# Weston Surgical Centre

## Quality Report

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

## Overall summary

We found the following areas of good practice:

- We saw that when an incident was identified, the service conducted investigations to learn and improve. Outcomes from the investigation was discussed and shared at staff meetings.
- We saw that clinical risks to patients were assessed and that staff acted appropriately when risks were identified.
- The most recent results of an annual audit conducted showed that the centres rates of complications including infections were lower than other hospital providers it compared with.
- We saw that the service followed recommendations outlined in National Institute of Health and Care Excellence (NICE) guidelines for sedation.
- We spoke with parents who told us they had felt reassured by the information provided by staff, were all positive about their experience of the service and told us that there had been no concerns.
- Staff gave examples of improvements to the service as a result of patient feedback.
- There was a positive open working culture. We saw that there were staff meetings held every clinic day to debrief and discuss any concerns or good practice.

However, we also found the following issues that the service provider needs to improve:

- We saw that there was no clear and effective governance framework to ensure that the service was running safely and delivering high quality care.
- We saw that there was no risk register in place to record and monitor potential or actual risks of the service.
- We found concerns over the supply, ordering, prescribing and disposal of controlled drugs.
- We saw that controlled drugs were stored and used at the centre but that staff were not documenting the use of them in accordance with up to date legislation.
- We saw that not all records of patient care was documented.
- We saw that staff mandatory training completion was unclear due to the lack of clear documentation and that the service policy was overdue for review.
- During the inspection we saw that some equipment was out of date and was stored with equipment that was fit for use.
- We had concerns over the security and suitability of the environment for treating young children.
- The service did not have standard operating procedures in place to ensure that the service was working to the most current and up to date recommendations.

# Summary of findings

- We saw that audits were conducted however these did not reflect concerns we had during the inspection and therefore did not provide assurance of the monitoring of quality and safety.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
| --- | --- | --- |
| Community health services for children, young people and families | | |

# Summary of findings

## Contents

# Weston Surgical Centre

**Services we looked at:**
Community health services for children, young people and families

# Summary of this inspection

## Background to Weston Surgical Centre

Weston Surgical Centre provides male circumcision surgery for predominantly religious purposes. It is a day care centre with a waiting and receiving area for patients operating theatre and recovery for day case surgery.

The service predominantly provides care and treatment to children under 18 years old as day patients, although adults can also access the service.

The service is part of the Children's Surgical Consortium Limited and registered with CQC in September 2012. The nominated individual of the Children's Surgical Consortium Limited and the registered manager of Weston Surgical Centre is Mr Shiban Ahmed. He has held these roles since the service was registered. The service is registered for diagnostic and screening procedures, surgical procedures and treatment of disease, disorder or injury.

The registered manager was also the operating surgeon. There was also one paediatric anaesthetist, one operating department practitioner, one health care assistant and two receptionists. All of the staff worked on an 'as available' basis. Staff only attended when patients were booked in for surgery and outpatient appointments.

The clinic was open according to the numbers of patients referred to the service and availability of staff. The registered manager informed us that this was usually one Saturday per calendar month.

Between April 2016 and March 2017 the service saw 309 patients overall as outpatient first attendances. A total of 295 patients were treated as day case discharges. Of these, 243 were children under the age of two years, 48 were young people aged 16 and 17 and four were adults aged between 18 and 74 years. There were six outpatient follow up appointments recorded.

The service was inspected in August 2013. At this time the service was found to be meeting the following standards: treating people with respect and involving them in their care, providing care, treatment and support that meets people's needs, caring for people safely and protecting them from harm, caring for people safely and protecting them from harm and staffing. However, it was found that the service was not meeting the requirement that people's personal records, including medical records should be accurate and kept safe and confidential.

## Our inspection team

The inspection was overseen by Debbie Widdowson, Inspection Manager. The inspection team comprised of two CQC inspectors.

## Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive community health services inspection programme.

## How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?

# Summary of this inspection

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

Before the inspection visit, we reviewed information that we held about the location and data provided by the service.

During the inspection visits on 9 and 11 September 2017, the inspection team:

- visited the centre and observed how staff were caring for patients.
- spoke with the registered manager.
- spoke with four other staff members; including consultant anaesthetist, operating department practitioner, nursing assistant and receptionist.
- spoke with the chairman of the Islamic centre who was also the chair of the commissioning body for the service and an elected councillor of the local council.
- looked at 18 care and treatment records of patients:
- carried out a specific check of the medication management.
- looked at a range of policies, procedures and other documents relating to the running of the service.

## What people who use the service say

During our inspection, we spoke with seven parents or carers of patients who were using the service and reviewed patient feedback about the service from 50 patient or their parents and carers.

Parents and carers were all positive about their experience of the service and told us that there had been no concerns. The patient feedback questionnaires we looked at supported this.

# Summary of this inspection

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

We always ask the following five questions of services.

