# BMI The Princess Margaret Hospital

## 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

## Ratings

| | |
|---|---|
| Overall rating for this location | Good |
| Are services safe? | Good |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive? | Good |
| Are services well-led? | Good |

# Summary of findings

## Letter from the Chief Inspector of Hospitals

The Princess Margaret Hospital based in Windsor is operated by BMI Healthcare Ltd. The service has 66 beds. Facilities include four operating theatres and an endoscopy suite. There is an outpatient department with consulting and treatment rooms, X-ray, and diagnostic facilities including magnetic resonance imaging (MRI), computed tomography (CT) and ultrasound.

The Princess Margaret Hospital provides surgery, medical care, outpatients and diagnostic imaging to people who have private medical insurance, pay for themselves and some NHS funded patients.

This was a focused inspection to follow up on the four serious incidents that had been reported to the Care Quality Commission (CQC) between May 2017 and December 2017. Two serious incidents related to complications during surgery and two for wrong medical device insertion during surgery. In addition, we looked at the areas of improvement identified in the previous surgery inspection report, published December 2016. As the serious incidents occurred in surgery we only inspected surgery. We inspected this service using our focused inspection methodology but for completeness looked at all five key questions, is the service safe, is the service effective, is the service caring, is the service responsive and is the service well-led. We carried out an unannounced inspection on 06 November 2018.

The hospital offers cosmetic procedures such as dermal fillers, ophthalmic treatments and cosmetic dentistry. We did not inspect these services.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

**Services we rate**

Our rating of this service stayed the same. We rated it as **Good** overall. However, well-led which was previously rated as Requires Improvement improved to Good. We found the service had learnt lessons from when things had gone wrong and put measures in place to prevent reoccurrence.

We found good practice in relation to surgery:

- The service provided mandatory training in key skills to all staff.
- Staff had training on how to recognise and report abuse.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- The service had enough staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment. However, there was high usage of bank and agency staff within the service.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- The service followed best practice when prescribing, giving, recording and storing medicines.

# Summary of findings

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff assessed and monitored patients regularly to see if they were in pain.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them.
- The service made sure staff were competent for their role.
- Staff of different roles worked together as a team to benefit patients.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.
- Staff cared for patients with compassion.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.
- The service planned and provided services in a way that met the needs of local people.
- The service took account of patients' individual needs.
- People could access the service when they needed it.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results and shared these with staff.
- The service promoted a positive culture, creating a sense of common purpose based on shared values.
- There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, and sustainable services.
- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients, staff and the public to plan and manage appropriate services.

However,

- Gas cylinders in the theatre area were not stored according to national guidance.
- There was dust in higher to reach parts of the theatre area.
- Level of patient harm was not always recorded when incidents were reported.
- Not all information was cascaded down to agency staff.
- The sepsis screening tool was not embedded by staff.

**Dr Nigel Acheson**

Deputy Chief Inspector of Hospitals (Acute South)

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Surgery** | Good  | Surgery was the main activity of the hospital. We rated this service as good because it was safe, effective, caring, responsive and well-led. |

# Summary of findings

## Contents

Good

# BMI The Princess Margaret Hospital

**Services we looked at**

Surgery

# Summary of this inspection

## Background to BMI The Princess Margaret Hospital

The Princess Margaret Hospital is operated by BMI Healthcare Ltd. The hospital opened in 1980. It is a private hospital in Windsor, Berkshire. The hospital primarily serves the communities of Berkshire. It also accepts patient referrals from outside this area.

The hospital has a registered manager who has been in post since July 2016.

## Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and two specialist advisors with expertise in surgery. The inspection team was overseen by Helen Rawlings, Head of Hospital Inspection.

## Why we carried out this inspection

This was a focused inspection to follow up on the four serious incidents that had been reported to the Care Quality Commission (CQC) between May 2017 and December 2017. Two serious incidents related to complications during surgery and two for wrong medical device insertion during surgery. In addition, we looked at the areas of improvement identified in the previous surgery inspection report, published December 2016. As the serious incidents occurred in surgery we only inspected surgery. We inspected this service using our focused inspection methodology but for completeness looked at all five key questions, is the service safe, is the service effective, is the service caring, is the service responsive and is the service well-led. We carried out an unannounced inspection on 06 November 2018.

