Trent Cliffs Private Healthcare Limited

Meridian House

Inspection report

Meridian House
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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	Requires Improvement
Are services safe?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Meridian House is a private outpatient doctors' consultation and treatment centre, seeing patients via referral or self-referral on a private basis and via health insurance. The hospital provides a range of elective surgery treatments for NHS and other funded (insured and self-pay) adults in a range of surgery specialties.

At the time of the inspection, the service had a registered manager in post. The service comprised of 5 clinic rooms, a patient waiting area, 2 dedicated endoscopy rooms, an endoscopy preparation room and wait area. In addition, there was a surgical pre-assessment clinic, 2 operating theatres, 2 consent rooms, a 6 bedded dedicated recovery area and 10 individual en-suite room for overnight stays.

Following this inspection, we wrote to the registered manager to notify them of the serious concerns identified during the inspection. We invited them to send us an action plan, setting out how either they had already addressed each of the concerns identified above, or how they intend to address them immediately. We received a response in the form of an action plan.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires Improvement 	Our rating of services went down. We rated them as requires improvement. We rated it as required improvement because: • Mandatory training records were incomplete and did not evidence that all staff had the training to undertake their roles safely. • The service did not provide induction training for bank staff when they started working at the service. • Not all staff had undertaken safeguarding training in line with national guidance. • The service did not control infection risk well. • The service did not suitably assess the risk of performing surgery for high-risk patients. • Staff did not feel respected, supported, and valued. • The service did not have effective governance systems or have effective recruitment checks in place to grant staff practicing privileges. There were no systems in place to ensure persons employed had undergone safe recruitment procedures and employment checks. • The service put users at the risk of harm because staff did not always have the equipment they need to deliver safe care. However: • Staff followed systems and processes to prescribe and administer medicines safely. • Records were comprehensive and could be accessed easily by staff. • Staff treated patients with compassion and kindness, respected their privacy and dignity. • People could access the service when they needed it and did not have to wait too long for treatment.

Summary of findings

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Summary of this inspection

Background to Meridian House

We carried out this unannounced focused inspection because we received information raising concerns relating to patient safety and the quality of the services provided.

We inspected the safe and well-led key question for the service.

How we carried out this inspection

During the inspection visit, the inspection team:

- Inspected and rated the safe and well led key questions
- Visited the ward, operating theatres, recovery area and clinic rooms.
- Looked at the quality of the environment and observed how staff were caring for patients.
- Spoke with the registered manager and senior management team for the service.
- Spoke with other members of staff including all grades of medical, allied health professionals and nursing staff.
- Spoke with one patient who was using the service
- Reviewed 10 patient records and 3 staff files.

You can find further 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.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement

Requires Improvement

Surgery

Safe	Requires Improvement
Well-led	Requires Improvement

Is the service safe?

Requires Improvement

Mandatory training

The service had a mandatory training programme for staff. However, they did not make sure everyone completed it.

Mandatory training records were incomplete and did not evidence that all staff had the training to undertake their roles safely. Some staff members had expired training in modules such as adult resuscitation and blood transfusion.

It was unclear how the service received assurances and monitored the competencies of bank staff. The mandatory training tracker showed that evidence of training had been requested but not provided.

Bank staff told us that they did not receive induction training when they started working at the service.

Staff members listed as management on the mandatory training tracker also worked clinically, however there was no record to show they had completed any mandatory training. For example, one manager who was the chief nurse had no record of completing any training including basic life support and safeguarding.

Consultant staff attended mandatory training at their employing NHS trust, and this was monitored through appraisals.

We spoke with one healthcare assistant (HCA) who told us that they were an experienced HCA but not in surgery and they had received no training when they started the role.

Safeguarding

Not all staff had training on how to recognise and report abuse. However, staff were able to tell us how they would identify adults and children at risk of harm.

The service had 16 staff members employed working in roles including hospital manager, pharmacy technician and HR that were deemed to not require safeguarding training for adults or children. However, the safeguarding intercollegiate guidance states that all staff working in a healthcare setting clinical or non-clinical must be trained to a minimum of level one.

Staff we spoke to told us they would escalate any safeguarding concerns to their manager who would then take over responsibility. Staff we spoke with were able to identify adults and children at risk of harm.

Requires Improvement

Surgery

The service had 32 bank staff whose roles where operating department practitioner, registered nurse and HCA. Of these, only 12 had evidenced that they had undertaken safeguarding training for adults and children. One bank staff member had expired training. The evidence had been requested in March, but at the time of the inspection these had still not been received and there was no evidence of them being followed up.