### Are services safe?

We do not currently have a legal duty to rate this service, below is a summary of our findings:

We found the following issues that the service provider needs to improve:

- We saw that not all aspects of patient care were documented in records. This included dosage and times of medicines administered, pre-operative checks and times as well as telephone contacts prior to and following surgery.
- The theatre did not have a separate scrub room or a screen in place to ensure there could be no contamination from the sink area in theatre to the operating table.
- We did not see evidence that ventilation in theatre had been serviced.
- We saw that staff mandatory training completion was unclear due to the lack of clear documentation and that the service policy was overdue for review.
- We found concerns over the supply, ordering, prescribing and disposal of controlled drugs at Weston Surgical Centre
- During the inspection we saw that some equipment was out of date and was stored with equipment that was fit for use.
- We had concerns over the security and suitability of the environment for treating young children.
- We did not see evidence that all staff had completed safeguarding adults training.

However we also found the following areas of good practice:

- We saw that when an incident was identified the service conducted investigations to learn and improve. Staff discussed outcomes from investigations at staff meetings.
- We saw that risks to patients were assessed and that staff acted appropriately when risks were identified.

### Are services effective?

We do not currently have a legal duty to rate this service, below is a summary of our findings:

We found the following issues that the service provider needs to improve:

- The service did not have standard operating procedures in place to ensure that the service was working to the most current and up to date recommendations.

# Summary of this inspection

- We saw that in two out of 11 records the consent of both parents had not been documented. It is not a legal requirement to gain the consent of both parents however this was not in line with the consent policy of the service.

However we also found the following areas of good practice:

- The most recent results of an annual audit conducted showed that the centres rates of complications including infections were lower than other hospital providers it compared with.
- We saw that the service followed recommendations outlined in National Institute of Health and Care Excellence (NICE) guidelines for sedation.
- We saw that all necessary staff were involved in the assessment, planning and delivering care and treatment at the service.
- All staff working at the centre had completed an appraisal and a copy of this was held on site.

## Are services caring?

We do not currently have a legal duty to rate this service, below is a summary of our findings:

We found the following areas of good practice:

- We saw that families who attended the centre were given appropriate and timely support by the staff team.
- We spoke with parents who told us they had felt reassured by the information provided by staff, were all positive about their experience of the service and told us that there had been no concerns.
- We saw that 97% of participants in the service feedback survey said they were very satisfied or found the service exceptional across the range of questions asked.

However we also found the following issues that the service provider needs to improve:

- We saw that on some occasions patients were examined prior to theatre in the office area that was not fully screened from other families attending. This did not ensure that their privacy and dignity needs were always met.

## Are services responsive?

We do not currently have a legal duty to rate this service, below is a summary of our findings:

We found the following areas of good practice:

# Summary of this inspection

- We saw that the service considered the needs of patients in vulnerable circumstances and gave examples of how they adapted the service appropriately in these situations.
- We saw that consideration was given to meet the timing needs of patients surgery which could be affected by their religion or culture, preferences or risk.
- The registered manager of the service told us they had followed guidance to improve the service for a range of religious needs.
- Staff gave examples of improvements to the service as a result of patient feedback.

However we also found the following issues that the service provider needs to improve:

- We saw that staff did not monitor how long patients waited for surgery from the time they arrived at the centre.
- Staff told us that concerns raised by patients or their families verbally or informally were not documented.

## Are services well-led?

We do not currently have a legal duty to rate this service, below is a summary of our findings:

We found the following issues that the service provider needs to improve:

- We saw that there was no risk register in place to record and monitor potential or actual risks of the service
- We saw that there was no clear and effective governance framework to ensure that the service was running safely and delivering high quality care.
- We saw that audits were conducted however these did not highlight concerns we had during the inspection and therefore did not provide assurance of the monitoring of quality and safety.
- The service had no clear structure in place to ensure staff had an up to date Disclosure and Barring Service (DBS) certificate

However we also found the following areas of good practice:

- Staff told us the registered manager of the service was approachable and supportive.
- We saw that there were staff meetings held every clinic day to debrief and discuss any concerns or good practice.

# Community health services for children, young people and families

| | |
|---|---|
| Safe | |
| Effective | |
| Caring | |
| Responsive | |
| Well-led | |

## Are community health services for children, young people and families safe?

### Incident reporting, learning and improvement

- Never events are wholly preventable, where 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. Between April 2016 and March 2017, there had been no never events reported for this service.
- Staff we spoke with said they were aware of the policy in place for managing incidents.
- Staff informed us there were incident forms to complete if they were to witness anything that they would class as an incident. However, when we asked for an example of the form staff were unable to find any. They did say that if they had any concerns or were made aware of incidents they were always able to speak with the registered manager who provided support and dealt with these.
- In the reporting period there had been no serious injuries or deaths recorded and there had been one clinical incident recorded. Whilst on site the registered manager provided further information about this incident. We saw the incident had been appropriately investigated and categorised as being of no harm to the patient. This information was documented as part of the patient's records. Outcomes from the investigation was discussed and shared at staff meetings to learn and improve.
- We saw and staff told us that readmissions to theatre or cancellations of any kind were not recorded as incidents although were discussed during staff meetings. During the reporting period, there had been one unplanned return to theatre and this was not recorded as an incident.
- We saw that there was no formal log to collate incidents together and identify harm caused or trends.

### Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Between April 2016 and March 2017, there had been no cases where the duty of candour was required to be put into practice.
- The registered manager of the service told us they took responsibility for dealing with any incidents and if an error occurred they would be open and honest with those concerned. We saw evidence of a no harm incident where an apology had been provided and a meeting with the patient's family offered.

### Safeguarding

- In March 2014, the Royal College of Paediatrics and Child Health published the Safeguarding Children and Young People: roles and competence for health care staff, Intercollegiate Document. The document defines the level of child safeguarding training that is required for various staff groups. The providers policy stated that, in line with this document, all staff working in CYP services should receive children's safeguarding training as appropriate to their role as part of their mandatory training programme.
- We saw evidence that 100% of staff working for the service had received Level 2 safeguarding children training.
- The registered manager of the service had completed Level 3 safeguarding children training, acted as the safeguarding lead for the service and was on site at all times.

- Staff we spoke with were aware of issues that may require action with regards to safeguarding and gave examples of where they had acted on such concerns. Staff showed awareness of female genital mutilation and had completed training around this.
- Staff were unable to provide evidence that safeguarding adults training had been completed.

**Medicines**

- We found concerns over the supply, ordering, prescribing and disposal of controlled drugs at Weston Surgical Centre.
- The provider used two 'schedule two' controlled drugs, namely morphine and ketamine. The Misuse of Drugs Regulations 2001 requires those who store, administer and dispose of 'schedule two' controlled drugs to keep accurate records in relation to this for a minimum of two years. The provider had no records in relation to this. This posed a risk as we were not assured of the origin of the medication, or when it was used, how much was used and on which patients.
- The registered manager told us they had previously used a controlled drugs register; however, destroyed this in 2016 after deciding to no longer use morphine. We saw during our inspection that the morphine was still stored on site. The registered manager could not provide a reason why the medication had not been destroyed in accordance with Misuse of Drugs Regulations 2001, and did not understand the requirements to keep records for a minimum of two years.
- Staff told us they did not know ketamine was a 'schedule two' controlled drug following amendments in 2015 to the Misuse of Drugs Regulations 2001.and therefore had no records of the purchasing, administration or destruction of ketamine, as required under these regulations.
- On raising our concerns with the registered manager, they offered to dispose of the morphine into a sink so that it was no longer on site. This was not in line with the requirements of the Misuse of Drugs Regulations 2001 or Controlled Waste (England and Wales) Regulations 2012, which requires the destruction of controlled drugs to be witnessed by an authorised person, and a record of this kept. The registered manager then agreed to make immediate arrangements for the safe and appropriate disposal of the medication.
- Following the inspection, the registered manager provided CQC with evidence that the morphine had been taken to a pharmacy and disposed of within 24 hours of us raising our concerns. Additionally, the registered manager also provided evidence of the destruction of the existing stock of ketamine and the implementation of a controlled drug register that complied with regulations..
- We found the medical staff did not always record the doses of controlled drugs administered to patients during operations. We reviewed 11 records and found eight did not contain accurate information in relation to the prescribing and administration of controlled drugs. Medical staff documented the drug name; however, did not document the strength or dose of medication administered, or an accurate time or route of administration. This posed a risk to patients and we were not assured patients received the correct doses of medication or at what time. The registered manager provided evidence of improvements to the recording of medicines administered following the inspection.
- Senior staff told us they followed the latest National Institute of Health and Care Excellence (NICE) guidance for administering ketamine; however, the service did not have a standard operating procedure or policy in place to support this. The prescription charts used did not contain any reference to the latest guidance. Therefore, we were not assured that staff administered controlled drugs in line with the latest guidance.
- We found the storage of medication was good. Only registered healthcare professionals had access to the medication cupboard, and the service stored controlled drugs behind two locked doors.
- The service did not have standard operating procedures, risk assessments or policies in place to take account of the access, storage, risks or environment in which controlled drugs were kept, in line with the Misuse of Drugs (Safe Custody) Regulations 1973. We were not assured the provider had risk assessed the storage, access, risks and environment in which they stored all medication, controlled and non-controlled.

**Environment and equipment**

- We had concerns over the security and suitability of the environment for treating young children.

