

The Karri Clinic Ltd

Kinvara Private Hospital

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, 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?

Inspected but not rated



Are services responsive to people's needs?

Good



Are services well-led?

Inadequate



Summary of findings

Overall summary

Our rating of this location. We rated it as inadequate because:

- Managers did not ensure all staff completed mandatory and safeguarding training, and received a performance appraisal. There was no formal programme of clinical supervision to help staff improve.
- Clinical and patient environments were not safe, clean, well maintained and fit for purpose.
- Safety checks of emergency equipment were inconsistent and not in accordance with local policy.
- Prescribing, storage and management of medicines and consumable items was not in accordance with local policy.
- The service did not provide care and treatment based on national guidance and evidence-based practice. Managers did not check to make sure staff followed guidance.
- Staff did not consistently monitor the effectiveness of care and treatment.
- The service was not well led, and the governance processes did not ensure that procedures ran smoothly.
- The provider did not ensure there is an effective system in place for the management of practising privileges.
- Privacy and dignity of patients was not always respected.

However:

- Staff worked well together as a multidisciplinary team.
- Staff planned patient discharge well and liaised with services that would provide aftercare. Patients' lengths of stay were short.

We have used our enforcement powers and served a warning notice on this Registered Provider and a warning notice on the Registered Manager. The warning notices were served under Section 29 of the Health and Social Care Act 2008. The warning notices told the Registered Provider and Registered Manager they were in breach of Regulation 17: Good Governance. The Registered Provider and Registered Manager now have a fixed period of time to make improvements and comply with the regulations. We will undertake further inspection activity to check that the registered provider and registered manager are compliant with the regulations.

For more information on action we have taken, see the sections on areas for improvement.

Summary of findings

Our judgements about each of the main services

Service

Rating

Summary of each main service

Outpatients

Inadequate



We rated it as inadequate because:

- Staff did not have training in key skills and safeguarding to ensure they understood how to protect patients from abuse, and managed safety well.
- The service did not always control infection risk well.
- The service did not provide care and treatment based on national guidance and evidence-based practice.
- Staff did not consistently monitor the effectiveness of care and treatment. Managers did not conduct robust audits to monitor the effectiveness of the service and make sure staff were competent.
- The provider did not ensure all staff received an annual appraisal.
- Leaders did not fully understand and manage the priorities and issues the service faced.
- The service did not have a vision for what it wanted to achieve and a strategy to turn it into action.
- Leaders did not operate effective governance processes, throughout the service. They did not have regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders did not use reliable information systems. Staff could not always find the data they needed, in easily accessible formats, for example, policies and minutes of meetings.
- We were concerned there was a risk that patient and staff privacy and dignity may be compromised due to inappropriate locations of CCTV equipment.

However:

- The service had enough nursing and medical staff to care for patients
- Staff completed and updated risk assessments for each patient and removed or minimised risks.

Outpatients is a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.

Summary of findings

We rated this service as inadequate because it was not safe and well led. However, responsive was rated good. We do not rate effective for outpatient services. Caring was inspected but not rated.

Surgery

Inadequate



Our rating of this service. We rated it as inadequate because:

- Staff did not have training in key skills and safeguarding to ensure they understood how to protect patients from abuse, and managed safety well.
- The service did not always control infection risk well.
- The design, maintenance and use of facilities, premises and equipment did not always keep people safe.
- The service did not always use the systems and processes to manage medicines safely.
- The service did not provide care and treatment based on national guidance and evidence-based practice.
- Staff did not consistently monitor the effectiveness of care and treatment. Managers did not conduct robust audits to monitor the effectiveness of the service and make sure staff were competent.
- The provider did not ensure all staff received an annual appraisal.
- Leaders did not fully understand and manage the priorities and issues the service faced.
- The service did not have a vision for what it wanted to achieve and a strategy to turn it into action.
- Leaders did not operate effective governance processes, throughout the service. They did not have regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders did not use reliable information systems. Staff could not always find the data they needed, in easily accessible formats, for example, policies and minutes of meetings.
- We were concerned there was a risk that patient and staff privacy and dignity may be compromised due to inappropriate locations of CCTV equipment.

However:

- The service had enough nursing and medical staff to care for patients

Summary of findings

- Staff completed and updated risk assessments for each patient and removed or minimised risks.
 - Staff gave patients enough to eat and drink.
 - Staff treated patients with compassion and kindness and took account of individual needs.
- People did not have to wait too long for treatment.

We rated this service as inadequate because it was not safe and well led and we rated effective as requires improvement. However, responsive was rated good. Caring was inspected but not rated.

Summary of findings

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Summary of this inspection

Background to Kinvara Private Hospital

Kinvara Private Hospital Limited is an independent hospital owned by The Karri Clinic Ltd.

It is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury.
- Surgical procedures.
- Diagnostic and screening procedures.

The hospital has a manager registered with CQC.

The hospital provided a range of elective day-case and in-patient surgery treatments for NHS and other funded (insured and self-pay) adults, (the service did not admit children). The hospital provided a range of specialities including gynaecology, orthopaedic surgery, cosmetic surgery and general surgery. The surgery service had 14 beds. These were arranged as 10 single ensuite rooms and 4 double rooms with ensuite, across 2 floors.

There were 2 operating theatres and 2 anaesthetic rooms. There was a separate recovery area.

There was a dedicated out-patient's department.

Our inspection was unannounced (staff did not know we were coming). This was the first time we had inspected this service.

Outpatients is a small proportion of hospital activity. The main service provided by this hospital was surgery. Where arrangements were the same, we have reported findings in the surgery section.

How we carried out this inspection

The provider leased theatre and out patient facilities to consultants who held practising privileges with named third party providers. Regulated activities provided by named third party providers were not within the scope of our inspection.

The service had no patient activity during our inspection. However, the inspection team:

- inspected all 5 key questions
- visited the wards, operating theatres and outpatients department
- looked at the quality of the environment
- spoke with 8 members of clinical and non-clinical staff, including the senior management team for the service

Summary of this inspection

- reviewed 15 health care records.

After our inspection, the inspection team:

- looked at a range of policies, procedures and other documents relating to the running of the service
- spoke remotely with the Registered Manager
- spoke remotely with 2 patients who used the surgery service. Their contact details were provided by the provider, who confirmed the patients had given consent to be contacted by CQC.