Consultants completed safeguarding training at their employing NHS trust and a record of this was kept on their practising privileges file. We reviewed a sample of four consultant files, all of which had evidence that required safeguarding training had been completed.

Cleanliness, infection control and hygiene

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

The service had no dedicated cleaning staff. Admin and HCA staff were responsible for cleaning. We spoke with 3 staff who told us that the cleaning was very basic as staff have no time to do it. We raised this with the service, and we were told new cleaning staff had been recently employed.

The theatres had not been deep cleaned for three weeks prior to inspection.

We spoke with one scrub nurse who told us the theatres were not clean, when they requested cleaning a maintenance person was sent in normal clothes who came with a yard brush and only swept the theatre floor.

Staff told us theatre beds were washed down with damp cloths only which increased the risk of cross infection and does not follow IPC recommendations.

Two HCA's that were untrained as runners meant that sterile fields within theatres were broken.

Following the inspection, we sent a letter of intent highlighting the concerns relating to IPC. Evidence of compliance was shared in the form of an IPC audit, however this was not signed or dated so unclear when this was completed.

We spoke with one anaesthetist who told us that the cleaner had their contract terminated as they had dipped a urine sample at the request of an anaesthetist due to theatres running with a shortage of clinical staff.

Following the inspection, we issued the service with a letter of intent relating to infection prevention and control concerns. The response to this was that two staff members had their contracts terminated with immediate effect due to not meeting the standards the service required. However, these staff were not employed as cleaners and had not been trained to undertake this role.

Environment and equipment

The design of the environment followed national guidance. However, staff told us they did not feel that suitable equipment was always available.

Clinic rooms were located on the ground floor and the lay out of the rooms and equipment was consistent with good access principles. Theatres, recovery area and individual rooms were also located on the ground floor. Access to theatre areas was secure and controlled by a fob key.

We reviewed the emergency resuscitation equipment trolley located within theatres. These were sealed with tamperproof tags in place.

Four bank staff members including doctors and nurses told us that theatre equipment was unsuitable and inadequate. Due to an unpaid bill, the company who provided the theatre equipment came and removed all of the equipment. The service then introduced a kit that could be used of essential items, however surgeons felt this was not appropriate as it did not include all equipment needed to safely carry out surgery. Following the letter of intent, the service sent an action plan which stated they had a record of all the equipment purchases and flows to demonstrate their availability. We were told the site managers have knowledge of the equipment and where they can be found on the site.

Bank nursing staff told us equipment was cleaned offsite which meant that there was only one set of equipment onsite. Therefore, if anything happened with that equipment during surgery there would be no backup.

Patients could reach call bells; however, one patient told us that the bell would only intermittently work and they had to shout when they needed staff.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. However, not all staff were competent to do this and high-risk patients were not suitably assessed by an appropriate clinician.

Not all staff were trained to undertake pre-assessments. We spoke with two staff members that had not been trained to do that and as a result surgeries were cancelled due to issues that were not identified during pre-assessment. For example, one patient who was on anticoagulants had not been advised to stop taking them prior to surgery.

The service did not assess the risk of performing surgery for patients who required continuous positive airway pressure (CPAP) machines. We were told that the service did not perform surgery on patients who use CPAP due to them being a high-risk cohort of patients, however upon review of patient records we found that they had undertaken these surgeries. These patients did not have their conditions stability assessed by an appropriate clinician prior to surgery in line with British Obesity and Metabolic Surgery Society (BOMSS) guidance.

CPAP machines were not checked to be functioning prior to surgery taking place in line with guidance.

We reviewed the records of seven patients who had CPAP overnight following their procedure. Although the admission criteria had been updated following our previous inspection in May 2022 to include bariatric patients who receive CPAP, we did not see evidence that all staff had been trained to deliver high dependency care, including patients using CPAP or that staffing levels were sufficient to meet guidance for high dependency care.

Following our inspection, we issued a letter of intent relating to the concerns around CPAP patients. The service updated their policies to include treatment of CPAP patients, however they did not evidence staff training or competencies. The service had an inclusion and exclusion criteria which contradicted the treatment for this cohort of patients as it stated patients requiring CPAP did not meet the admission criteria.

We saw evidence in patient notes that a clinical review took place via telephone for a patient who was clinically unwell, this patient was not further reviewed for 2 hours as the RMO was not onsite.

Requires Improvement

Surgery

The service shared an audit with us that RAG rated if they were meeting national standards for patients requiring bariatric surgery. The audit stated that they accepted patients requiring CPAP unless they had poor compliance. However, in records we looked at, the pre-assessment did not include details around compliance.