# Community health services for children, young people and families

- Weston Surgical Centre had limited security at the entrance to the building. We observed families entering the building and staff not being available to greet them. This posed a risk that unauthorised people could enter the building unchallenged.
- Children and young people had access to blinds with loose cords in the waiting room and recovery room. This posed a ligature risk to children and young people, the provider had not recognised this as a risk.
- Throughout the building, the majority of windows had safety catches to prevent them opening fully. However, we found two windows that did open fully. This posed a risk of injury to young children as they were accessible and children may be left unsupervised for periods within the waiting room.
- We found wall mounted radiators throughout the building, which were uncovered and accessible to patients, visitors and staff. The radiators were hot throughout the inspection, and this posed a risk of burns to patients, visitors and staff.
- We reviewed multiple pieces of equipment throughout the centre, including resuscitation, monitoring, single patient use and anaesthetic equipment. We found the portable suction, anaesthetic, defibrillator and monitoring equipment had been serviced within the last 12 months. The service had a contract with a local NHS trust to service all the medical equipment annually.
- We found out of date equipment within the theatre, recovery area and stored in the centre's office. We found out of date defibrillator pads for the automated external defibrillator (AED), emergency airways and bag-valve-mask (BVM), used to breathe for a patient in respiratory or cardiac arrest, within the recovery area. We found an out of date vile of sodium chloride and intravenous access equipment within the advanced life support boxes within theatre. These issues had not been rectified when we returned for the second day of the inspection.
- Within the office, the service stored multiple pieces of equipment, including equipment needing and following the autoclave process (which sterilises equipment between uses), intravenous fluids, airway management equipment and dressing packs. The equipment within the office was mixed 'in date' and 'out of date' equipment, was stored on a metal shelving unit that was rusting and had chemicals (including battery top up fluid and de-ionising agent) which were leaking onto the equipment below and the floor. Staff moved the inappropriate equipment by the second day of the inspection.
- Senior staff told us most of the equipment in the office was going to be sent overseas and was not to be used for clinical care. However, staff accepted that the storage arrangements and labelling of equipment that was 'not for use' was insufficient. Senior staff told us they would not use the advanced life support boxes within theatre in the event of a cardiac or respiratory arrest, as all required equipment was stored on the anaesthetic machine. Senior staff could not provide a reason why the equipment had not been removed; however, staff gave assurances that this would be removed.
- Senior staff told us that staff would not use the AED in the event of a cardiac arrest as the centre had a manual defibrillator, which is required to provide full advanced life support. Staff told us the out of date equipment should not be there, but could not provide a reason as to why it had not been removed. During the second day of inspection, we noted staff had not removed the AED and out of date BVM in the recovery room.
- The centre had appropriate hard flooring throughout and hand wash sinks in the toilet, recovery area and dirty utility room.
- The majority of surgical equipment was single patient use. Staff autoclaved one piece of equipment, which is a process of sterilising equipment ready for use on another patient. We saw records for the autoclave and suitable storage bags following sterilisation.
- Staff segregated waste within the centre, ensuring clinical, general and sharps were disposed of appropriately and safely. The service had a contract to remove sharps and clinical waste from the premises as and when required. However, we found no contract for the removal of general waste. Senior staff told us they take all non-clinical waste to the local household recycling centre for disposal after each clinic.
- The acquisition, storage and use of medical gases was good. We found all cylinders of oxygen and nitrous oxide (a gas used during the anaesthetic process) stored safely within the recovery room and theatre. All cylinders were in date and staff knew how to order replacement cylinders.

- We asked the service to provide evidence to show that the ventilation in the theatre had been serviced however this was not supplied and we could not be assured that there was adequate ventilation to ensure patients were safe from infection.

### Quality of records

- When the service was inspected in 2013 it was not meeting the requirement that people's personal records, including medical records should be accurate and kept safe and confidential. We saw that there were still issues with accurate record keeping during the inspection in 2017.
- The centre was self-contained and patient records all remained on site. During the reporting period, 100% of patients seen in outpatients had their relevant medical records available.
- We saw that records were stored securely in a locked filing cabinet.
- We saw that the start and finish times of surgery or induction were not documented, and not all pre-operative checks were fully signed for. Two out of 11 records had no anaesthetic medication documented.
- We saw that audits of the World Health Organisation (WHO) checklist were conducted annually. These audits were done from patient records. The results of the 2016-2017 audit showed 100% compliance.
- The registered manager of the service told us that 10 days after surgery all patients had a follow up telephone call. However, we saw and staff told us that these calls were not documented on patient records unless there were any specific issues and they were to return to the clinic.
- We also saw that staff did not record if letters given to patients to provide to their GP had been received and if not, when this was sent. Staff told us that if the surgery had not been straightforward, a copy of the letter sent to the GP would be kept with the patient record but standard letters were not.
- We saw that the service conducted a records audit in February 2017 where 10 patient records were reviewed against a set of 29 questions. The results showed that the time was not recorded on health records and that the senior lead present was not identified. Records we reviewed did show the time patients went to theatre and the senior lead present.