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action a service **SHOULD** take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service **MUST** take to improve:

Service wide

- The provider must assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities. **(Regulation 17(2)(a)).**
- The provider must assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. **(Regulation 17 (1)(2)(b)).**
- The provider must ensure all identified risks affecting the service in line with local policy are escalated to the risk register. **(Regulation 17(1)(2)(b)).**
- The provider must ensure all policies and procedures are specific, relevant to the service and reviewed in accordance with review dates. **(Regulation 17(1)(2)(d)).**
- The provider must ensure there is an effective system in place for the management of practising privileges. **(Regulation 17 (1)(2)(b)).**
- The provider must ensure systems and processes are in place to ensure staff are suitably qualified, competent, skilled and experienced. **(Regulation 17(1)(2)(d)).**
- The provider must implement effective systems and processes to ensure all staff are compliant with mandatory training, including but not limited to, safeguarding vulnerable adults and children, to a level appropriate for their role. **(Regulation 17(1)(2)(a)(b)).**
- The provider must ensure all premises and equipment used by the service provider for providing care and treatment, are safe, clean and properly maintained, and that this is recorded appropriately. **(Regulations 12(1)(2)(e)(h) and 15(1)(a)(c)).**
- The provider must ensure that all furnishings, including but not limited to fabric curtains, are suitable for the purpose for which they are being used. **(Regulation 15(1)(c)).**

Summary of this inspection

- The provider must ensure all staff, including but not limited to bank staff, receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out their duties. **(Regulation 18(1)(2)(a)).**
- The provider must develop a clear vision for what it wants to achieve and a clear strategy to turn it into action. **((Regulations 17(1)(2)(d)).**
- The provider must assess the use of CCTV in all patient accessible areas to ensure its use does not unnecessarily compromise patients' privacy and dignity. **(Regulation 10(1)).**

Surgery core service

- The provider must ensure there is a system in place to ensure service users do not receive expired items and expired medicines. **(Regulation 12(2)(g)).**
- The provider must ensure the proper and safe prescribing, storage and management of medicines. **(Regulation 12(1)(2g)).**

Action the service SHOULD take to improve:

Service wide

- The provider should consider implementing regular safeguarding supervision for staff, in accordance with intercollegiate safeguarding adults and children guidance.
- The provider should ensure all service level agreements are reviewed in accordance with review dates.
- The provider should ensure all written complaint responses address all of the issues raised and signpost the complainant to the next steps in the complaint process, should they remain dissatisfied with the provider's response.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients	Inadequate	Inspected but not rated	Inspected but not rated	Good	Inadequate	Inadequate
Surgery	Inadequate	Requires Improvement	Inspected but not rated	Good	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Inspected but not rated	Good	Inadequate	Inadequate

Outpatients

Safe	Inadequate 
Effective	Inspected but not rated 
Caring	Inspected but not rated 
Responsive	Good 
Well-led	Inadequate 

Are Outpatients safe?

Inadequate 

Mandatory training

The service provided mandatory training in key skills to all substantive staff but did not make sure everyone completed it.

See also under 'Surgery'.

The provider clarified only substantive staff worked in the outpatient department.

Safeguarding

The provider was not assured all staff understood how to protect patients from abuse. They did not ensure all substantive staff had training on how to recognise and report abuse.

See also under 'Surgery'.

The provider clarified only substantive staff worked in the outpatient department.

Cleanliness, infection control and hygiene

The service did not control infection risk well. They did not keep equipment and the premises visibly clean.

See also under 'Surgery'.

Clinic rooms were visibly clean and had suitable furnishings which were visibly clean and well-maintained.

Housekeeping staff were responsible for cleaning all environmental areas. However, cleaning schedules were not comprehensive and did not demonstrate all areas were cleaned regularly.

Although records indicated the emergency resuscitation equipment trolley shared across the wards and outpatients department was cleaned regularly, we observed this was dirty.

Outpatients

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

See also under 'Surgery'.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

See also under 'Surgery'.

During inspection we asked to review the procedure register to determine the type and frequency of activity undertaken within the outpatients department and consulting rooms. The service did not use a procedure register. However, the provider clarified all clinical procedures carried out in the consulting rooms were documented in the patient's record and on the electronic clinic booking system. This system provided oversight for managers.

The consulting rooms were equipped to carry out clinical assessments and minor procedures. These included, for example, pre-operative assessments, joint injections with steroids and minor skin lesion removal under local anaesthetic.

Follow-up physiotherapy sessions and consultations following surgical procedures were being carried out.

Staffing

The service had enough staff with the right qualifications, skills, and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

See also under 'Surgery'.

During the inspection, we were not able to observe clinics for outpatients.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

See also under 'Surgery'.

Patient notes were comprehensive, and all staff could access them easily.

Medicines

The service stored medicines safely. However, prescribing documentation was not always stored and managed securely.

See also under 'Surgery'.

Non-prescription medicines used in the department were stored securely.

Outpatients

However, prescription pads used for outpatient clinics were not stored securely when not in use.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers ensured that actions from patient safety alerts were implemented and monitored.

See also under 'Surgery'.

Are Outpatients effective?

Inspected but not rated 

Evidence-based care and treatment

The service did not provide care and treatment based on national guidance and evidence-based practice. Managers did not check to make sure staff followed guidance.

See also under 'Surgery'

Although, managers presented audit results to staff at departmental meetings, we did not see evidence of local audits for outpatient clinics.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

See also under 'Surgery'.

Patient outcomes

Staff did not consistently monitor the effectiveness of care and treatment.

See also under 'Surgery'.

Staff did not follow up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

The provider did not provide evidence of robust outpatient audit activities. The schedule and audit data we received was not specific or relevant to the service provided.

Competent staff

Managers completed appraisals for most substantive staff to provide support and development.

See also under 'Surgery'.

Outpatients

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

See also under 'Surgery'.

Seven-day services

Outpatient services were not available seven days a week.

See also under 'Surgery'.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

See also under 'Surgery'.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

See also under 'Surgery'.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Patients were risk assessed against specified admission criteria.

Are Outpatients caring?

Inspected but not rated 

Compassionate care

Staff treated patients with compassion and kindness, and took account of their individual needs.

See also under 'Surgery'.

There was no outpatient activity in the department during our inspection. However, patients we spoke with remotely told us they were satisfied with the way outpatient staff treated them.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

See also under 'Surgery'.

Outpatients

There was no out patient activity in the department during our inspection. However, patients we spoke with remotely told us they were satisfied with the way outpatient staff treated them.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

See also under 'Surgery'.

There was no out patient activity in the department during our inspection. However, patients we spoke with remotely told us they were satisfied with the way outpatient staff treated them.

Are Outpatients responsive?

Good 

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

See also under 'Surgery'.

Managers planned and organised services so they met the needs of the local population. During interview the Registered Manager told us consultants with practising privileges suggested the provision of new procedures for the hospital. These proposals were discussed and decisions made whether these were appropriate and safe.

Facilities and premises were appropriate. The hospital was accessible throughout, with the department on the ground floor and accessible for people who used a wheelchair. The car park provided free parking spaces with a level entry into the building.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

See also under 'Surgery'.

There was no out patient activity in the department during our inspection. However, patients we spoke with remotely told us they were satisfied with the way outpatient staff treated them.

Access and flow

People could access the service when they needed it and received the right care promptly.

See also under 'Surgery'.

Outpatients

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service investigated them and shared lessons learned with all staff.

See also under 'Surgery'.

Are Outpatients well-led?

Inadequate 

Leadership

Leaders had the skills and abilities to run the service, however, senior leaders were recently appointed, and the leadership team was not embedded. They did not fully understand and manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

See also under 'Surgery'.

Vision and Strategy

The service did not have a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

See also under 'Surgery'.

Culture

Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work.

See also under 'Surgery'.

Governance

Leaders did not operate effective governance processes, throughout the service. They did not have regular opportunities to meet, discuss and learn from the performance of the service.

See also under 'Surgery'.

Management of risk, issues and performance.