## Information about BMI The Princess Margaret Hospital

The hospital has two surgical wards and is registered to provide the following regulated activities:

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

During the inspection, we visited the two surgical wards, theatres, the physiotherapy unit and the pharmacy. We spoke with approximately 20 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with six patients. During our inspection, we reviewed six sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital was last inspected in September 2016 which found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity

In the reporting period October 2017 to September 2018. There were 6,874 inpatient and day case episodes of care recorded at The Hospital; of these 13% were NHS-funded and 87% other funded.

# Summary of this inspection

- 2% of all NHS-funded patients and 19% of all other funded patients stayed overnight at the hospital during the same reporting period.

There were 242 surgeons, anaesthetists, physicians working at the hospital under practising privileges. The regular resident medical officer (RMO) was employed via an agency and worked on a 24-hour, seven-day rota. The hospital had regular agency RMOs who provided this cover.

The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

Between September 2017 to September 2018;

- 1 Never event
- 215 clinical incidents: 75 no harm, 99 low harm, 17 moderate harm, 0 severe harm, 1 death
- 0 serious injuries
- 0 incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),
- 0 incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- 0 incidences of hospital acquired Clostridium difficile (c.diff)
- 0 incidences of hospital acquired E-Coli
- 24 complaints

**Services provided at the hospital under service level agreement:**

- Transfer agreement for adults and children to an NHS hospital
- Microbiology services
- Holistic therapies for cancer patients
- Laser Protection Advisor and Radiation Protection Advisor for nuclear medicine
- Security services
- Interpreting services
- Maintenance of medical equipment
- Pathology and histology
- Resident Medical Officer provision

# 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?

Good

We rated safe as **Good** because:

- The service controlled infection risk well.
- Staff completed and updated risk assessments for each patient.
- Staff kept detailed records of patients' care and treatment.
- The service managed patient safety incidents well.

### Are services effective?

Good

We rated effective as **Good** because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff assessed and monitored patients regularly to see if they were in pain.
- Staff of different roles worked together as a team to benefit patients.

### Are services caring?

Good

We rated caring as **Good** because:

- Staff put patients at the centre of all that they did.
- Staff took time to involve patients in their care and provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.
- We observed how staff demonstrated a kind and caring attitude to patients and took time to speak with patients and their relatives in a respectful, patient and considerate way.
- Staff supported patients through their investigations, ensuring they were well informed and knew what to expect.

### Are services responsive?

Good

We rated responsive as **Good** because:

- The hospital planned services around the needs and demands of patients and considered patients' individual needs.
- People could access the service when they needed it.
- The service treated concerns and complaints seriously, investigated them and learnt lessons from the results.

### Are services well-led?

Good

We rated well-led as **Good** because:

# Summary of this inspection

- The service promoted a positive culture, creating a sense of common purpose based on shared values.
- There was an effective clinical governance structure.
- There were systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- The service collected, analysed, managed and used information well to support its activities.
- The service engaged well with patients, staff and the public to plan and manage appropriate services.

# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Surgery | Good | Good | Good | Good | Good | Good |
| Overall | Good | Good | Good | Good | Good | Good |

Good

# Surgery

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

## Are surgery services safe?

Good

Our rating of safe stayed the same.We rated it as **good.**

**Mandatory training**

**The service provided mandatory training in key skills to all staff.**

- The BMI Healthcare corporate mandatory training policy defined the mandatory training requirements of staff including bank workers. This included a mandatory training matrix which identified the mandatory training required dependent on job role.
- All staff working in a BMI Healthcare Hospital were required to complete the following mandatory training: fire safety in a hospital environment, safety, health and the environment, information and data, equality and diversity, basic life support (BLS), infection prevention and control, safeguarding children and safeguarding adults level 1 and PREVENT (protecting people at risk of radicalisation). Depending on their role, staff were also expected to complete role specific mandatory training, for example consent to examination or treatment, medical gases and manual handling.
- BMI The Princess Margaret Hospital set a target of 90% for completion of mandatory training. Training modules were a mix of e-learning, practical sessions and assessments. Mandatory training compliance rates provided for staff working in the surgery service were not reported by individual training modules but by staff group. Theatre staff achieved 96% compliance, theatre management staff and theatre sterile supply unit staff achieved 100% compliance and ward staff achieved 93% compliance with their mandatory training.
- Staff we spoke with told us mandatory training was easy to access. However, some staff reported it was not always easy to find the time to complete the training required in their normal working hours. They told us this was because of staffing problems within certain departments. To mitigate this, and in line with the corporate mandatory training policy, we were told by senior staff that staff had been asked to complete training at home. Senior staff told us staff would be given time off in lieu or paid for the time taken to complete their mandatory training.

