in May 2016. It showed good overall compliance, with an action for reminding nursing staff to record baseline observations for all patients having minor procedures.
- Records were stored securely in the medical records department. A register was completed to indicate if a record had been removed and where it had gone.

## Safeguarding

- The intercollegiate document, Safeguarding children and young people: role and competences for health care staff, March 2014 states clinical staff must be trained to safeguarding level three, with the safeguarding lead trained to level four. Nursing staff and physiotherapists were only trained to level two and the safeguarding lead trained to level three. Therefore, the hospital did not have adequately trained staff in safeguarding children. However, the paediatric consultant had completed appropriate level three safeguarding children training.
- The hospital had a service level agreement (SLA) in place with BMI Chelsfield Park hospital with regard to the lead paediatric nurse providing services relating to patients between the ages of zero and 16 years of age, however this SLA was due for review in September 2015 and had not been reviewed. It included the arrangement for the lead paediatric nurse to act as or support the lead nurse for child safeguarding and be available to advise or assist in the event of a child protection issue arising. When asked, staff were not aware of access to a paediatric nurse but said they could contact a paediatrician if needed.
- Up to date policies for safeguarding adults and safeguarding children were in place.

Requires improvement

# Outpatients and diagnostic imaging

- At the hospital, 100% of required staff had completed level one safeguarding vulnerable adults training, 95% had completed level two training. The hospital's safeguarding lead had completed level three safeguarding vulnerable adults training.
- At the hospital, 100% of required staff had completed level one safeguarding children's training and 93% had completed safeguarding level two training.
- Staff in the outpatients and diagnostic imaging department knew who the hospital safeguarding lead was.
- One hundred per cent of required staff had attended Prevent training. Prevent is part of the government counter-terrorism strategy. It is designed to tackle the problem of terrorism at its roots, preventing people from supporting terrorism and becoming terrorists themselves.

## Mandatory training

- Staff completed a number of mandatory training modules mainly via e-learning packages, with some practical sessions such as manual handling. Staff told us that mandatory training was easy to access, completed during working hours and staff and their managers received an email reminder if they had any training due to be completed.
- In the outpatients department, 97% of staff completed required mandatory training, which was better than the hospital target of 90%.
- In diagnostic imaging, 99% of staff completed required mandatory training, which was better than the hospital target of 90%.
- In the physiotherapy department 92%, of staff completed required mandatory training, which was better than the hospital target of 90%.

## Assessing and responding to patient risk

- In the diagnostic imaging department, we found concerns regarding compliance with the IRR99. There was a sign on one wall of Room 1 (fluoroscopy) that stated "Do not point x-ray tube at this wall", andwe did not see any risk assessment undertaken in relation to this sign.
- There was a radiation protection supervisor on site and appointed radiation protection advisors (RPA) under a service level agreement with an NHS trust. The RPA was available 24 hours a day, seven days a week. This was in line with IRR99 and IRMER.
- We saw evidence of quality assessment checks taking place every time the DEXA scanner was used. This demonstrated that equipment was working as it should.
- We saw examples of local rules that included the dose investigation level and contingency arrangements in the DEXA scan room and Room 1, both reviewed on 15 April 2016. These were accessible to staff in the rooms, and staff demonstrated knowledge of the protocols and where they were kept.
- Signs advising women who may be pregnant to inform staff, were clearly displayed in the diagnostic imaging departments in line with best practice.
- We saw 'stop and check' signs in rooms of the diagnostic imaging department to remind staff to carry out patient identification checks.
- Staff told us that the World Health Organisation (WHO) safety checklist was used for interventional radiology. The WHO checklist is a national core set of safety checks for use in any interventional environment. The checklist consists of five steps to safer surgery (or procedure). It was developed to decrease errors and adverse events, and increase teamwork and communication. The WHO checklist was scanned onto one of the hospital electronic systems and we saw a completed example.
- We saw risk assessment forms related in the diagnostic imaging department, which were up to date. However, we had concerns that not all risks had been assessed, for example there was no risk assessment related to the ""Do not point x-ray tube at this wall" sign in Room 1.
- In the outpatients department and physiotherapy department, we saw risk assessments had been completed including control of substances hazardous to health (COSHH). These included signature lists of staff who had read them indicating that the staff within the department had an awareness of the risks.
- The resident medical officer (RMO) would attend to any patients who were unwell in the outpatient and diagnostic imaging department if required.