The service undertook regular audits of their compliance with the WHO checklists. We reviewed compliance figures which were 97%. WHO checklists were a standardised item on the agenda of audit meetings.

Staff completed risk assessments for each patient on admission, however these did not include assessments of all risks such as patients who use CPAP machines.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

The service had a clear escalation process for transfer of a deteriorating patient to emergency care.

Nurse Staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers did not give bank and agency staff a full induction.

We spoke with multiple bank nursing staff who told us that theatres are not staffed to national standards. We reviewed staffing levels and saw there were gaps in the rota.

All staff we spoke with told us that the service has a high staff turnover.

The service had high rates of bank and agency nurses.

Managers did not make sure all bank and agency staff had a full induction and understood the service.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience. However, we were not assured that the service always had appropriate medical cover overnight.

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 are not employed directly by the hospital but have been approved to practise there.

Consultants conducted daily ward rounds and were always accessible by phone following surgeries.

Surgical and anaesthetic consultants remained responsible for their patients throughout their stay in hospital.

Requires Improvement

Surgery

We had concerns that the required Resident Medical Officer (RMO) was not on site overnight. Although we were told during the inspection that they always remained onsite, we looked at 10 patient records that indicated staff had spoken to an RMO over the phone for advice as they were offsite. We also spoke with staff and patients who said the RMO does not stay overnight. Following the inspection, we issued a letter of intent highlighting this concern, the service then adapted their policy to state that the RMO can provide cover onsite or on call.

Ther service had six RMO's listed on a rota. However, when we contacted these one of them stated that they were not an RMO and two of them where the same person but with different names listed.

We spoke with one RMO who worked set days in A&E at an NHS hospital. We found that on some days they would be working in A&E until 9pm, however they were also scheduled to provide RMO cover at Meridian House from 8pm on the same day.

All medical staff we spoke with told us that the service has a very high staff turnover.

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 were electronic and staff could access them via individual logins.

Records contained a nationally approved sepsis-6 screening pathway, completed where applicable. The service undertook regular audits of medical records to ensure compliance.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely.

Allergies were recorded in all records we looked at.

Staff completed medicines records accurately and kept them up-to-date.

Staff stored and managed all medicines and prescribing documents safely.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

The service managed patient safety incidents well. However, staff did not report incidents directly to an internal system themselves.

Requires Improvement

Surgery

Staff knew what incidents to report and how to report them. However, these were reported to the general manager rather than directly onto the incident reporting system.

The service had no never events in the last 12 months.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong.

Is the service well-led?

Requires Improvement

Leadership

Leaders had the skills and abilities to run the service. However, leaders did not always manage the priorities and issues the service faced. They were visible in the service for patients and staff, however not always approachable.

The hospital was led by a chief executive officer, who was also the registered manager. There was a wider support structure which included a medical director and responsible officer.

All staff we spoke with considered the leadership team to be visible and present within the service. We were told they attended departmental meetings and regularly visited clinical and administrative areas. Senior leaders had based their offices within the centre of the hospital. However, we were told by multiple staff members that they did not feel leaders were approachable and staff were hesitant to speak up about issues in case their contract was terminated or they were subject to bullying in the workplace. We spoke with staff who were currently employed and formerly employed who provided examples of leaders shouting at staff members in front of colleagues and told us this was a regular leadership style.

We were not assured that leaders always managed the priorities and issues the service faced as we were not assured they were always aware of issues due to a closed culture. Staff told us they were not always reporting issues for fear of having their contracts terminated.

Feedback from staff around developing skills and taking on more senior roles was mixed. Some members of staff told us that there were development opportunities provided by the leadership team, however we were also told that some promotions to management positions were given to employees that did not have the skills or understanding to safely manage the service.

There were regular staff huddles and briefings across the service.

Vision and Strategy

We did not review the service's vision and strategy as part of this focussed inspection.

Requires Improvement

Surgery

Culture

Staff did not feel respected, supported and valued. The service did not have an open culture where staff could raise concerns without fear.

We spoke with staff who were previously employed at the service within the last couple of months. One ex-employee told us their contract was terminated for leaving a clinical waste bag near a fire exit. Other staff members who had their contracts terminated with immediate effect included an unqualified heath care assistant who had not advised a patient taking anticoagulants to stop taking them.

Staff we spoke with told us there was a poor culture within the service. Outcomes of poor performance was that staff members had their contract terminated with immediate effect. Staff members told us they would be fearful of retribution if they spoke up.

On site, we spoke with one staff member who told us they enjoyed their role. We contacted regular staff members to ask of their experience working at the service however most staff members were not willing to engage. We spoke with one employee on the phone following the inspection, however the phone was taken from them by the general manager who told us we were not allowed to contact staff until she had spoken with the Chief Executive.