**Safeguarding**

**Staff had training on how to recognise and report abuse**.

- BMI healthcare corporate safeguarding adults policy (issue date May 2015, review date November 2018) provided staff with guidance about safeguarding adults. The safeguarding adults' policy followed relevant national legislation and guidance, for example Department of Health (May 2011) Statement of Government Policy on Adult Safeguarding.
- The required level of safeguarding training for staff working at the hospital was documented in the BMI healthcare corporate mandatory training policy. All staff required safeguarding adults level 1, clinicians and all non-clinical staff in a managerial role required level 2 training and the Director of Clinical Services, who was the safeguarding lead for adults required level 3 training. Staff had completed mandatory training in safeguarding

vulnerable adults. Information received from the hospital post inspection provided an overview of compliance with this training for the service. It was reported 97% of staff had completed level 1, 96% had completed level 2 and 100% had completed level 3 training against the provider's target of 90%.

- Consultants submitted evidence that they had completed their mandatory safeguarding training in their substantive post, for their practising privileges to be renewed.
- Staff we spoke with were aware of the signs of abuse and demonstrated an understanding about safeguarding processes. They knew who the safeguarding leads were at the hospital and how to escalate if they had concerns. However, staff we spoke with told us they had not needed to raise safeguarding concerns whilst working at the hospital.
- Information about female genital mutilation (FGM) was included in the BMI Healthcare corporate safeguarding adults' policy. There was no separate safeguarding instructions for staff to follow but the policy did highlight that the police must be informed if FGM was suspected.
- All BMI staff were required to complete PREVENT mandatory training, we were not provided with staff compliance rates for this training. PREVENT is about safeguarding people and communities from the threat of terrorism. PREVENT training raises awareness to stop individuals from getting involved or supporting terrorism or extremist activity. Information about PREVENT was included in the BMI Healthcare corporate safeguarding adults' policy.
- There was a BMI Healthcare corporate policy for provision of chaperones during examination, treatment and care (issue date September 2015, review date September 2018) which provided staff with guidance about the role and responsibilities of chaperones. Staff were aware of this policy. Patients were given information in their 'your visit to our hospital' leaflet on how to request a chaperone.

**Cleanliness, infection control and hygiene**

**The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.**

- BMI Healthcare had corporate infection control policies to help control infection risk, these included the standard infection prevention and control precautions policy, Peri-operative swab instrument and needle count policy and the waste management policy. Staff we spoke with were aware of these policies.
- All areas we inspected, including the pre-assessment area, surgery inpatient wards and the theatre suite were visibly clean and tidy. Staff completed daily cleaning routines and cleaning records. The cleaning records we reviewed during the inspection were up-to-date and complete.However, there was observed to be some dust in higher to reach areas in the theatre area.
- 'I am clean' stickers were used on equipment in the clinical areas to identify that items had been cleaned and were ready for use.
- Emergency equipment, including the emergency suction equipment and the defibrillator in theatre and inpatient wards were visibly clean and dust free.
- Surgical instruments and equipment was sterilised off-site by a contractor. In the operating theatre, there was a crossover of clean and dirty instruments as the clean instrument trolley had to be delivered to the same area where the used instruments were collected from. At the previous inspection (2016) the risk of cross contamination from clean and dirty instruments was highlighted. During this inspection it was observed that the same system was still in place and the dirty and clean instrument process was still on the department's risk register. Therefore, it was still considered a risk to the service. The risk of cross contamination was now being mitigated by keeping the doors of the dirty instrument trolley shut. Throughout our time in the theatre suite the dirty trolley doors remained closed except when dirty instruments were being placed inside the trolley, this showed the practice of keeping the doors closed was embedded by the staff. Staff did not know if a different solution to the problem was being looked in to.
- There was a BMI Healthcare corporate waste management policy which the hospital and staff

followed. During the inspection we saw the correct management of containers for sharps and the use of coloured bags to correctly segregate of hazardous and non-hazardous waste.