Requires improvement

# Outpatients and diagnostic imaging

- The physiotherapy department had a local policy regarding working with children; it outlined the need for a risk assessment to be completed before treating a child. The policy stated that paediatric referrals in the physiotherapy department were screened and patients booked in with a physiotherapist trained in paediatric basic life support.

### Staffing

- A registered nurse was available in the outpatients department during opening times. The department employed 3.08 full time equivalent (FTE) registered nurses and 1.6 FTE health care assistants (HCAs). There was a HCA vacancy of 0.6 FTE.
- From April 2016 to June 2016 the department had 18 nursing shifts and five HCA shifts covered by bank staff. The department did not use agency staff, the department's own staff worked as bank staff when required.
- The hospital had a service level agreement (SLA) in place with BMI Chelsfield Park hospital with regard to the lead paediatric nurse providing services relating to patients between the ages of zero and 16 years of age, however this SLA was due for review in September 2015. It included the arrangement for the lead paediatric nurse to provide on-call advice to support the care of children at the hospital.
- The hospital had a standard operating procedure in place for the care of children and young adults. It stated that any procedures in the outpatients department that require local anaesthetic will require a paediatric nurse on site for patients aged three to 16 years. Nurses in the outpatients department should contact a named bank paediatric nurse or the lead paediatric nurse as per SLA.
- All consultants worked within the outpatients department under practising privileges. Practising privileges is a term, which means consultants have been granted the right to practise in an independent hospital.
- The radiology department consisted of one full time and two part time radiographers with two additional bank radiographers when required. There were two full time and three part time imaging assistants for administrative duties. All staff we spoke with felt that this was sufficient.
- However, on the morning of the visit on 22 August 2016 there was one sonographer and no radiographers in the department. We were informed that there was one radiographer in theatres. Staff were not able to describe how any urgent procedures would be provided should it be required.
- There were six visiting radiologists and two who solely undertook radiology reporting.

### Major incident awareness and training

- There was an up to date BMI business continuity policy in place.
- Staff told us that the policy and its related procedures were kept at the main reception, and any major incident was managed from there.
- The manager of the radiology department was the fire officer for the day. There were fire drills with one held four to five weeks ago. Staff evacuated the hospital and lessons were learnt from the actions taken.

## Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate effectiveness, as we do not currently collect sufficient evidence to rate this. Overall, we found:

- The outpatients department had an ongoing audit programme which monitored areas for improvement.
- Policies and guidelines were based on National Institute for Health and Care Excellence (NICE) and other learned bodies guidance.
- Staff were competent to perform their roles.
- Health professionals worked together to provide services for patients.
- The diagnostic imaging and pharmacy departments provided on call services, 24 hours a day seven days a week.

### Evidence-based care and treatment

- The outpatients department had an ongoing audit programme. Regular audits included infection control,

hand hygiene and a range of medicines management audits. We saw minutes of head of departments meetings where results of audits were discussed. For example at the May 2016 meeting, non-compliance to sharps bins being closed and dated was noted following an audit, attendees were requested to review the audit on the shared drive and add comments of action taken.