### Cleanliness, infection control and hygiene

- Between April 2016 and March 2017, there were no reported cases of Methicillin-resistant Staphylococcus Aureus (MRSA), Methicillin-sensitive Staphylococcus aureus (MSSA), Clostridium difficile (C. difficile) and E.Coli.
- During the inspection, all staff were arms bare below the elbows at all times.
- We saw that all visitors entering theatre were provided with suitable protective clothing and appropriate shoes.
- We saw hand sanitiser available for use throughout the premises and we saw staff using this appropriately.
- We saw staff used suitable personal protective equipment including gloves and washed their hands prior to and following examination of patients.
- The sinks in the recovery room and theatre had non-touch taps which met the department of health Health Building Note 00-09: infection control in the built environment standards.
- Staff told us that all toys were cleaned every day and we saw that they seemed clean. However, there was no log to evidence this.
- Staff told us that the entire premises was cleaned weekly including theatre. Staff told us that on each clinic day prior to use they cleaned the theatre again. We saw that all areas were visibly clean however there was no log to evidence each time the areas were cleaned.
- Staff reviewed patients and undertook physical examinations prior to surgery on a sofa in the office. The sofa, although wipe clean, was covered in a blanket and had cushions on it which were not wipe clean. We did not see evidence to show that the service routinely cleaned the blankets and cushions. This posed a risk of cross infection due to the inability to sufficiently clean the covers on the sofa.
- We saw that there was no separate scrub room or area for staff to prepare for surgery. There was also no screen or equipment in place to ensure that spray from the sink did not contaminate the surgical area. Sterile and non-sterile equipment, for use during the surgery, was kept close to the sink. This posed a risk of staff inadvertently contaminating sterile equipment whilst washing their hands.

### Mandatory training

- The provider had a policy in place that outlined the requirements for staff to complete mandatory training

and for appraisals to review training needs. Training and appraisals were completed with the staff member's main employer. We saw that this policy was due for review in 2015 but had not been updated.

- We saw that staff had copies of key training certificates in the staff file at the centre. However, not all mandatory training certificates were available and some staff members had copies of these that were not included in the staff file. There was no clear database or log to demonstrate the completion of training overall by those working at the centre.

**Assessing and responding to patient risk**

- The provider had a resuscitation policy in place that outlined the protocol for staff to follow in the event of a medical emergency at the centre. Staff we spoke with were aware of their role and actions to take.
- There was a standard operating procedure in place for transfer of patients to the local hospital in the event of an emergency.
- We saw that there was always at least one advanced paediatric life support trained staff member at the centre and also one staff member with advanced airway support training.
- A consultant paediatric surgeon was always at the centre when patients attended.
- We saw that patients were recovered in theatre and were not transferred to the recovery/ward area until they could manage their own airway. A nursing assistant remained with the patient once transferred and theatre staff remained available until the discharge process took place. Staff waited for the discharge process to be complete before the next patient went into theatre.
- We saw that information was provided to patients about fasting prior to surgery and the importance of this. We saw that this was checked when patients attended and if the guidelines had not been adhered to the surgery was cancelled and patients were rebooked.
- Staff told us that if a patient presented with additional medical needs the consultant surgeon would speak with the patient's specialist to ensure that the child was fit for surgery and if any specific risks required consideration.
- We saw that staff used the World Health Organisation (WHO) 'five steps to safer surgery' checklist to ensure required pre and post-operative safety checks were undertaken. We reviewed 10 records and saw from these that staff checked the correct patient was present and that consent had been obtained. We also saw that there was verbal confirmation of the procedure checked with parents present.
- We found staff did document allergies on the initial assessment and staff checked these with patients or their next of kin (for example a parent) before commencing the operation.
- As the team in place worked throughout the surgery session there were no handovers for staff required.

**Staffing**

- At the time of the inspection there was one consultant surgeon (who was also the registered manager of the service).
- The service had a team in place that met the Royal College of Anaesthetists (RCoA) recommendations for the provision of paediatric anaesthesia services.
- The team on clinic days comprised of one paediatric anaesthetist, one operating department practitioner, one nursing assistant and one receptionist, in addition to the consultant surgeon.
- All of the staff volunteered at the centre and worked on an 'as available' basis.
- The centre planned surgery based upon the needs of the patients and therefore staff only attended when patients were booked in for surgery and outpatient appointments. The service had a bank of staff to make up the team. The staff available comprised of one paediatric anaesthetist, one operating department practitioner, one health care assistant and two receptionists in addition to the consultant surgeon.

**Managing anticipated risks**

- The registered manager of the service would accept referrals to the service and organise confirmation when there was a team in place to cover the clinic. We saw that surgery was only conducted when adequate staffing levels were in place and if there were any changes to this, the clinic would be cancelled.

# Community health services for children, young people and families

## Are community health services for children, young people and families effective?
(for example, treatment is effective)

### Evidence based care and treatment

- We saw that the service followed the National Institute of Health and Care Excellence (NICE) protocol for sedation but we found that this was not formalised into a standard operating procedure or policy for staff to follow.
- We saw that there was a criteria for patients attending the centre for surgery to meet based upon the NICE guidelines for sedation in children. This included the patient to be minimum age of four weeks and over four kilograms in weight. We saw that if patients did not meet this criteria surgery was not booked.
- The service followed recommendations for fasting prior to surgery from NICE guidelines for sedation based upon the age of the patient.
- The service followed current best practice in the prescribing of pain relief to children and young people. For example, not prescribing or suggests the use of ibuprofen in children under one year old.
- The registered manager was not registered to receive updates from the Medicines and Healthcare Products Regulatory Agency (MHRA), which is the agency responsible for safety updates in relation to medicines and medical equipment. We were not assured that the provider was fully aware of the latest alerts and updates from MHRA. For example, the senior team were unaware of the change in status of ketamine in March 2016 when it was reclassified as a 'schedule two' controlled drug.