- All hospital staff completed infection prevention and control training as part of their mandatory training. We were not supplied with a breakdown of staff compliance rates for individual training modules.
- Staff were observed to follow effective infection control practices to reduce risk of the spread of infection such as 'bare below the elbow' and cleaning their hands before and after contact with patients. Staff had access to personal protective equipment, such as gloves and aprons in a variety of sizes. Staff adhered to theatre dress code.
- Throughout the hospital and the surgery service areas, hand sanitiser gel was available.
- The hospital provided patients with a leaflet in their pre-admission information pack that explained how hand hygiene prevented and controlled infection. It included information about hand washing, including hand washing technique and when the use of hand sanitiser gel was appropriate.
- Included in the pre-admission information pack was a leaflet about surgical site infection and information for patients on how to spot the signs and symptoms of an infection and what action needed to be taken.
- The hospital had a total of 12 surgical site infections reported between October 2017 and September 2018 which was a rate of 0.18% of the total number of procedures performed at the hospital. When we spoke with the new infection control lead of the hospital, we were told as part of their new role, surgical site infections would be reviewed to see if trends could be identified and areas of infection control improved on.
- There was no BMI Healthcare policy or local hospital standard operating procedure (SOP) on the recognition, diagnosis and treatment of sepsis in adults at the hospital. The hospital used the inpatient sepsis screening and action tool taken from the UK Sepsis Trust, The Sepsis Manual 4th edition 2017-2018. It was not evident from speaking with clinical staff what, if any, training staff had received to use this tool.
- Nursing staff carried out infection control risk assessments on all patients as part of their pre-admission assessment process. This included details about any recent illnesses; MRSA status and possible exposure to MRSA or infectious diseases in the month prior to pre-admission screening. This facilitated the identification of infection risks at the earliest possible time in the patient's care pathway to ensure correct infection prevention and control practices were instigated.
- The hospital reported no incidences of c.difficle, methicillin sensitive staphylococcusaureus (MSSA) and methicillin resistant staphylococcus aureus (MRSA) between September 2017 to September 2018.
- There was a hospital wide annual infection prevention audit program, which included monthly hand hygiene audits and once every two months patient equipment audits. The results of these audits from October 2017 to September 2018 showed results of 81-100% and 92-98% compliance respectively. Local audits in the surgery service included aseptic non-touch technique and catheter and peripheral venous cannula insertion audits. Audit programmes in the surgery service had been used to increase and maintain standards and help prevent the spread of infection.
- There were carpets and fabric chairs throughout the hospital which posed an infection control risk due to these surfaces not being wipe clean. The hospital management team and IPC lead nurse recognised the hygiene and infection risks of having carpet and fabric chairs but stated it was unlikely the hospital could change these items immediately due to cost constraints. There was no risk assessment in place but we were told the new IPC lead nurse was looking at ways to mitigate the risk, for example by developing a deep clean cleaning schedule. This mitigation was not in place at the time of our inspection.
- Lack of dedicated hand washing sinks in some clinical areas was highlighted in the previous inspection report 2016. During this inspection we found this issue had not been resolved. It was still identified by staff in certain areas as a concern, for example in the physiotherapy department. The new IPC lead nurse told us they would be carrying out a review and findings or mitigating actions required would be fed back to the senior management team.

- The hospital had a water safety committee that met every three months. There was a set agenda which included water flushing round the hospital, the results of water testing and the risk assessments for legionella and pseudomonas. We saw evidence that regular water testing had been carried out and any actions required were implemented.
- The lead infection prevention and control (IPC) nurse had commenced in post a month prior to our inspection. Since joining the hospital, they had completed an analysis of IPC issues and requirements across the hospital and were working on an IPC action plan.
- The hospital held infection prevention and control committee meetings monthly which had membership from senior staff from across the hospital. There was a set agenda which covered topics such as mandatory and ad-hoc training, IPC audits and policies and protocols.
- Post inspection we reviewed minutes from the last three meetings, March, June and September 2018. From the minutes we could see IPC topics were discussed but meetings were not always well attended, especially by inpatient and outpatient representatives. However, with the start of a new IPC lead there was now a designated member of staff to lead the service at the hospital.
- The hospital had a microbiologist on call to give advice and who attended the IPC committee meetings and the water safety committee. From the minutes we reviewed we could see the microbiologist attended these meetings.