- We looked at a range of BMI policies and saw they referenced relevant national guidance such as that from the National Institute for Health and Care Excellence (NICE).
- Consultant radiologists and radiographers we spoke with demonstrated a focus on minimum radiation doses and exposure to ensure patient safety. This was in line with the Ionising Radiations Regulations 1999 (IRR99) and the requirement to ensure that radiation is kept as low as reasonably practicable and does not exceed dose limits specified for patients. The regulations also include staff safety.
- Consultant radiologists told us they followed the same guidelines as they used in the NHS, these included relevant Royal College guidelines.
- Staff demonstrated knowledge of IRR99 and IRMER regulations. They worked to local rules and standard operating procedures. There were protocols in each room as well as the BMI guidelines.
- The diagnostic imaging department subscribed to monthly journals and staff were members of the Society of Radiographers which expects all members to engage in continuing professional development and provides a range of resources to support this. This means that patients were getting treatment from staff who were up to date with current evidence based information.
- Physiotherapists told us that treatment they provided was based on evidence from bodies such as the Chartered Society of Physiotherapists.
- The hospital had a service level agreement (SLA) in place with BMI Chelsfield Park Hospital with regard to the lead paediatric nurse providing services relating to patients between the ages of zero and 16 years of age, however this SLA was due for review in September 2015. It included the arrangement for the lead paediatric nurse to review policies and procedures relating to paediatrics to ensure that these are up to date and reflect best practice.

### Pain relief

- In the outpatients department doctors could prescribe pain-relieving medication as required.
- Staff in the physiotherapy department told us they would recommend pain-relieving medication available to buy from pharmacies, if required.
- There was not a recognised child specific pain score tool in use for children.

### Patient outcomes

- Physiotherapists used a standardised questionnaire as a measure of health outcome at the initial patient assessment. They also used a recognised screening tool to match patients with back pain to treatments based on the likelihood or risk of poor clinical outcome.
- Staff in the physiotherapy department also maintained a spreadsheet of patient outcomes including the discharge date, reason for discharge and discharge destination.
- Staff completed an outpatient outcome form for NHS patients which included follow-up requirements or discharge destination for the patient.

### Competent staff

- In the outpatients department 100% or nurses and health care assistants (HCAs) had an appraisal in the last year.
- Staff in the diagnostic imaging department and physiotherapy department told us that they had a mid year appraisal and an annual appraisal.
- Nursing staff told us they felt that access to training was adequate to maintain their registration with the Nursing and Midwifery Council (NMC).
- We saw evidence of radiation protection supervisor training undertaken as well as annual updates.

Requires improvement

# Outpatients and diagnostic imaging

- Staff told us they were encouraged to develop, and this was discussed as part of their appraisal. We saw evidence of a radiographer training in mammography. The course was funded by the hospital and the member of staff was allocated time to attend the training.
- The hospital had a service level agreement (SLA) in place with BMI Chelsfield Park hospital with regard to the lead paediatric nurse providing services relating to patients between the ages of zero and 16 years of age, however this SLA was due for review in September 2015. It included the arrangement for the lead paediatric nurse to provide on-call advice to support the care of children at the hospital.
- The hospital had a standard operating procedure in place for the care of children and young adults. It stated that any procedures in the outpatients department that require local anaesthetic will require a paediatric nurse on site for patients aged three to 16 years. Nurses in the outpatients department should contact a named bank paediatric nurse or the lead paediatric nurse as per the SLA.

## Multidisciplinary working

- The hospital ran a number of 'one stop' clinics, where a variety of health care professionals worked together. For example, nursing staff completed visual field tests prior to the patient seeing the consultant in the ophthalmology clinic.
- We observed nursing staff work closely with consultants and pharmacy staff in the outpatients department.
- Non-clinical staff such as the outpatient administrator and housekeepers described a good working relationship with nursing staff and consultants in the outpatients department.
- The physiotherapists described a good working relationship with consultants. They told us that consultants visited the physiotherapy department to discuss patients if needed.
- We observed staff in the diagnostic imagining department working closely with radiologists and the outpatient department.
- Radiographers routinely worked as part of the theatres team.