### Pain relief

- We saw that the service used paediatric pain score when patients were of an age appropriate to inform staff.
- We saw that the service gave advice about pain relief and, if necessary, prescribed this for patients.

### Patient outcomes

- In the reporting period (April 2016 to March 2017), there was one unplanned return to theatre.
- In the reporting period, there were no unplanned transfers of patients to other hospitals. Between April and August 2017, one patient had returned to theatre at another hospital. An investigation and follow up had taken place by the service.
- An annual audit was conducted that compared the rates of complications including infection for patients treated by the centre and compared with other hospital providers. The most recent data showed that between 2015 and 2017 the rate of complications for patients treated by the centre was 0.38% compared with the average 6.74% rate for the other hospital providers.

### Competent staff

- We saw that 100% of staff had completed an appraisal with their main employer during the reporting period and copies of these were held in the staff file at the centre.
- We saw that staff training needs were highlighted in appraisals (conducted at their main place of employment) of which copies were kept in a file at the centre.
- One staff member told us they had completed additional training, which had been supported and financed by the provider.
- All staff we spoke with told us if they required any support they were able to have a one to one session with the registered manager.
- After each clinic day a debrief session took place which gave staff an opportunity to reflect and for learning.

### Multi-disciplinary working and coordinated care pathways

- We saw that all necessary staff were involved in the assessment, planning and delivering care and treatment at the service.
- Staff told us that when necessary communication took place with specialists in other services and guidance sought as appropriate. The registered manager gave an example of a patient with a longstanding heart condition, where the provider sought advice from cardiologists before undertaking the procedure.

### Referral, transfer, discharge and transition

- Patients self-referred to the service by telephoning the registered manager and providing their information. A telephone appointment took place where the registered

manager took further details including medical history and gave information about the procedure. A letter followed with information and potential dates for the surgery to take place.
- When patients were discharged from the service, a letter was given to them to provide to their GP. The registered manager of the service contacted the GP to ensure that the letter had been received and if it had not been, would email a copy to them.
- The registered manager provided his mobile telephone number to all patients at the time of discharge with information.

**Access to information**

- Staff showed us how they accessed policies and procedures that were kept in a file at the centre.
- We saw that staff did not routinely record all telephone calls and contacts with patients which meant that all details of communications and information provided may not be up to date and accessible for all staff members.

**Consent**

- During our observations, we saw that all parents/carers were asked for their consent prior to any care or examinations conducted. We saw that consent was documented and that written consent was given prior to surgery.
- On occasions where both parents were unable to attend and provide consent, the registered manager would gain the other parent's consent over the telephone prior to attendance and the receptionist would follow this up on the day of surgery by telephoning, checking key details and then documenting consent in the patient record. In nine out of 11 records, we saw that two signatures were gained or a telephone discussion recorded. It is not a legal requirement to gain the consent of both parents.
- The 'Gillick Competency Assessment' helps clinicians to identify children aged 16 or under who have the legal capacity to consent to medical examination and treatment. Staff told us that they would assess whether young people were able to provide consent themselves and if so would gain their written consent. They told us that if a child or young person told them they did not want the procedure they would not conduct it with only the consent of the parents/carers.

## Are community health services for children, young people and families caring?

**Compassionate care**

- We spoke with seven parents or carers of patients attending the centre during the inspection. They were all positive about their experience of the service and told us that there had been no concerns. They told us they were happy they were able to have their children seen at this centre.
- One parent told us the team had "given a lot of information and have been very supportive".
- The service provided each family with a questionnaire to complete to ask how satisfied they were with different aspects of the service provided.
- We saw that where children or young people were able to, a child friendly questionnaire was used for them to complete themselves.
- The service provided us with 50 patient questionnaires completed in 2017. We saw that 96% of those who completed this said they would recommend the service to others.
- We saw that 97% of participants said they were very satisfied or found the service exceptional across the range of questions asked.
- We saw that staff interacted with patients and their families in a respectful and considerate manner.

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

- We saw that staff recognised when people using the service required additional support to help them understand the processes. The registered manager of the service spoke additional languages which was helpful for patients attending who could then discuss their needs in their first language.
- The registered manager of the service gave his mobile telephone number to each patient and we saw that he provided advice and reassurance over the telephone when patients or their parents or carers had concerns prior to or after surgery.

**Emotional support**

- We saw that families who attended the centre were given appropriate and timely support by the staff team.

# Community health services for children, young people and families

- We spoke with parents who told us they had felt reassured by the information provided by staff.
- Staff told us that they asked families to try to minimise the numbers of people attending with the patient; however, we saw that they were supportive when siblings and other family members also attended.

## Are community health services for children, young people and families responsive to people's needs?
(for example, to feedback?)