Leaders and teams did not use systems to manage performance effectively. They did not identify and escalate all relevant risks and issues and identify actions to reduce their impact. They did not have plans to cope with unexpected events.

See also under 'Surgery'.

Outpatients

Information Management

The service collected data and analysed it. Staff could not always find the data they needed, in easily accessible formats. The information systems were mostly secure. Data or notifications were submitted to external organisations as required.

See also under 'Surgery'.

Engagement

Leaders and staff actively and openly engaged with patients, staff, and local organisations to plan and manage services.

See also under 'Surgery'.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

See also under 'Surgery'.

Surgery

Safe	Inadequate 
Effective	Requires Improvement 
Caring	Inspected but not rated 
Responsive	Good 
Well-led	Inadequate 

Are Surgery safe?

Inadequate 

Mandatory training

The service provided mandatory training in key skills to all substantive staff but did not make sure everyone completed it. Bank staff training compliance was low.

There was a training policy, however, this was overdue review.

We reviewed mandatory training compliance data, for 19 substantive employees, including 1 bank staff who did not have a substantive NHS role, and worked solely at the hospital. The provider's target compliance was 100%. The training plan was a 12-month rolling programme from the staff's start date. Compliance across all mandatory modules varied between 58% and 89% across the hospital. For example, only 74% had completed basic life support training.

Managers we spoke with told us there were 35 bank staff who had active contracts. However, training data was only provided for 25 bank staff, who had worked within the last 4 months. This meant there were a further 10 bank contracted staff, who had the potential to be offered work, but we did not see their training compliance. Managers we spoke with told us bank staff accessed all mandatory training via their substantive NHS employer and this was recorded on their NHS electronic staff record (ESR).

All bank staff were required to provide printed evidence of modules completed and this was monitored by managers, on a central tracker. However, compliance was low. For example, in the data we received for 25 bank staff, none showed as fully compliant. With specific regard to resuscitation training, 27% were recorded as overdue or had not provided evidence of training.

Managers we spoke with told us consultants attended mandatory training at their employing NHS trust, and this was monitored through the appraisal process, GMC revalidation and at review of practising privileges. However, we were unclear how the provider was assured all consultants had completed mandatory training as the practising privileges review process was not robust and we did not see ESR print out documents in consultant files.

This meant we were concerned that staff may not have the appropriate skills and knowledge to care for patients safely.

Surgery

The provider clarified they provided mandatory and safeguarding training to the 3 substantive Resident Medical Officers (RMOs). However, the training compliance data provided for substantive staff, following our data request, did not include the RMOs.

Safeguarding

The provider was not assured all staff understood how to protect patients from abuse. They did not ensure all staff had training on how to recognise and report abuse.

The hospital had safeguarding policies. However, the safeguarding children policy we saw on site was overdue review, and not specific and relevant to the services provided. For example, it alluded to discovery of non-accidental injuries in children under 2-3 years of age and children not brought to appointments, although the hospital did not provide consultations or treatments for children.

Staff accessed training specific for their role. For example, The named safeguarding and PREVENT lead completed level 3 safeguarding training, in accordance with intercollegiate guidance and maintained professional contact with the local authority safeguarding lead.

The provider's target for all safeguarding training was 100%. However, compliance for children and young people and vulnerable adults safeguarding training across the hospital, was 58% and 74% respectively. PREVENT training compliance was 68%.

The provider clarified they provided safeguarding training to the 3 substantive RMOs. However, the training compliance data provided for substantive staff, following our data request, did not include the RMOs.

In addition, in the data we received for 25 bank staff, 48% were overdue or had not provided evidence of safeguarding adults training. 64% were overdue or had not provided evidence of safeguarding children training and 56% were overdue or had not provided evidence of PREVENT training.

This meant we had concerns staff may not have the appropriate skills and knowledge to protect patients from abuse and to recognise and report abuse.

Staff we spoke with described the different types of abuse, including female genital mutilation (FGM). We asked staff specific questions about how they would recognise, for example, domestic abuse. They clearly described the warning signs and told us if they considered someone may be in immediate danger they would report to police without delay. This was in accordance with local policy.

Staff including the named lead did not receive any formal safeguarding supervision, in accordance with national intercollegiate safeguarding guidance.

Cleanliness, infection control and hygiene

The service did not control infection risk well. They did not keep equipment and the premises visibly clean.

The provider had infection prevention and control (IPC) and COVID-19 policies.

Surgery

Staff received mandatory IPC and hand hygiene training. Compliance was 84% and 63% respectively against the provider's target of 100%. However, 44% of bank staff were overdue or had not provided evidence of IPC training. This meant we were unclear how the provider was assured all staff understood and consistently demonstrated robust IPC practices.

The provider conducted periodic IPC audits which included, for example, observations of theatre scrub procedures and hand hygiene. Although audit results we saw indicated high compliance, they provided limited assurance. For example, theatre asepsis audit data recorded in June 2022, indicated full compliance. However, the number of compliant cases (numerator) and total number of cases observed (denominator) were not indicated. This meant we were unclear if the result represented an individual or multiple cases. Similarly, ward and theatre hand hygiene audit data recorded April and August 2022 respectively, indicated high compliance but did not show the number of staff observed.

Most ward areas had suitable furnishings which were clean and well-maintained. For example, vinyl covered floors and upholstered patient seating were impermeable and could be wiped clean.

Housekeeping staff were responsible for cleaning all environmental areas. However, cleaning schedules were not comprehensive and did not demonstrate all areas and frequently-touched fixtures and fittings, were cleaned regularly. For example, bedroom door handles were not on the ward cleaning schedule, and there were artificial plants in patient bedrooms, which could not be cleaned effectively and were dusty. Although visibly clean, there were no records to demonstrate when fabric curtains were last laundered or due to be cleaned and disposable curtains in a double room on the ground floor ward were dated as last changed in November 2020.

We saw weekly cleaning schedules displayed in all patient bedrooms. However, rooms were only cleaned following occupancy. For example, a schedule we saw indicated the room was cleaned 22 August, 31 August, 14 September and 15 September. This meant we were concerned some rooms may not be routinely cleaned during periods of low hospital activity.

We saw a corridor which led to decommissioned rooms, which had undergone building work. This corridor, and particularly the door which allowed access to clean areas, was covered with building dust. Staff accessed the rest room via this door, and there was a risk of cross contamination. We brought this to the attention of managers as the time and the area was thoroughly cleaned prior to the end of our visit.

Nursing staff were responsible for cleaning all clinical equipment. However, we saw it was not always cleaned effectively. For example, there were no cleaning records for the ground floor ward nurses store / clean utility room. We saw dusty cabinet tops used to store clinical items. The emergency blood transfusion box, first aid box and eye wash station and a gratnell trolley containing sterile consumables were very dusty.

Inappropriate items were stored in the nurses' store / clean utility room. For example, we found a single-patient use tube of lubricating gel, which had been used multiple times and not discarded after first use. We brought this to the attention of a manager, and it was disposed of immediately. We also found stationery supplies, a paper shredder, clean linen, and food in a drawer. We brought this to the attention of managers at the time and the food was removed. After our inspection, we received assurance the provider had reviewed storage arrangements for clean linen and non-clinical items.