## Seven-day services

- The diagnostic imaging department and pharmacist provided an on call service to inpatients 24 hours a day, seven days a week.
- The outpatient department ran clinics between 9am and 8pm Monday to Friday and 8.30am to 12pm on Saturday to give patients a choice of late evening and weekend appointments.
- The physiotherapy department was open from 8am to 4pm Monday to Friday; with late clinics on Tuesday and Thursday until 8pm. Clinics were available on Saturdays when required.

## Access to information

- Staff demonstrated that they had electronic access to BMI policies and training packages.
- Staff told us that imaging, histology, and pathology results were accessible electronically. Consultant radiologists told us that electronic access to images and results worked well in the hospital.
- In the diagnostic imaging department, there were two main electronic systems that contained patient information that included demographics, booked appointments and results. There were also paper clinical and referral records.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- At the hospital, 100% of required staff had completed training related to consent; this was above the hospital target of 90%. The hospital did not provide us with a breakdown of data to demonstrate compliance with training for different services.
- An up to date BMI policy for consent was in place and the BMI safeguarding adults' policy incorporated MCA and DOLs.
- All patients attending for diagnostic imaging completed the BMI registration form that included signed consent in respect of the cost of treatment and use of personal information. The procedure was discussed on referral, on booking the appointment and full explanations again before undertaking the procedure.

Requires improvement

# Outpatients and diagnostic imaging

- A patient we spoke to attending a follow up clinic told us that consent had been discussed with them, and had signed a consent form during their pre assessment clinic.
- The physiotherapy department had a local procedure regarding working with children; it outlined the process of obtaining consent for treating children based on Gillick competence. Gillick competence is a term used in medical law to decide whether a child is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

## Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good for the outpatient and diagnostic imaging services. This was because:

- Staff treated patients in a kind and considerate manner.
- Patients told us they were happy with the care they received.
- Signs offering chaperones were clearly displayed and we saw evidence of completed chaperone registers.

However:

- Although there was a private room available for confidential discussions, the changing rooms in the diagnostic imaging department and outpatient reception area did not maintain privacy and confidentiality. Other patients, visitors, and staff in the area could overhear conversations and there was no sign at reception to notify patients there was a private room available.

### Compassionate care

- The most recent NHS Friends and Family Test (FFT) data provided to us was January 2016 to June 2016. The data was not broken down by department, therefore results were for all patients attending the hospital. The results indicated that 98% or more patients attending the hospital would recommend it. However, the response rate was variable ranging from 14% to 49% each month. The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received.
- Patients we spoke to told us that staff were caring, courteous and helpful. We observed staff interacting with patients in a friendly and kind way.
- We observed all clinical activity was provided in individual consulting rooms with the doors closed to maintain privacy.
- The hospital patient led assessment of the care environment (PLACE) audit score in 2015 for privacy, dignity and wellbeing scored 96%, which was better than the England national average of 87%.
- However, the changing rooms in the diagnostic imaging department provided very limited privacy. Any patients, visitors and staff in or walking through the waiting room, would easily overhear any conversation. We were told that all discussions were done in the relevant x-ray room to ensure privacy and confidentiality.
- At the unannounced visit on 22 August 2016 the notice on the door of Room 2 showed that it was 'free'. When we opened the door, we saw that there was a radiographer alongside a patient on the table.
- There was a lack of privacy and confidentiality when patients booked in for their appointment at the outpatient reception desk as conversations at the desk could be overheard by patients seated waiting for their appointments.
- An up to date BMI policy related to chaperoning was in place. Staff in the diagnostic imaging department told us they received training and gave examples of scenarios practiced.
- We saw a copy of the chaperone register in the outpatients department and saw signs in the consulting rooms informing patients they can ask for a chaperone if required.
- We did not observe any children attending the department as patients during our inspection.