Governance

Leaders operated governance processes throughout the service and with partner organisations, however these were not always effective. Not all staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a policy in place for management of consultant practising privileges. Practicing privileges were reviewed as part of the monthly hospital board meetings. Review included General Medical Council (GMC) registration, appraisals, indemnity insurance, and disclosure and barring service checks, however the chief executive told us references were not always sought. Consultants with practising privileges, where required, were all listed on the GMC specialist register. The service also ensured processes were in place to formally notify consultants to explain privileges would be suspended if required documentation was not submitted by a specified due date, the service used a spreadsheet to track this.

The clinical leadership team and wider staff cohort met monthly at the governance meeting, clinical and non-clinical staff were invited to attend.

Clinical governance meetings took place regularly, and we were told all staff were invited. Key areas for discussion were clinical incidents, accidents and near-misses, patient safety issues and opportunities to review new policies and procedures. Meeting minutes were stored on a central drive which could be accessed by staff. However, staff told us that not all clinical incidents were reported as they should be, and that near misses and patient safety issues were not always formally recorded or reported.

Medical staff we spoke with were clear about their roles and responsibilities. Other staff we spoke with told us they were asked to do tasks that were not trained to undertake.

There were some policies and procedures available for public viewing on the website, however not all policies were up to date, for example the Standard Operating Policy for adults undergoing elective surgery was due for review in February 2023.

Requires Improvement

Surgery

Management of risk, issues and performance

Leaders and teams used systems to manage performance, however we were not assured that these reflected all risks within the service. Staff did not always contribute to decision-making to help avoid financial pressures compromising the quality of care.

The hospital had a risk management policy, which outlined the process for identifying, escalating and reviewing potential risks to the service. We saw a comprehensive electronic risk register, which tracked risks that were highlighted, showed they were reviewed regularly and escalated appropriately. However, we could not be assured that this reflected the risks and issues within the service due to staff feedback stating there was a culture of under reporting.

The service did not identify all risks, for example untrained staff members completely pre-assessments. When this was identified the service changed their policy to ensure pre-assessments were completed by trained professionals.

Staff told us they did not always feel able to contribute to decision making. Employees and former employees shared concerns about the financial viability of the service, this included unpaid staff and unpaid subcontracts to external services such as equipment supply.

Leaders had not identified the risk of untrained staff undertaking preassessments for high-risk patients.

We were not assured that staff performance was being monitored and managed appropriately. Staff were dismissed with immediate effect without clear investigations or formal disciplinaries.

Information Management

The service collected data and analysed it, however we were not assured all relevant data was included. Staff could find the data they needed, in easily accessible formats. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

All staff we spoke with could access information such as policies and minutes of meetings that were stored electronically on a shared hospital drive.

Staff viewed health records electronically. We observed good adherence to the principles of information governance, computer screens and tablets were password protected and closed when unattended.

The registered manager of the service demonstrated an understanding of the requirements for notifying external organisations, however we were told this does not always happen given the lack of internal reporting.

Engagement

We did not request evidence of engagement as part of this focussed inspection.

Learning, continuous improvement and innovation

Requires Improvement

Surgery

We did not request evidence of learning, continuous improvement and innovation as part of this focussed inspection.

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 Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose Action the trust MUST take is necessary to comply with its legal obligations. Action a trust 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 provider MUST take to improve: • The provider must ensure all staff complete required mandatory training. Regulation 12 (2) (c)). • The provider must ensure all staff complete safeguarding training in line with national guidance. Regulation 12 (2) (c)). • The provider must ensure that infection prevention and control measures are in place that reflect national guidelines for surgery. Regulation 12 (2) (h) • The provider must ensure that staff of all grades are trained to undertake their roles. Regulation 12 (2) (c)). • The provider must ensure patients are appropriately assessed by qualified staff prior to surgery to ensure all risks are identified. Regulation 12 (2) (c)). • The provider must ensure that equipment in theatres is suitable and appropriate for the surgeries being undertaken. Regulation 12 (2) (e)(f)).

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

This section is primarily information for the provider

Requirement notices

- The provider must implement effective governance systems to ensure persons employed undergo safe recruitment procedures and employment checks. Regulation 17 (1) (2) (a) (b)).
- The provide must ensure there is an effective system to identify all risks and ensure there is an effective process for monitoring and mitigating risks. Regulation 17 (1) (2) (a) (b)).

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The provider must ensure there is appropriate medical cover 24 hours a day. Regulation 18 (1)(2)(a)(b)(c)).