The ward emergency resuscitation equipment trolley, face protection shield, portable suction machine and oxygen cylinder were dirty, although records of completed checks indicated the trolley and associated equipment were cleaned.

Surgery

We saw stored equipment for patient use, for example, commodes and toilet seat raisers, were not labelled to show when they were last cleaned. This meant the provider was not assured all equipment that was stored was appropriately decontaminated and ready for use.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff in clinical uniform complied with arms 'bare arms below the elbows' policy, in accordance with national institute for health and care excellence (NICE) guidance. Patients we spoke with confirmed they saw staff washed their hands and used hand gel between patient interactions.

We observed public areas had posters and hand gel stations to promote COVID-19 awareness and hand hygiene.

Staff worked effectively to prevent, identify and treat surgical site infections. For example, surgical patients were screened for healthcare acquired infections and risk assessments were incorporated into the patient's health record.

Theatre environments were clean and fit for purpose. The 2 operating theatres had laminar airflow. Laminar airflow is used to separate volumes of air or prevent airborne contaminants from entering an area. Sterile services equipment, such as surgical instruments, was provided by the local NHS trust hospital under a service level agreement and sterile supplies were stored safely.

Quality reports we reviewed for 2021-2022, showed there were no surgical site infections reported.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

Access to the premises was via an automatic door and staff at reception had a clear line of sight to the entrance. The hospital was arranged in 3 adjacent buildings. The main hospital building was by internal, secured doors. The adjacent buildings were decommissioned at the time of our inspection. Access to restricted areas such as administration and clinical storage, was controlled with digital key-pad locks.

Fire exits and corridors were clear of obstructions. All fire extinguisher appliances we inspected were signposted and serviced within an appropriate timescale. However, some were very dusty. Although there was a fire procedure in place, and fire alarms were tested weekly, we did not see evidence of a completed fire evacuation exercise.

All clinical areas had call bells to ensure patients could alert staff when needed. Call bell activation and reaction was monitored via a remote monitoring system. Patients we spoke with told us staff responded quickly when called.

The design of the environment mostly followed national guidance. However, fabric curtains in patient bedrooms were domestic specification and not designed for hospital use. For example, they were not washable, for thermal disinfection and not certified to BS5867 Part 2C, to ensure they were inherently flame retardant.

Staff did not consistently record safety checks of all specialist equipment. We saw significant gaps in checking records for the ward emergency resuscitation trolley. For example, there were 12 checks completed in April 2022 and 18 checks completed in June 2022, and the records did not indicate when the department was closed. In addition, some checks were not dated or signed by the checker. We brought this to the attention of managers at the time and were told they would discuss with staff and ensure all checks were recorded correctly in future.

Surgery

There were no calibration or test records available for the blood glucose monitoring meters stored on the ward. This meant we were unclear how staff were assured the machines were correctly calibrated for accuracy prior to patient use.

Most consumable items we inspected were within expiry dates however, on the ward we found blood sampling syringes and needles in the emergency blood transfusion box had expired in December 2021 and July 2022.

Although theatre staff documented anaesthetic machine checks when theatres were operational, we saw breathing circuit lot numbers were not recorded. We brought this to the attention of staff at the time and they told us they would ensure lot numbers would be recorded in future.

The service had enough suitable equipment to help them to safely care for patients. There were systems for recording the service and maintenance of equipment identified through a central asset register and equipment compliance stickers, which indicated the dates tests were due. Medical devices were serviced and maintained under a service level agreement with an external provider.

We inspected several pieces of equipment, which included defibrillators, suction machines, monitoring equipment, anaesthetic machines and intravenous pumps. Most were serviced and maintained appropriately. However, the suction machine on the ward emergency resuscitation trolley did not have a test sticker on it.

Patient weigh scales we inspected were calibrated within the last year.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

The provider had a preoperative assessment policy with clearly defined exclusion criteria, to ensure only appropriate patients were admitted to the hospital. For example, patients with American Society of Anaesthesiologists (ASA) scores of 3-4 were not admitted. ASA grades are a simple scale describing a person's fitness to be given an anaesthetic for a procedure.

Pre-assessment was by telephone, face to face and/or a pre-admission medical questionnaire. Discharge planning was considered at this stage; especially requirements for home care packages or periods of convalescence.

Surgical patients were screened for healthcare acquired infections and risk assessments were incorporated into the patient's health record.

Pathology and microbiology services for processing blood samples and screening swabs, were provided by the local NHS trust under service level agreements. However, the agreements we saw stated the contracts were to be reviewed annually and the documents we saw were dated as due review in 2020.

The management of the deteriorating patient policy was overdue review.

Surgery

Staff used a nationally recognised NEWS2 tool to identify deteriorating patients and escalated them appropriately. The service had a formal service level agreement with the local NHS trust, if emergency transfer to the NHS was required. The emergency transfer pathway was kept at the nurses' station for easy reference. There were 3 unplanned transfers to another hospital for treatment between April 2021 and March 2022.

Staff completed risk assessments for each patient using recognised tools. For example, pressure areas, moving and handling, malnutrition universal screening tool (MUST) and venous thromboembolism (VTE) risk assessments.

Staff knew about and dealt with any specific risk issues. For example, we saw 'stop before you block' prompt posters displayed in anaesthetic rooms and a management of sepsis flow chart on the ward.

Consultants had 24-hour access to mental health liaison and specialist mental health support via direct referral, if concerned about a patient's mental health.

Shift changes and handovers included all necessary key information to keep patients safe.

Managers held a daily, 9.15am comm-cell safety huddle. Themes discussed included clinical workload, staffing and operational risks. These were documented.

The hospital conducted observational and documentation audits of compliance with world health organisation (WHO) safer surgery checks. The audit data we reviewed for April 2022 showed high compliance. However, clinical governance minutes for April and July 2022 reported WHO checklist completion by temporary workers was 'inconsistent for all steps'.

Day case patients assessed unfit for discharge were accommodated on the ward overnight with an RMO on site.

Discharges were mostly RMO/nurse led. Patients we spoke with told us they were given contact details for the ward should they have any concerns.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. Theatre staff rotas we reviewed showed staffing met Association of Anaesthetists of Great Britain and Ireland, (AAGBI) and The Association for Perioperative Practice (AfPP) recommendations.

Managers did not use an acuity tool to calculate ward staffing requirements but planned for 1 registered nurse to 4 patients and occasionally 1 to 6, depending on patient acuity. Patients we spoke with told us staff were available at all times.

The service had high rates of bank and agency nurses. The hospital employed 5 substantive registered nurses, 2 operating department personnel and 3 healthcare assistants. Managers we spoke with told us there were 35 bank contracted staff. However, the core of nursing and theatre workforce was provided by 25 bank staff. The Clinical Services Lead was a registered nurse who also worked clinically on the wards when required to support.

Managers made sure all bank and agency staff had a full induction and understood the service.

Surgery

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe.

There were 3 RMOs who worked in rotation. The RMO was on site 24 hours a day when patients required overnight stay.

Managers could access locums when they needed additional medical staff. For example, if the RMO became unwell.

Managers made sure locums had a full induction to the service before they started work.

The surgery service was consultant- led. All patients were admitted under a named, validated consultant with practising privileges. The term 'practising privileges' means medical practitioners not employed directly by the hospital but approved to practise there.