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

Requires improvement

# Outpatients and diagnostic imaging

- Patients told us helpful information had been provided with the appointment letter and they felt able to ask any questions and staff provided clear explanations.
- Staff telephoned patients to clarify the process as well as information on the very narrow roads leading to the hospital and to assist in bad weather.
- We saw a variety of health-education literature and leaflets produced by BMI. Some of this information was general in nature while some was specific to certain conditions. The literature was available in waiting areas of the outpatient department and main reception.
- We saw pre-printed forms to be completed by consultants during clinics with information for patients to take home. These included specific instructions related to care provided, information related to dressings, stitches in place, wound appearance, and pain relief. This demonstrated that appropriate information was available to give to patients.

### Emotional support

- Patients told us that staff were understanding and they felt listened to.
- Nurses told us they attended clinic appointments with patients to provide emotional support if required.

## Are outpatients and diagnostic imaging services responsive?

Requires improvement

We rated responsiveness as required improvement for the outpatient and diagnostic imaging department. This was because:

- A paediatric nurse was not present in the department when children and young people attended for their appointments. The diagnostic imaging and outpatient departments did not have waiting areas, facilities and surroundings that were tailored to the treatment of children and young people. Additionally, information such as patient information leaflets was not available in child friendly formats.
- Although staff had up to date dementia training and access to a dementia lead, staff we spoke with were unable to describe changes to care and the environment for a patient living with dementia. Staff relied on carers and family to support, which is not best practice.
- Relatives and occasionally members of staff were used if translation was required which is not as per the BMI equality and diversity policy which states that trained interpreters should be used.
- There was a lack of information given to patients on how to make a complaint about their care or treatment.
- Although we asked for information about RTT waiting times and cancellation data, the hospital did not provide this.

However:

- The service offered a variety of appointment times to suit the needs of the patients.
- The hospital had a robust system for dealing with complaints. These were discussed at various meetings where learning and themes were identified.

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

- The outpatient department was open between 9am and 8pm Monday to Friday and 8.30am to 12pm on Saturday. Opening hours for the diagnostic imaging department matched the outpatient department. Patients told us they had been offered a choice of times and dates for their appointments.
- The physiotherapy department was open from 8am to 4pm Monday to Friday; with late clinics on Tuesday and Thursday running until 8pm. Clinics were available on Saturdays when required which gave patients a range of times and days for their appointment.
- The hospital pharmacy was open on Monday to Friday from 8am to 4pm. Private patients could have their prescriptions dispensed here. However, it was not located in an area accessible to patients; it did not have a reception or waiting area. Therefore, patients had to wait at main reception while their prescription was taken to pharmacy. Nursing and pharmacy staff told us that patients usually took their prescriptions to their local chemist.

Requires improvement

# Outpatients and diagnostic imaging

- The hospital ran a number of 'one-stop' clinics. For example, nursing staff completed visual field tests prior to the patient seeing the consultant in the ophthalmology clinic. This decreased the amount of times a patient would have to attend the hospital. We asked the hospital for further information on 'one stop' clinics, however this data was not given to us.

## Access and flow

- An up to date BMI policy regarding Referral to Treatment (RTT) access was in place. We asked for but were not provided with RTT waiting times for non-admitted patients beginning treatment within 18 weeks of referral and therefore were not able to compare this to the standard.
- We requested data but the hospital did not provide us with data for how many patients Did Not Attend (DNA) clinics. We were not given assurance of the processes followed if there were safeguarding issues related to children who DNA.
- Patients told us they were happy with the speed at which they had received their appointments. Most of them told us they were given an appointment within two weeks; however, one patient said he had waited six weeks for a follow up appointment.
- We were told that the waiting times for NHS patients for a DEXA scan was four to six weeks with a three-week turnaround for follow up with the GP or other referring clinician. The standard is that less than 1% of patients will wait for more than six weeks to have a DEXA scan. However, we did not have the data to compare against the standard.
- None of the patients we spoke to had experienced clinic delays. The hospital did not provide us with data related to clinic delay and cancellation rates and reasons for cancellations. Nursing staff told us that when delays occurred, patients were informed when booking in if possible and if delays were longer than 15 minutes a sign would be placed in the waiting area. Patients were offered a drink if longer delays were expected.
- On the day of inspection, we observed a consultant running late for clinic due to roadworks on the route to the hospital. He was apologetic when he greeted waiting patients on arrival and promptly started the clinic on arrival. Nursing staff had informed patients of the delay.