**Environment and equipment**

**The service had suitable premises and equipment.**

- The ward and theatre environments were suitable for the level and type of care delivered. In-patients had an individual room with ensuite bathroom and toilet facilities. The rooms were comfortably furnished which most patients said met their needs.
- The hospital provided the annual inspection and re-verification reports for the ventilation systems used in theatres (November 2018). These reports assessed compliance with the minimum standards of the Department of Health Publication: Health Technical Memorandum 03:01: Specialised ventilation for healthcare premises. These requirements were met however, there were some advisory recommendations on the reports mainly regarding aging equipment.
- Resuscitation equipment, for use in an emergency in operating theatres and the ward area were regularly checked and documented as complete and ready for use. The resuscitation trolleys were secured with tags, which were removed daily to check the trolleys and that their contents were in date. This showed there was a consistent and regular approach to safety checks. On each trolley were contact details for transferring patients to the local NHS trust.
- The theatre suite had a difficult airways trolley with records confirming that this was checked weekly.
- Theatre staff checked anaesthetic machines daily and the tubing weekly. Records we reviewed during the inspection showed that these checks were carried out.
- There was sufficient equipment to maintain safe and effective care, such as anaesthetic equipment, theatre instruments, blood pressure and temperature monitors, commodes and bedpans.
- The risk register highlighted that there needed to be a replacement programme for equipment, this was in progress.
- Equipment and consumable items such as dressings were neatly stored on shelves raised off the floor which enabled cleaning of the storage areas. Staff maintained stock levels well for both reusable and single use items. We checked a random sample of consumables and found all stock in date.
- We observed two large oxygen gas cylinders not stored as per health and safety guidelines. Small gas cylinders were stored in an unlocked cupboard.
- Staff had access to the use of a hoist for transferring patients. The hospital provided disposable slings for individual patient use.
- The hospital serviced and tested clinical equipment according to manufacturer's guidance; there were a number of service level agreements in place for servicing of equipment. Most equipment we checked during the inspection was in date for its electrical safety testing.

- The hospital participated in the Patient-Led Assessments of the Care Environment (PLACE) assessments. The PLACE audit results for 2018 showed a score of 93.5% for the condition, appearance, and maintenance. The assessment for condition, appearance, and maintenance covers areas such as decoration, the condition of fixtures and fittings, tidiness, signage, lighting (including access to natural light), linen, access to car parking, waste management, and the external appearance of buildings and maintenance of grounds.
- Systems were in place for details of specific implants and equipment to be recorded and reported. There was a national system of recording. We saw that all equipment, implants and prosthesis were tracked and traced. All records that we looked at had clear evidence of this with batch numbers recorded.