Consultants conducted daily ward rounds. This was confirmed by patients we spoke with. Staff we spoke with told us consultants were always contactable by telephone for advice.

There was always appropriate anaesthesiologist cover. Consultant surgeons arranged alternative cover if their usual anaesthetist was not available.

Surgical and anaesthetic consultants remained responsible for their patients throughout their stay in hospital and were required to be available within 45 minutes or to arrange cross cover with another consultant if they were unable to provide the required level of availability. For example, during annual leave.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Records, including medicine prescription charts were predominantly on paper.

We reviewed 10 sets of patient paper records. Medical and nursing records were held securely in a single folder. They were detailed, with appropriate nursing risk assessments and individualised care plans. For example, in relation to pressure area care and moving and handling.

Records we reviewed were completed consistently well, which concurred with record keeping audit data completed in April 2022.

We saw lockable records cabinets on the ward to ensure records were stored securely when in use. Records were scanned into an electronic system when patients were discharged. Archived paper records were stored in boxes in a file room with a key- pad lock.

The operating theatre register was completed comprehensively.

Surgery

Medicines

The service did not use systems and processes to safely prescribe, administer, record and store medicines.

There were medicines management policies in place. However, staff did not always follow systems and processes to prescribe and administer medicines safely. For example, we reviewed 7 medicine prescription charts and found 4 prescriptions for medicines to be given 'as required' were not dated by the prescriber. Another prescription did not have the patient's height and weight recorded, and one prescription did not indicate the time a medicine was administered to the patient. Three prescriptions had regular medicines prescribed but were not given. The appropriate code to indicate the reason medicines were not given was not recorded.

Although the provider explained there was online access to British National Formulary (BNF), we saw a BNF reference book which was dated March 2020. BNF publish 2 editions each year; March and September. It is a United Kingdom pharmaceutical reference book for prescribers that contains a wide spectrum of information and advice on prescribing and pharmacology. This meant we were concerned prescribers may not always refer to the most up to date guidance for prescribing. We brought this to the attention of managers at the time.

There was no system in place to control and monitor the use of private prescription pads. Although they were stored securely in a locked cupboard, the sequential prescription numbers were not recorded, and prescriptions issued to consultants were not signed out and back in when returned. After our inspection, the provider put a system in place to address this.

Staff did not always manage and store medicines safely. For example, on the ward we saw mixed batches of intravenous fluids stored together in a drawer, which is not best practice. In addition, we found emergency medicines used to treat hypoglycaemia (low blood sugar), had expired and were not replaced. We brought this to the attention of a manager at the time and were told replacements would be ordered. After our inspection, we received assurance the provider had reviewed storage of intravenous fluids.

We saw a box of mixed consumables stored on the floor of the clean utility room, which included medicines for bowel preparation. We brought this to the attention of managers at the time and were told the delivery was for another provider that used the Kinvara facilities. Although the clean utility room had a digital key-pad lock, the medicines were still accessible to persons entering the room and were still not locked away when we returned to check the following day.

We saw 10% glucose intravenous solution for the emergency resuscitation trolley was recorded as 'missing' in January, February and March 2022 and not replaced until April 2022. We brought this to the attention of a manager at the time and were told there had been problems with supplies. However, this was not recorded as an action on the records of checks.

Staff did not record ambient room temperatures consistently, where medicines were stored, in accordance with the provider's policy. For example, there were no checks recorded in January 2022, 3 checks recorded in March, 4 in April and no checks recorded in May. However, there were no gaps during August and September 2022, up to the date of our inspection. This meant the provider was not assured all medicines, were stored in accordance with manufacturer's instructions.

Refrigerated medicines were stored in theatres. No fridge temperature records were available for September, however, the records for previous months were mostly completed.

We saw controlled drugs (CDs) were stored securely and the CD register was mostly completed correctly. The exception was that errors were not corrected in accordance with policy. Local audit data we reviewed also identified this.

Surgery

Medicines were supplied by external providers, in accordance with formal service level agreements. Managers we spoke with explained these arrangements were under review.

Managers we spoke with explained the RMO reviewed (reconciled) patients' medicines on admission and provided specific advice to patients and carers about their medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers ensured that actions from patient safety alerts were implemented and monitored.

The adverse incident reporting policy was overdue review.

Staff we spoke with knew what incidents to report and how to report them. They gave specific examples of incidents and near misses they had reported, in line with the service's policy. There were no serious patient harm incidents reported in the last 12 months to the date of our inspection; incidents were mostly regarding administration errors. Learning was shared via a staff newsletter.

The provider also reported serious incidents attributed to third party providers (these were not Kinvara Private Hospital incidents) and applied the learning to improve safety at the service.

However, we found two incident forms completed 5 September 2022 and submitted 15 days previously, were not entered onto the electronic system. We brought this to the manager's attention, and they ensured the forms were processed immediately. The provider did not routinely monitor incident reporting timescales against policy.

Staff understood the duty of candour. However, we saw the Duty of Candour policy was not specific and relevant to the services provided.

After our inspection, the provider sent us another version of this policy dated 2021. However, the document was not relevant and specific to the services provided. For example, it directed staff to input information onto an electronic risk management system Kinvara private hospital did not use.

There was a system in place which ensured actions from patient safety alerts were implemented and monitored.

Are Surgery effective?

Evidence-based care and treatment

The service did not provide care and treatment based on national guidance and evidence-based practice. Managers did not check to make sure staff followed guidance.

Staff did not follow up-to-date policies to plan and deliver high quality care according to best practice and national guidance. For example, of 67 policies we reviewed on site, 54 had exceeded the review date. This meant we were concerned staff did not have access to policies that reflected current best practice, national guidance and local arrangements.

Surgery

The Registered Manager was aware and acknowledged many policies required to be made specific and relevant to the services provided. They explained senior leaders had commenced a programme of policy review and told us they expected this work to be completed by the end of December 2022.

Managers and staff we spoke with told us there was a full audit plan for the year, to check that staff followed policies and guidance. However, we saw the plan, was not specific and relevant to the services provided. For example, it was dated 2019 and included audits recorded as completed for services the hospital did not provide, such as cancer services, endoscopy JAG accreditation compliance and diagnostic imaging.

Managers explained audit results were presented to staff at departmental meetings. However, we saw clinical performance information displayed on a notice board on the ward corridor dated 3rd quarter 2021 and was significantly out of date. Staff we spoke with were unable to articulate results of recent audit activities or changes made as the result of recent audit.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. A choice of ready-meals, including for example, vegetarian, vegan, and gluten-free options was offered to patients and these were reheated in the ward kitchen.

The hospital was rated 5 for food hygiene compliance.

Mealtimes were specified but flexible according to patient needs.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Patients waiting to have surgery were not left nil by mouth for long periods. Staff we spoke with explained patients were fasted for 6 hours prior to surgery and could drink clear fluids up to 2 hours prior to surgery.

All patients we spoke with were satisfied with the quality of food and drinks provided.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patients we spoke with told us they received pain relief soon after requesting it.

Patient outcomes

Staff did not consistently monitor the effectiveness of care and treatment.