### Planning and delivering services which meet people's needs

- The service received referrals from patients directly and planned theatre lists based upon demand and confirmed patient numbers.
- The service communicated with GPs following patient procedures and sent them follow up information when required. The registered manager told us they did not usually receive any referrals for the service from GPs.
- We saw that there was no designated nappy changing area at the centre. Many of the patients who attended were infants and when this was required staff provided a changing mat and the nappy was changed in the office area.
- The service used a text service to remind patients or their parents or carers about their appointment and key information such as fasting requirements. Staff told us that although they had also telephoned patients and would do so when necessary; they found that the text service had the best response and that this met the needs of the community using the service.
- Staff told us and we saw that the team were understanding of the religious, personal and cultural needs of those attending the centre.
- We saw that at times patients were examined prior to theatre in the office area on a sofa that was next to the reception desk. Although staff closed the door, there was a window that other families could speak with the receptionist through. Also, the sofa could be seen from the car park through a window. Therefore, this did not always ensure the privacy and dignity of patients. Staff told us that if the patient was older than a baby they would always ensure examinations took place in the recovery area or theatre rather than in the office.

### Equality and diversity

- We saw that the service had an equality policy that outlined their commitment to be non-discriminatory to staff and patients. However, we saw that this policy had been due for review in 2015.
- We saw that staff working at the service were skilled in speaking a number of languages. This meant that when a patient attended whose first language was not English the staff could speak with them about the care and treatment directly. However, staff told us that when a patient attended who spoke a language that no staff members were skilled in there was no formal interpreting service used. The staff would ask a family member to interpret or used an individual recommended by local religious leaders over the telephone. This does not follow best practice and would not ensure that the information was received accurately or appropriately and also may not ensure confidentiality.
- There was a room in the office area that was available as a prayer room if patients or families required this.
- The registered manager of the service told us they had followed guidance to improve the service for a range of religious needs. For example, washing facilities were provided for patient, visitors and staff to use in the bathroom. This promoted the requirements of certain cultures and religions, who require water to clean after using the toilet.

### Meeting the needs of people in vulnerable circumstances

- Staff told us they had worked with looked after children and in these cases worked collaboratively with social services to ensure that the needs for appropriate consent and support were provided.
- Staff told us they had received referrals for patients whose mothers were living in a refuge that supported women experiencing domestic violence. The registered manager of the service told us they worked closely with social services in these cases to ensure they followed the appropriate protocols.
- We saw that the service provided care for patients with a learning disability. Staff told us they worked closely with parents or carers to gain information for how to best support them and the patient in these circumstances. A marker was put on the patient record to ensure that all staff were aware of the additional needs of the patient.

# Community health services for children, young people and families

### Access to the right care at the right time

- Due to varying religious needs, the registered manager of the service told us they tried to ensure that patients were able to access the service at the most appropriate time to meet their religious needs and also lower risks.
- The registered manager told us that due to the large numbers of referrals, they managed a waiting list and that patients would receive information to update them of the dates they were likely to have an appointment at the centre.
- The service did not record or monitor the length of time patients were waiting when they arrived at the centre to going into theatre.

### Learning from complaints and concerns

- Between April 2016 and March 2017, the service received no formal complaints.
- We saw there was a complaints policy in place that outlined the procedure for both verbal and written complaints received.
- We saw that although there were some good examples of where staff had listened to the concerns of patient or their families and learnt from these, there were no logs of these changes or records of the complaints raised. The registered manager told us they would record complaints that had been received as a written formal complaint. This did not adhere to the complaints policy that stated that complaints would be recorded on a complaints form even if received verbally.
- The registered manager of the service told us that after each clinic day, the patient feedback questionnaires were reviewed and if there were any specific issues raised, they would be looked into.
- Senior staff gave an example of one questionnaire stating that the family were dissatisfied with the cleanliness of the centre. The registered manager called all patients that had been treated that day to establish any themes or patterns to the concern. One family raised concerns about blood in the sink in theatre; however, staff discovered this was staining from the pink liquid soap that was in use. To avoid further complaints, the service changed the type of soap used.

## Are community health services for children, young people and families well-led?

### Leadership of this service

- The registered manager of the service was the consultant surgeon who treated all patients.
- As the registered manager was at the centre for every clinic, they were visible and approachable for all patients, their families and the staff working at the centre.
- We saw and staff told us that the manager encouraged appreciative, supportive relationships among staff.
- We saw that the registered manager of the service was an experienced consultant surgeon who demonstrated skills and knowledge of the surgical service.

### Service vision and strategy

- The service vision and values were not clearly set out; however, all staff members told us that they felt the service aimed to provide a reasonably priced, safe service that met the needs of religious communities.
- The registered manager told us that the service vision was to increase the staff team so that more clinics could take place and meet patient demand.
- Staff we spoke with were clear about their roles and what they were accountable for.

### Governance, risk management and quality measurement

- We did not see a clear and effective governance framework to support the delivery of care.
- We did not see evidence of a comprehensive assurance system as we found staff did not record incidents on a central log and staff did not formally record verbal concerns from patients and the public. This meant that we did not see evidence of monitoring of this information and action taken to improve performance.
- Although we saw that internal audits took place, we did not see evidence that these provided assurance of the safety and quality of the service. For example, the records audit did not highlight that times and dosages of medications were not documented appropriately. We did not see evidence that these audits were followed up.