**Assessing and responding to patient risk**

**Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.**

- The hospital had an emergency resuscitation team and they met daily in the morning to allocate roles if a medical emergency should happen that day.
- All staff at the hospital completed adult basic life support, immediate or advanced life support training depending on their role. Data provided by the hospital post inspection showed, as of October 2018, 84% of required staff had completed adult basic life support (BLS), 97% had completed adult immediate life support (ILS), and 95% had completed adult advanced life support (ALS).
- The hospital had an admission criteria which meant that the hospital only admitted patients whom the hospital had facilities to care for. Patients with complex co-morbidity and bariatric patients would not routinely be admitted for treatment.
- Admission exceptions were only considered on the presentation of all relevant clinical evidence, a risk assessment and the mitigation of risk and with the agreement from all clinicians (nursing and medical) and the senior management team involved in the care of the patient.
- Once a patient was booked for surgery they had a pre-assessment to ensure they met the inclusion criteria for surgery. This assessment was carried out by a registered nurse. Pre- assessment was a clinical risk assessment where the health of a patient was considered to ensure that they were fit to undergo an anaesthetic and therefore the planned surgical operation. It also provided an opportunity to ensure that patients were fully informed about the surgical procedure and the post-operative recovery period.
- The service used criteria based on type of surgery to determine which patients received telephone assessments rather than face-to-face assessments. For example, patients undergoing a local anaesthetic would normally have a telephone pre-assessment.
- All patients having a general anaesthetic were assessed face-to-face in a nurse led pre-operative assessment clinic, at the hospital, prior to their surgery.
- Information collected at the patient's pre-assessment included health, social and emotional well-being. If the pre-assessment was via a telephone call this was noted in the care record, together with details of who made the call. Information collect in pre-assessment was used to helped evaluate and highlight any potential patient risks. Potential risks could then be mitigated by the nursing staff or flagged to other teams, for example surgeons, anaesthetists or physiotherapists for their attention.
- We observed one face to face pre-assessment and found that all questions were covered and recorded in the patient's care records and any potential risks identified and passed to the relevant teams.
- Included in the patient care record was information on any allergies the patient might have. Care records we reviewed showed this was completed. Nursing staff told us that patients with known allergies would wear a red wristband to alert staff of their allergic status and helped to mitigate the risk of allergic reactions.
- Patients were swabbed to assess for any colonisation of MRSA at the pre-assessment clinic as per hospital policy. If results were found to be positive the patient was provided with a treatment protocol to use at home, according to the hospital's MRSA policy. If necessary surgery would be deferred until patient had a negative swab result.

Good

# Surgery

- We reviewed six patient care records and found that all questions were covered and recorded in the patient's care records and any potential risks identified and passed to the relevant teams.
- Staff followed the corporate BMI Healthcare safer surgery policy which helped to keep patient's safe during their treatment.
- Theatre staff attended a safety huddle each morning and afternoon, where the operating list was discussed. Any potential patient risks or issues were highlighted and planned for. We observed a huddle during our inspection and noted effective communication with all staff involved.
- Nursing staff on the wards undertook handover between each shift which included an update on all patients currently admitted and highlighted any specific concerns such as infection risks or safeguarding concerns, to all staff.
- On the day of surgery patients would be admitted to one of the hospital's wards and a registered nurse would complete further pre-procedure risk assessments using nationally recognised tools. For example, Waterlow score to assess patients risk related to pressure ulcers, mobility, moving and handling and venous thromboembolism (VTE). We reviewed patient care records and found these to be completed.
- Qualified nurses accompanied patients from the ward to the theatre suite where the procedure would be carried out.
- The theatre team used the five steps to safer surgery, which included the World Health Organisation (WHO) surgical safety checklist. The safety checklist is a recognised tool developed to help prevent the risk of avoidable harm and errors during and after procedures and should include safety-briefing, sign in, time out, sign out and debriefing. The theatre team had designated a WHO checklist champion, who wore a different colour surgical hat and was responsible for making sure the checklist was followed.
- The hospital audited the WHO checklists and good compliance was generally demonstrated. Regular feedback was given to the surgical team to make sure the checklist was used correctly and fully. Patient records we reviewed showed the good compliance with the checklist.
- Staff had immediate access to blood products, to stabilise patients with life threatening haemorrhage. The blood fridge temperature and stock was checked and recorded daily.
- Whilst in the recovery unit patient's health and wellbeing was monitored using the nationally recognised national early warning scores (NEWS). NEWS is a tool used to quickly determine the degree of illness of a patient. It is based on six patient observations, breathing rate, amount of oxygen in the blood, blood pressure, heart rate, level of consciousness and temperature. It is used to help recognise a patient whose condition was deteriorating. Staff we spoke with could explain that NEWS had recently been updated by NHS England and NHS Improvement for use in hospitals in England to NEWS2.
- Venous thromboembolism (VTE) assessments were carried out and recorded in the patient's care record on admission and post-procedure.
- Following recovery from the procedure a registered nurse would accompany patients back to the ward for further assessment and supervision.
- Each patient room and bathroom had emergency call bells, which were used to alert staff when urgent assistance was required.
- Staff could describe how they would escalate concerns about a deteriorating patient. The hospital had a resident medical officer (RMO) on duty 24 hours a day to provide medical attention and attend any emergencies. Staff said that they were always responsive and attended when needed. The consultant medical staff were also available by telephone in the event of any concerns about a patient.
- If a patient deteriorated, the RMO would review and liaise with the consultants for advice about managing increased risks or to consider transfer to an acute hospital if needed.