The service participated in relevant national clinical audits. For example, they submitted data to the National Joint Registry (NJR) and NHS digital Breast and Cosmetic Implant Registry.

Surgery

We reviewed the latest available data from the NJR for the period 1 April 2020 to 31 March 2021. This showed better than expected compliance with submission data within 30 days of surgery.

However, the provider scored 42.9% (national average 92%), for obtaining patient consent to NJR processing their personal data. For every operation, hospitals must give patients the opportunity to have their personal details stored alongside their operation information. This allows the NJR to measure how long implants last as well as monitoring other areas of surgical performance. A low figure tends to indicate process issues at the hospital rather than patients declining to give consent.

In terms of mortality and revision surgery, the hospital performance was within the national average, (as expected).

The provider did not collect Patient Reported Outcomes Measures (PROMs) programme data, which measures patient improvement following surgery. The Registered Manager told us they would consider collecting this data in future.

The provider submitted data to the private healthcare information network (PHIN). This included information on unplanned transfers, unplanned returns to theatre, unplanned readmissions within 31 days, infections rates, mortalities, patient satisfaction and the number of patients seen. PHIN ensures robust information is received about private healthcare to improve quality data and transparency. The hospital was not an outlier.

Competent staff

The service did not make sure all staff were competent for their roles. Managers completed appraisals for most substantive staff to provide support and development. They did not appraise bank staff's work performance, although the bank supplied the core of the workforce.

Managers gave all new substantive staff a full induction tailored to their role before they started work.

New starters were expected to complete a competency programme during probation, and we saw blank example templates for theatre healthcare assistants, theatre practitioners, recovery staff and anaesthetic practitioners. However, they were not all specific and relevant to the services provided. For example, the competencies for anaesthetic practitioners included children in the anaesthetic room. However, the service did not treat children.

Bank staff received an induction booklet prior to commencing work and there was a form in place to record agency staff induction.

There was an appraisal system in place to monitor and support substantive staff's performance. Overall compliance was at 73.7% against the provider's target of 100%.

However, there was no appraisal system in place for bank staff, who were most of the nursing and theatre workforce. Managers we spoke with explained monitoring of bank staff performance was through informal discussions and was not documented.

This meant we were unclear how the provider was assured all bank staff were competent in their roles, that poor performance was identified promptly, and that bank staff were supported to improve.

Managers we spoke with told us they supported substantive nursing staff through regular face-to-face meetings however, there was no formal programme of clinical supervision in place.

Surgery

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff worked across health care disciplines and with other agencies when required to care for patients. For example, if imaging services were required, the provider requested a radiographer from an agency or local NHS trust bank.

Seven-day services

Key services were not available seven days a week.

The hospital was operational on weekdays only. Consultants led daily ward rounds on the wards.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day.

Pharmacy supplies services were provided by service level agreement with another provider. The ward held a small stock of over labelled medicines for patients to take home if required out of hours, and these were dispensed and checked by ward staff and RMO.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles.

Staff assessed each patient's health as part of their pre-operative assessment and provided support for any individual needs to live a healthier lifestyle.

Staff provided procedure-specific information leaflets. This facilitated informed consent and enhanced patient recovery by providing better understanding of what to expect and their role in their own recovery. Patients we spoke with confirmed they received useful verbal and written information prior to admission.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The hospital consent policy described consent as a two-stage process.

Staff recorded consent in the patients' records. Patients we spoke with told us they were provided with sufficient verbal and written information, to enable them to give informed consent.

The provider did not routinely audit consent documentation against the consent policy; the records audit policy alluded to verbal consent to anaesthesia but did not capture the written consent process.

There was a mental capacity act and deprivation of liberties policy in place.

Surgery

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. For example, the provider had a procedure in place to support surgeons in their assessment of patients and identification of when a referral to psychological service was required, for patients that request cosmetic surgery. This was in accordance with NICE guidance.

Staff we spoke with explained patients were individually risk assessed against specified admission criteria and the hospital rarely had patients subject to Deprivation of Liberties Orders (DoLS).

Are Surgery caring?

Inspected but not rated 

Compassionate care

Staff treated patients with compassion and kindness, and took account of their individual needs.

Patients we spoke with told us staff were discreet and responsive and said they were treated well and with kindness. For example, they said “staff couldn’t do enough,” “staff are incredible” and “nothing is too much trouble”. We also observed positive feedback from patients in thank you cards displayed.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Visiting times were between 6pm and 8pm but could be flexible according to patient wishes.

Staff we spoke with explained restrictions were in place during COVID-19, and visitors were subject to risk assessment if patients required emotional support of a named relative.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. For example, we saw patient feedback questionnaire data for May and June 2022 and testimonial feedback on the website showed consistently high patient satisfaction results.

Staff involved patients in decisions about their care and treatment. For example, patients we spoke with told us they felt fully informed about their treatment plans and arrangements for discharge.

Staff we spoke with gave us examples of how they used patient feedback to improve daily practice. For example, they increased vegetarian and vegan meal choices and were installing a new roadside sign to make locating the premises easier for patients and visitors.

Surgery

Are Surgery responsive?

Good 

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population.

The provider promoted a positive working relationship with other health providers in the area. For example, a range of services were available for NHS patients where commissioners had identified capacity shortfalls.

Facilities and premises were appropriate for the services being delivered.

The hospital car park provided free parking spaces.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

There was an equality, diversity and inclusion policy.

Staff we spoke with told us how they made adjustments for patients who were particularly anxious due to phobias. For example, they ensured patients were given extra appointment time and put first on the theatre list to minimise distress.

Staff gave examples of how they supported patients living with learning disabilities by ensuring their carer was present to meet them from theatre after surgery.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Pre-assessment staff identified individual needs such as hearing, sight or language difficulties or disabilities. Translation services were available by prior arrangement, for patients where English was not their first language, and the contact number was displayed on the wards.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Wards and departments were accessible for patients with limited mobility and people who used a wheelchair. Toilet facilities were available throughout the hospital for patients, carers and relatives including those living with a disability.

Patients were provided with printed information regarding risks and benefits of surgery and could review this before their procedure.

Access and flow

People could access the service when they needed it and received the right care promptly.

Surgery

The hospital was operational Monday to Friday 7.30am to 5pm for day cases and until 8pm for afternoon day cases. The hospital remained operational overnight if accommodating inpatients. Overnight occupancy was usually fewer than 8 patients.

Cancellation rates for non-clinical reasons such as list over-running, equipment issues or short notice consultant sickness, were low. For example, data we reviewed for the period February to August 2022 showed 1.6% of patients were cancelled on their day of surgery. Cancelled patients were rebooked as soon as possible.

Managers and staff worked to make sure patients did not stay longer than they needed to.

Managers and staff worked to make sure that they started discharge planning as early as possible, at preassessment. Staff we spoke with explained medicines to take home were prescribed and dispensed from the ward to facilitate prompt discharge.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service investigated them and shared lessons learned with all staff.

The service clearly displayed information in patient areas, about how to raise a concern. For example, directly with managers, by telephone to the patient co-ordination team, by email or formal letter to the Hospital Director.

The provider subscribed to an independent complaints advocacy service to help resolve any disputes raised by self-pay and privately insured patients. NHS patients were signposted to the Parliamentary and Health Service Ombudsman (PHSO).