## Meeting people's individual needs

- A paediatric nurse was not present in the department when children attended for appointments.
- The diagnostic imaging and outpatient departments did not have waiting areas, facilities and surroundings that were tailored to the treatment of children and young people. Additionally, information such as patient information leaflets was not available in child friendly forms. We observed a member of staff at reception offer children attending the department colouring books while they waited.
- The hospital did not have a policy in place related to the care of patients living with dementia and the environment was not adapted to suit patients living with dementia. One hundred percent of staff had up to date dementia training and access to a dementia lead who they could refer to for advice. However, when we spoke to staff, they were unable to describe how they would make changes to care and the environment for a patient living with dementia. Staff relied on carers and family to support, which is not best practice.
- The hospital did not provide data related to the number of patients with dementia and learning difficulties that attended each year.
- Staff told us that a translation service was available but was not used. Relatives and occasionally members of staff were used if translation was required which is not as per the BMI equality and diversity policy which states that trained interpreters should be used.
- We did not see any leaflets in other languages, but staff told us they could access these if required from a central database.
- There were lifts and ramps available in the departments for wheelchair access. However, wheelchair users could not have fluoroscopy treatment at the hospital due to the lack of disabled toilet facilities in the treatment room. Other wheelchair accessible toilets were available in the department.
- A hearing loop was available in the department and we saw signs asking patients with a hearing impairment to inform nursing staff on arrival.
- Parking was available and patient transport organised if required.

Requires improvement

# Outpatients and diagnostic imaging

## Learning from complaints and concerns

- From July 2015 to June 2016 the hospital received 43 complaints, which was a decrease from July 2014 to June 2015 when they received 45. One complaint had been sent to the ombudsmen or the Independent Healthcare Sector Complaints Adjudication Service (ISCAS) in each year. The hospital did not provide us with a breakdown of complaints for different services; therefore, we do not know how many of these complaints related to the outpatients and diagnostic imaging departments.
- There was an up to date BMI complaints policy in place. It outlined the process and timescales for investigations and responses and included guidance on keeping the complainant informed if there were any delays.
- Staff were able to describe the process they would follow if they received a verbal complaint from a patient, and this was in line with the BMI policy.
- We saw minutes of monthly head of department meetings, departmental meetings, clinical governance meetings and health and safety meetings where learning and themes of complaints were discussed.
- We saw the most recent complaint for the radiology department, received 18 July 2016. The complaint was investigated and action taken. The manager telephoned the patient to discuss and ensure a solution was found.
- There was no information displayed in the hospital informing patients of how to make a complaint. Staff told us that patients could use the patient feedback cards to express any concerns they had about the care and treatment they had received. We saw that these were available in the department. The hospital website detailed the BMI complaints process and contact details.

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

Requires improvement

We rated well-led as requires improvement for the outpatient and diagnostic imaging department. This was because:

- There were environmental and infection prevention and control areas of concern found which reflected a lack of oversight from the hospital management team.
- Not all risks we identified had risk assessments and in some cases, when risks were identified there was no date for completion.
- The hospital did not have a specific local risk register. There was a BMI corporate risk register in use but it was not specifically tailored to Fawkham Manor Hospital and departments.
- Most staff were not able to articulate the corporate or hospital vision.

However:

- Staff were proud of the work they did at the hospital.
- Staff were positive about their direct line management and felt senior management was visible and approachable.