- The service did not have a risk register in place to record the main concerns of the staff. They told us that staffing was a main concern due to the sustainability of the service if members of the team were unavailable or could no longer commit to attending clinics.
- The service had no clear structure in place to ensure staff had an up to date Disclosure and Barring Service (DBS) certificate. The registered manager told us that all staff worked at an NHS trust as well as Weston Surgical Centre, and continued employment within the NHS was taken as evidence of a suitable DBS certificate. As routine renewal of DBS checks is uncommon in the NHS, we were not assured the service had a robust system for ensuring staff were not barred from working with vulnerable groups, such as children. The service also did not require staff to submit previous DBS certificates at the commencement of employment at Weston Surgical Centre.
- We saw that there was a granting of practicing privileges policy that outlined the service commitments however this was due for review in 2015.

**Culture within this service**

- All staff we spoke with told us they felt respected and valued by the registered manager and their colleagues.
- The registered manager told us that if there were concerns about any staff member's behaviour or performance that was inconsistent with the values of the service then this would be addressed appropriately.
- We saw that the focus of all staff was on providing care that met the needs and experience of the people who used the service.
- All staff we spoke with demonstrated openness with patients and colleagues and we saw that this was encouraged.

**Public engagement**

- The service provided each patient or their parent or carer with a feedback questionnaire following their attendance at the centre. We saw that these were reviewed and improvements made as a result.
- The registered manager of the service had led some talks at local religious centres to provide information about the service and options for the local community.
- The service worked closely with key religious leaders who gave feedback and information about the changing needs of the local population.

**Staff engagement**

- Staff told us there was open communication between them and the registered manager of the service and that they felt comfortable to discuss improvements that could be made to the service.
- Staff told us the registered manager of the service was flexible to meet their needs when necessary and that they felt involved with the planning and delivery of services.

**Innovation, improvement and sustainability**

- The registered manager of the service told us that there were large numbers of referrals to the service This meant there were often not enough clinics to meet the demand of all of the patients that would choose to use the service. The service depended on voluntary staff members and so could only run when these staff members were available and willing to attend.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider MUST take to improve

- The provider must document the use of controlled drugs in an appropriate register and ensure that processes are in place to receive up to date information regarding medicines.
- The provider must ensure patient records are fully completed including the times and dosage of all medication administered.
- The provider must document the start and finish times of surgery and pre-operative checks fully in patient records.
- The provider must document patient contacts including telephone calls on patient records.
- The provider must remove or ensure the servicing is complete and documented for all out of date equipment.
- The provider must ensure that opening windows, uncovered radiators and ligature risks are adapted to ensure the safety of patients and their families.
- The provider must ensure that the ventilation in theatre is fit for use and maintained in accordance with current guidance.
- The provider must ensure that all out of date equipment is removed or serviced to prove it is fit for use.
- The provider must review all policies to ensure they are up to date and meet current needs of the service.
- The provider must review the governance framework of the service.
- The provider must ensure that all staff members records of mandatory training completion and competencies are recorded clearly and accurately.
- The provider must gain consent from both parents as appropriate, document this process and gain both signatures where possible.
- The provider must have a risk register in place to document the risks to the service, how these are mitigated and action to be taken.
- The provider must record all complaints and concerns raised as well as the action taken and outcome.

### Action the provider SHOULD take to improve

- The provider should review the sink area in theatre to ensure that the risks of infection for patients are minimised.
- The provider should record all incidents formally, document investigation and outcomes and collate in a manner to ensure trends are easily identified.
- The provider should review the security of the building and consider how risks to patients could be mitigated.
- The provider should ensure that all staff have completed safeguarding adults training.
- The provider should review the use of the office area for examination of patients and ensure that this is meeting infection control and privacy and dignity requirements.
- The provider should audit the waiting times of patients from their arrival at the clinic.
- The provider should use a formal interpreting service for patients who attend and their first language is not English or a language that staff members are skilled in.

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 |
|---|---|
| Surgical procedures | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>Administration of controlled drugs was not meeting current legislation and guidance. Regulation 12 (2) (g). |

| Regulated activity | Regulation |
|---|---|
| Surgical procedures | Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints<br><br>The service did not have a formal and accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. Regulation 16 (2). |

| Regulated activity | Regulation |
|---|---|
| Surgical procedures | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>The service did not have formal systems in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). Regulation 17 (2) (a).<br><br>The service did not have formal systems in place to 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 (2) (b). |

This section is primarily information for the provider

# Requirement notices

The service was not maintaining an accurate, complete and contemporaneous record in respect of each service user. Regulation 17 (2) (c).

The service was not maintaining securely records kept in relation to the persons employed in the carrying on of the regulated activity. Regulation 17 (2) (d) (i).

The service was not maintaining securely records kept in relation to the management of the regulated activity. Regulation 17 (2) (d) (ii).