- The hospital had service level agreements in place with the local NHS trust for transferring patients for medical reasons. Staff told us they followed the BMI Healthcare policy for the transferring of patients if a transfer was required.
- Between October 2017 and September 2018 there had been 10 unplanned transfers, which was 0.17% of all day-case and inpatient admissions.
- The practising privileges arrangement required the named consultant to be contactable at all times when they had inpatients in the hospital. Furthermore, they needed to be available to attend the hospital within an agreed timeframe, when needed. It was also a requirement for consultants to arrange appropriate, alternative named cover if they were unavailable at any time when they had inpatients within the hospital. The RMO and nurses told us that consultants were easily contactable if they needed to contact them.
- The service had an on-call theatre team in case a patient had to be returned to theatre.
- On discharge patients would be given a leaflet on 'monitoring surgical wound for infection'. This gave patients information on wound care when they went home, the signs and symptoms of an infection and who to call if there was a problem.
- Patients were given out of hours telephone numbers on discharge from the hospital, in case they became unwell or had concerns after their treatment.
- Ward staff would routinely call patients 48 hours after discharge to check how the patient was recovering and this was recorded in the patient's records.

**Nursing and support staffing**

**The service had enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment. However, there was high usage of bank and agency staff within the service.**

- At the time of the inspection the clinical service manager (CSM) / head of department (HOD) for the inpatient wards post was vacant and the senior nursing staff were taking on additional duties to cover the gap.
- In addition, the wards had four registered nursing vacancies at differencing grades and one healthcare assistant vacancy. This meant the wards were reliant on bank and agency staffing for safe staffing levels. Nursing staff told us it could sometimes be a challenge getting the extra staff needed at the time they were needed. Bank and agency nurses, in general, regularly worked at the hospital and therefore familiar with how the ward ran.
- We were told by nursing staff there was sometimes only one contracted member of staff on shift. To help mitigate this and reduce the workload on the contracted staff, some of the more regularly used agency staff had been given additional training and responsibilities. This meant they were able to carry out duties that the contracted staff could do. For example, having access to the electronic incident reporting system which meant they could log incidents.
- Patient admissions were known in advance and staffing levels calculated using an electronic labour monitoring tool, this ensured safe staffing numbers were planned according to the number of patients. The tool could be manually adjusted to take account of individual patient needs. However, we were told by nursing staff that staffing numbers were higher than the labour tool suggested as they had to take in consideration such factors as supervision for agency nurses.
- To help manage staffing and if patient numbers allowed the day patient ward would be closed and patients nursed on the inpatient ward. The day case ward was shut on the morning of the inspection.
- The nursing roster was planned four weeks in advance as per the BMI Healthcare rostering policy but we were told by nursing staff that shifts were regularly changed last minute and they would be working different days and shifts from their original planned shifts. This often impacted on their plans and commitments outside of work.
- Data supplied by the hospital post inspection showed that the rate of bank and agency staff used in the surgical service from October 2017 to September 2018 was between 3.8 – 4.7% for bank staff and between 4.2 – 7.6% for agency staff.
- At the time of the inspection there were four vacancies in the theatre team, two scrub practitioners, one

healthcare assistant and one theatre practitioner. The vacant scrub practitioner roles were filled by two regular agency scrub nurses. This meant they were fully embedded and accustomed to the working practices of the team.

- The staffing of theatres was determined in accordance with the corporate BMI Healthcare policy for the provision of practitioners assisting in surgery. The theatre rota was completed three weeks in advance and was based on the surgical lists generated by the consultants. Consultants had to provide a written request at the time of booking patients for surgery so appropriate members of the theatre team could be rostered onto shift.
- Post inspection we requested the last three months of staffing rotas for the theatre and ward departments and saw staffing was at the correct level to keep patients safe.