## Leadership / culture of service

- The Executive Director, the Director of Clinical Services, and the Operations and Risk Manager led the management team. An additional eight managers who were part of the management team led individual departments.
- There were clear lines of leadership and accountability. Nursing staff in the outpatients department were managed by the outpatient lead, who was managed by the director of clinical services.
- We found environmental and infection prevention and control areas of concern which reflected a lack of oversight from the hospital management team. These included the lack of facilities for children and areas of non-compliance with Health Building Note 009: Infection control in the built environment (HBN 00-09).
- However, staff were positive about their direct line management and we found good management of appraisals, mandatory training, learning and development and incidents.
- All staff we spoke with told us that the senior management team were approachable and visible. They

all attended various meetings that included other departments and the senior team. We were told that there were no "inter-professional boundaries" in that everyone helped each other and worked together.

- We looked at staff sickness and vacancy rates as this can be an indicator of the culture within the service. We found this to be low, with no sickness reported in eight of the 12 months between July 2015 and June 2016 for nurses and health care assistants. This was reflected in staff comments saying they felt the hospital was a good place to work and they felt supported and valued for the work they did.

## Vision and strategy

- Staff told us they were aware that there was a corporate and hospital vision. However, most staff were not able to articulate what this was.
- Staff spoke highly of the service they provided and were proud of the facilities at the hospital and the care they could offer patients.

## Governance, risk management and quality measurement

- Minutes from the clinical governance meeting and the various sub-committees, for example health and safety and infection prevention, were reported to the medical advisory committee (MAC), and to the management team through the heads of departments (HODs) meeting. Minutes of all meetings were held on the shared drive for all staff to be able to access. A standard agenda template was used to ensure a coordinated approach to each meeting. Although the chair of the MAC reviewed minutes of the meeting, they did not attend the clinical governance meeting and there was no other medical input into this. There was no medical personnel present at the time of the meeting, and therefore review afterwards had a delayed impact.
- The hospital did not have a specific local risk register. There was a BMI corporate risk register in use but it was not specifically tailored to Fawkham Manor Hospital and departments.
- We saw risk assessment forms related to the diagnostic imaging department, which were up to date. However, we had concerns that not all risks had been assessed, for example there was no risk assessment related to the ""Do not point x-ray tube at this wall" sign in Room 1 which meant that staff and patients behind this wall could be at risk of radiation exposure if the wall did not provide adequate protection.
- In some cases, when risks were identified there was no date for completion of the action plan, for example non-compliant hand washbasins and carpets in clinical areas.
- The MAC, which met quarterly, reviewed clinical quality and governance matters. The minutes and actions from these meetings were circulated to all consultants. We saw evidence of minutes where consultants' practising privileges were reviewed.
- The hospital's MAC provided the formal organisational structure through which consultants communicated. The MAC advised the executive team and worked to maintain high standards and improve the quality of services.
- HOD's, senior staff and the management team met monthly and we saw minutes from these meetings. Items on the agenda included the risk register, complaints and audit results.
- We saw a copy of the hospital audit schedule. We saw audit results were discussed at the clinical governance and departmental team meetings.
- The hospital infection prevention & control committee (IPCC) met every three months and we saw from the meeting minutes that a variety of the multi-disciplinary team (MDT) attended these meetings. For example, the housekeeping lead attended this, which ensured a holistic approach to infection control and prevention.
- We saw the Radiological Protection Centre (RPC) Radiation Protection Procedures and Protocols for Medical Exposures available for the radiographers.
- There was an annual Radiation Protection meeting at the hospital with the last one held on 9 February 2016. Radiation exposure was monitored in theatres with no issues identified over the last six months.
- In the outpatients department and physiotherapy department we saw risk assessments had been completed including control of substances hazardous to health (COSHH).

Requires improvement

# Outpatients and diagnostic imaging

- There was a monthly corporate clinical governance bulletin. The bulletin identified changes in legislation relating to publications and alerts for example (drugs, equipment). It also provided details of issues and best practice at other sites so that shared learning could be applied locally.