Patients we spoke with told us they knew how to complain or raise concerns.

Staff we spoke with understood the policy on complaints and knew how to handle them. However, the complaints policy was overdue review and was being rewritten.

After our inspection, the provider sent us a policy titled Complaints, which had no issue date, but approval date was 10 September 2021. However, the document was incomplete. For example, the legislation and associated documents sections of the policy were marked as 'TBC' ('to be confirmed').

The service received few complaints. Managers investigated complaints and identified themes. For example, governance meeting minutes for April 2022 reported the main themes of complaints to be medical care and satisfaction with outcome, and cosmetic appearance.

Managers responded promptly to complaints. However, the complaint response letters we reviewed appeared dismissive. For example, they stated comments were passed to the patient's named consultants but did not describe the outcome. They did not offer patients the opportunity to discuss their concerns face to face and did not signpost them to the next stage should they remain dissatisfied with the response.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice. For example, the provider introduced a wider choice of meals as a result of the 'you said – we did' initiative.

Surgery

Are Surgery well-led?

Inadequate 

Leadership

Leaders had the skills and abilities to run the service, however, senior leaders were recently appointed, and the leadership team was not embedded. They did not fully understand and manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The Registered Manager registered with CQC in 2019. They were an owner of the parent company, The Karri Clinic and held practising privileges at both Kinvara Private Hospital Ltd and The Karri Clinic. The Registered Manager explained they split their time (2-3 days per week) equally between both locations although the Karri Clinic was not operational at the time of our inspection.

The hospital was led by a recently appointed Interim Hospital Director with extensive hospitals management experience. They were present on site 3 days a week.

They were supported by the Head of Clinical Services, a newly appointed Operations Manager, and the Medical Director, who was a clinician with practising privileges and was also recently appointed MAC Chair. The Hospital Director and Medical Director reported directly to the Board (owners) who were the Chief Executive Officer and the Registered Manager.

However, the leadership structure shown in the governance policy and displayed in clinical areas for staff to see, was unclear and was not specific and relevant to the services provided. For example, it showed, the Executive Director/Registered Manager reporting directly to the Board, which meant the Registered Manager reported directly to self. There was no Executive Director role in the present senior leadership team and the Hospital Director role was not shown on the organogram. The Head of Clinical Services was shown as a direct report to the Executive Director/Registered Manager, however, they clarified they reported to the Hospital Director. The document also showed a Hospital Co-ordinator (this role did not exist) reporting directly to the Registered Manager, and the Operations Manager role was not shown on the organogram.

The governance structure shown on the same document also alluded to an Executive Director, but this role was not apparent in the current senior leadership team.

Leaders had not identified, prioritised and managed all of the risks associated with the lack of effective governance processes throughout the service.

Vision and Strategy

The service did not have a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

The governance policy we viewed during our visit stated the board, (owners) set the strategy for the service and managers we spoke with described aspirational ideas to grow the business.

However, the Registered Manager confirmed there was no formalised vision and strategy for what the provider wanted to achieve and no workable plans to turn it into action.

Surgery

Culture

Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work.

Staff and clinicians we spoke with told us they were proud of the organisation as a place to work and spoke highly of the teamwork.

Mandatory training compliance for equality, diversity and human rights training was 63%. However, 68% of bank staff were overdue or had not provided evidence of training.

There was a whistleblowing policy, which was overdue review. After our inspection, the provider sent us another version with issue date 30 March 2022 and approved 30 March 2022. However, the document was not relevant and specific to the services provided. For example, it alluded to 'Monitor'; a body that was merged with the NHS Trust Development Authority to form NHS Improvement on 1 April 2016. This meant information in the policy was not accurate.

Staff were encouraged to speak up and raise concerns directly with their managers or to the named freedom to speak up guardian.

There was an abusive behaviour policy, which was overdue review in March 2022.

After our inspection, the provider sent us a policy titled, prevention of violence and aggression, which was in date. However, the document was not relevant and specific to the services provided. For example, it alluded to job titles not used at Kinvara and described the service as a 'trust', which was incorrect".

Patients we spoke with told us they felt confident and comfortable to raise any concerns with staff.

Governance

Leaders did not operate effective governance processes, throughout the service. They did not have regular opportunities to meet, discuss and learn from the performance of the service.

Governance was not proactively reviewed using a board to ward framework which reflected best practice.

There was no system in place for management and timely update of all policies.

There was no schedule of robust internal audit in place, to monitor compliance against policy.

In addition, the statement of purpose which described the services of the provider, was out of date and under review.

Managers we spoke with described governance as requiring 'a reset'; the governance and quality policy and framework were under review and new terms of reference for the governance committee were to be formally agreed.

We were concerned the process to manage consultant practising privileges was not robust and some consultants may be practising without formal Medical Advisory Committee (MAC) approval.

For example, the policy in place for management of consultant practising privileges was due for review in 2018 and not specific and relevant to the services provided.

Surgery

The Registered Manager told us the MAC advised the Hospital Director regarding eligibility for practising privileges, their continuation, withdrawal, suspension or restriction.

The consultant's handbook stated the MAC reviewed all applications and renewal requests biennially. At the time of inspection, the provider's tracker document showed there were 99 consultants with active practising privileges and 2 were revoked. Consultants with practising privileges for cosmetic surgery were on the GMC specialist register.

However, data provided showed 23 named active consultants were overdue review of practising privileges. Four of these were recorded as having expired GMC registration and 3 consultants had no date of when practising privileges were signed as granted. Minutes of MAC meetings we saw did not evidence review of any named consultant's practising privileges.

Files we reviewed for 3 consultants with most activity at the service were incomplete. Documents required to be submitted prior to approval included General Medical Council (GMC) registration, references, appraisals, indemnity insurance, and disclosure and barring service checks. However, in the files we reviewed, there was no evidence of appraisals or references, no up to date indemnity documents and practising privileges were not signed as approved by the 2 authorised signatories; the MAC Chair and Registered Manager.

The Registered Manager also shared concerns the current administration process did not identify consultants that were insufficiently indemnified and told us they were personally reviewing all consultant's indemnity insurance cover.

The Hospital Director and MAC Chair who were expected to oversee consultant practising privileges, reported directly to the Registered Manager, who was also an owner of the business. We saw the Registered Manager had approved their own practicing privileges 2 years previously. However, there was no second approval signature on the documentation. When we asked the Registered Manager about this, we were told the practising privileges process was 'abbreviated as a temporary measure, during the COVID-19 pandemic.'

The Registered Manager acknowledged there may be a conflict of interest and explained any concerns about their personal practise would be raised internally via the grievance procedure. However, they did not provide assurance about how this conflict of interest was being suitably and sufficiently managed.

The governance and quality policy we saw during our visit stated a minimum requirement of 10 governance meetings a year. However, this was not achieved; the last recorded governance meetings were April, July and August 2022 and the minutes we reviewed lacked detail.

MAC meetings were planned to be held 4 times a year. However, this was not achieved; the last recorded MAC meeting was April 2022 and the minutes we reviewed, lacked detail.

The Chair of the MAC told us they met weekly with the Hospital Director. These meetings included for example, review of serious complaints, clinical incidents and the provision of potential new services. However, they were not formally recorded.