## Public and staff engagement

- We were told that there were patient journey meetings every other month where hospital wide issues were discussed including ways to improve and were included in team briefs.
- Patient feedback cards were given to patients and the hospital participated in the NHS Friends and Family Test.
- Staff aimed to each get three completed patient questionnaires per week.
- Consultants collected sample patient feedback as part of their appraisal and revalidation. However, it was not clear if this information was shared with the hospital.
- Staff told us they recently had a staff wellbeing day. Treatments from therapists and investigations such as cholesterol testing were on offer.

## Innovation, improvement and sustainability

- A radiologist described how football injuries treated in private patients enabled significant learning that could be shared with NHS practice.
- The hospital was investing in improving its facilities with the refurbishment of the outpatients department in process at the time of the inspection.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider MUST take to improve
**Action the hospital MUST take to improve**

- The hospital must maintain securely an accurate, complete and contemporaneous record in respect of each patient
- The hospital must ensure staff are trained to the required level in vulnerable adult and children's safeguarding so that all staff working with children and young people have level 3 training.
- The hospital must ensure the environment and facilities are suitable for children and young people.
- The hospital must ensure there is emergency and standard equipment available for children and young people
- The hospital must ensure that care and treatment reflects current evidence-based guidance, standards and best practice.
- The hospital must ensure staff follow patient pathways and corporate policies and practices.
- The hospital must ensure appropriate documentation of controlled drugs is in line with hospital policy.
- The hospital must ensure infection control compliance and monitoring is given sufficient priority.
- The hospital must ensure the World Health Organisation 'five steps to safer surgery' is used appropriately and ensure staff engagement in the process.
- The hospital must assess medical patient outcomes.
- The hospital must ensure there is a robust system in place to ensure regular electrical testing and servicing of equipment.
- The hospital must assure themselves that risks are given sufficient priority, identified and lessened.
- The hospital must compile a hospital specific risk register and a process for monitoring this.

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

- The hospital should put systems in place to fully support patients living with dementia.
- The hospital should ensure that privacy and confidentiality of patients is maintained at all times
- The hospital should ensure lessons learnt from incidents are shared and embedded.
- The hospital should undertake a review of the facilities and identify areas where improvement is required.
- The hospital should ensure the difficult intubation trolley is fit for purpose.
- The hospital should ensure the anaesthetic machine checking log books are fully completed.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment<br><br>13(2) Systems and processes must be established and operated effectively to prevent abuse of service users.<br><br>• As part of their induction, staff must receive safeguarding training that is relevant, and at a suitable level for their role. Training should be updated at appropriate intervals and should keep staff up to date and enable them to recognise different types of abuse and the ways they can report concerns.<br><br>• Staff must be aware of their individual responsibilities to prevent, identify and report abuse when providing care and treatment. This includes referral to other providers. |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment<br><br>12(2)(b) doing all that is reasonably practicable to mitigate any such risks;<br><br>• Providers should use risk assessments about the health, safety and welfare of people using their |

This section is primarily information for the provider

# Requirement notices

service to make required adjustments. These adjustments may be to premises, equipment, staff training, processes, and practices and can affect any aspect of care and treatment.

- Staff must follow plans and pathways.

12(2)(e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;

- Providers must make sure that equipment is suitable for its purpose, properly maintained and used correctly and safely. This includes making sure that staff using the equipment have the training, competency and skills needed.

12(2)(g) the proper and safe management of medicines:

- Staff must follow policies and procedures about managing medicines, including those related to infection control.

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment<br><br>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Premises and equipment<br><br>15(1)(a) All premises and equipment used by the service provider must be clean:<br>• Premises and equipment must be kept clean and cleaning must be done in line with current legislation and guidance. |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance |

This section is primarily information for the provider

# Requirement notices

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance

17(2)(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

- Records relating to the care and treatment of each person using the service must be kept and be fit for purpose.
- Records must be kept secure at all times and only accessed, amended, or securely destroyed by authorised people.