Meetings between the MAC Chair and Registered Manager had not resumed since September 2021.

Team meetings on the ward and theatres were sporadic and did not follow a formal agenda, to ensure consistency. The minutes we reviewed did not demonstrate that governance information was shared. For example, incidents, complaints, new policies, safety briefings and risks.

Surgery

This meant we were not assured managers and staff had regular opportunities to meet, discuss governance and learn from the performance of the service.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not identify and escalate all relevant risks and issues and identify actions to reduce their impact. They did not have plans to cope with unexpected events.

The hospital risk management and major incident policies were overdue review.

After our inspection, the provider sent us a policy titled Risk Management, which was in date. They also sent an Incidents policy. This had no issue date but approval date was 22 April 2022.

However, the document was not relevant and specific to the services provided. For example, it alluded to other healthcare regulatory bodies, Healthcare Improvement Scotland and Health Inspectorate Wales, which did not regulate Kinvara. The policy also referenced 2015 legislation which was revised in 2018. This meant information in the policy was not relevant and specific to the services provided. There was no reference to approval of this policy in the Clinical Governance meeting minutes we requested for the last 3 meetings, which were held prior to and after the approval date.

There was no approved business continuity plan in place. For example, we saw a plan which was in first draft, incomplete and not specific and relevant to the services provided.

There was a risk register in place. However, we identified areas of significant risk that were not on the risk register. For example, risk associated with under- indemnified consultants, lack of a business continuity plan, lack of robust governance systems and processes, and lack of oversight of bank staff performance.

This meant we were not assured all identified risks affecting the service in line with policy, were escalated to the risk register.

Information Management

The service collected data and analysed it. Staff could not always find the data they needed, in easily accessible formats. The information systems were mostly secure. Data or notifications were submitted to external organisations as required

There was an information management policy.

We saw the provider was registered with the Information Commissioner's office (ICO) from 2018 until May 2023. However, the certificate on display in reception expired in May 2022.

Staff compliance with information governance training was 84% staff. However, 60% of bank staff were overdue or had not provided evidence of training.

Important information such as policies and minutes of meetings were held on paper and electronic formats. However, out of date paper policy documents were not replaced promptly, and clinical governance meeting minutes provided following our data request, identified electronic copies of some of the older policies could not be found on the network drive. This meant we were concerned staff may not always have access to the most up to date information and guidance.

Surgery

Patient health care records and medicine prescription charts were on paper, which were scanned on to an electronic system following discharge. The paper records were then archived alphabetically in a locked room. The Registered Manager told us these would be kept on site for a minimum 6 years.

We observed good adherence to the principles of information governance. For example, in reception and administration areas, computer screens were password protected and closed when unattended.

We observed closed circuit television (CCTV) was operational continuously and there was signage warning of the use of recording equipment. The reception camera system also had audio recording facility. The system recorded to a server in the plant room and data was over-written every 45 days.

There was a CCTV policy which showed on a plan where the cameras were located. Most were situated externally, in reception and clinical corridors. However, cameras also appeared to be in the theatre staff rest room and anaesthetic room. Although access to the CCTV data was restricted to the Chief Executive Officer and Registered Manager (the owners), images were remotely viewable externally, via an application. There was a risk that patient and staff privacy and dignity may be compromised.

Discharge letters and communications to GPs were sent by consultant's secretaries by post or electronically.

Engagement

Leaders and staff actively and openly engaged with patients, staff, and local organisations to plan and manage services.

The hospital's website provided a wide range of information about the clinical services available.

Staff we spoke with told us managers engaged with them and were very supportive.

Managers were visible in the departments, which provided patients and visitors with opportunity to express their views and opinions face to face.

Managers used the morning comm- cell meetings to share information and discuss the day's business.

Staff received a newsletter which contained, for example, business news, staff service recognition (employee of the month), mental health awareness information, learning from the staff survey, and policy awareness.

The provider also promoted staff wellbeing and the hospital had a mental health first aider, to provide support and guidance to colleagues.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

The service provided examples of innovative practice to improve service and experience. For example, they introduced a small stock of over labelled medicines for patients to take home. This meant they did not have to obtain medicines via a private prescription; they were able to access pain relief medicines more conveniently and this improved patient's discharge experience.

Surgery

Managers introduced pre-operative health screening questionnaires for patients to complete prior to admission. This enabled them to be involved in their own pre assessment process and informed clinical risk assessment.

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

Treatment of disease, disorder or injury
Surgical procedures
Diagnostic and screening procedures

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

- The provider did not ensure all staff, including but not limited to bank staff, receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out their duties. **(Regulation 18(1)(2)(a)).**

Regulated activity

Treatment of disease, disorder or injury
Surgical procedures
Diagnostic and screening procedures

Regulation

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

- The provider did not ensure all premises and equipment used by the service provider for providing care and treatment, are safe, clean and properly maintained, and that this is recorded appropriately. **(Regulations 12(1)(2)(e)(h) and 15(1)(a)(c)).**
- The provider did not ensure there is a system in place to ensure service users do not receive expired items and expired medicines. **(Regulation 12(2)(g)).**
- The provider did not ensure the proper and safe prescribing, storage and management of medicines. **(Regulation 12(1)(2g)).**

Regulated activity

Treatment of disease, disorder or injury
Surgical procedures
Diagnostic and screening procedures

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

- The provider did not assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities. **(Regulation 17(2)(a)).**

This section is primarily information for the provider

Requirement notices

- The provider did not assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. **(Regulation 17 (1)(2)(b)).**
- The provider did not ensure all identified risks affecting the service in line with local policy are escalated to the risk register. **(Regulation 17(1)(2)(b)).**
- The provider did not ensure all policies and procedures are specific, relevant to the service and reviewed in accordance with review dates. **(Regulation 17(1)(2)(d)).**
- The provider did not ensure there is an effective system in place for the management of practising privileges. **(Regulation 17 (1)(2)(b)).**
- The provider did not ensure systems and processes are in place to ensure staff are suitably qualified, competent, skilled and experienced. **(Regulation 17(1)(2)(d)).**
- The provider did not implement effective systems and processes to ensure all staff are compliant with mandatory training, including but not limited to, safeguarding vulnerable adults and children, to a level appropriate for their role. **(Regulation 17(1)(2)(a)(b)).**
- The provider did not develop a clear vision for what it wants to achieve and a clear strategy to turn it into action. **((Regulations 17(1)(2)(d)).**

Regulated activity

Treatment of disease, disorder or injury
Surgical procedures
Diagnostic and screening procedures

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

- The provider did not assess the use of CCTV in all patient accessible areas to ensure its use does not unnecessarily compromise patients' privacy and dignity. **(Regulation 10(1)).**

Regulated activity

Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Surgical procedures

Diagnostic and screening procedures

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

- The provider did not ensure all premises and equipment used by the service provider for providing care and treatment, are safe, clean and properly maintained, and that this is recorded appropriately. **(Regulations 12(1)(2)(e)(h)) and 15(1)(a)(c)).**
- The provider did not ensure that all furnishings, including but not limited to fabric curtains, are suitable for the purpose for which they are being used. **(Regulation 15(1)(c)).**