**Medical staffing**

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

- There was a corporate Practising Privileges Policy for Consultant Medical and Dental Practitioners. We noted that this was a corporate policy and overdue for renewal in October 2018. A practising privilege is, "Permission to act as a medical practitioner in that hospital" (Health and Social Care Act, 2008).
- All consultant surgeons, paediatricians and anaesthetists had to complete an application for admitting rights. This information was used by the hospital management team to determine whether the person had the required skills and experience to carry out treatments at the hospital. Medical staff who could not demonstrate they had the relevant skills were not granted practicing privileges.
- There were processes in place prior to medical staff being granted practicing privileges at the hospital. The hospital practising privilege agreement set out the requirements for each consultant concerning their indemnity, appraisal, General Medical Council registration, Disclosure and a Barring Service (DBS) check. The hospital director reviewed these every two years. Consultants had to submit their mandatory training, safeguarding training and appraisal information yearly. Consultants had to demonstrate they were competent to perform the procedures included as part of their practising privileges and they were working within their normal scope of practice.
- There were 242 clinicians with practising privileges at the hospital. These including but limited to, specialist surgeons such as orthopaedic, ear nose and throat and urology, and anaesthetists. We reviewed five set of consultant files and found these to be thorough and up to date.
- Each patient was admitted to the hospital under the care of a named consultant. The hospital required consultants to be available to attend to the patient within 30 minutes of being called, which met the recommendations set out by the Association of Independent Healthcare Organisation (AIHO). Nursing and theatre staff told us consultants and anaesthetists made themselves available to provide advice over the telephone or attended the hospital when required. They told us they had a good working relationship with the medical staff.
- The hospital maintained a medical advisory committee (MAC) whose responsibilities included ensuring any new consultant was only granted practising privileges if deemed competent and safe to practice.
- Day to day medical cover was supplied by the RMO who provided 24-hours a day, seven days a week service, on a rotational basis. RMOs were employed through a formal contract with an agency. The RMO provided support to the clinical team in the event of an emergency or with patients requiring additional medical support.
- Nursing staff told us the RMOs were approachable and responsive when required.

**Records**

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

- Patients admitted to the hospital for a procedure had a care record. This was a single and complete record in a booklet form, containing all information from when a patient had been booked in for a procedure until follow

up care after discharge had finished. These records were used for every patient and were multidisciplinary, meaning each clinical team wrote in the same set of records, including the surgical team.

- Staff used specific care pathway paperwork for each patient which ensured they kept the relevant records. For example, patients admitted for hip surgery had their clinical entries recorded in the 'Primary hip replacement care pathway' documentation.
- We reviewed six sets of patient records and found these to include the relevant assessments of care needs, risk assessments and were patient centred and personalised.All the records were completed fully and if a risk was identified there was an associated care plan. For example, a patient who had scored as being at risk of falling had a falls risk care plan.
- We saw evidence in the patent records of ward to theatre handover and theatre checklists completed. This ensured continuation of patient care between the teams.
- Where appropriate patient care records contained stickers identifying equipment and implants used during surgery. This meant that they could clearly be tracked and traced.
- Theatre staff maintained a log of implants on their prosthetics register to enable traceability if an incident occurred. Theatre personnel retained a sticker from each implant in the register as well as in the patient notes.
- All patient care records were in paper format and kept on the ward for three to five days post discharge. This was in case a patient contacted the ward with a question or concern regarding their surgery after returning home.

**Medicines**

**The service followed best practice when prescribing, giving recording and storing medicines.**

- We observed that medicines, including controlled drugs (CDs) were stored securely on the wards and in theatres.
- We checked the controlled drugs (CDs) on the wards and in the theatre department and found that these were correctly stored and matched the register. There were appropriate records of the administration of controlled drugs in these areas. Pharmacy staff told us they conducted an audit of CDs every quarter and we reviewed these audits and action plans.
- Medicines were stored at manufacturer recommended temperatures. Refrigerator and room temperatures were recorded daily, and staff sought advice from the pharmacy team when temperatures were found to be outside recommended ranges. Staff gave us examples when drugs had to be destroyed over the summer months due to high room temperature.
- Emergency medicines, including oxygen, were available for use and expiry dates were checked to ensure they were safe for use when needed. Emergency trolleys were stocked with the correct medicines for resuscitation. Anaphylactic drugs were available for the treatment of potentially life-threatening allergic reaction that can develop rapidly.
- The hospital had an on-site pharmacy that was responsible for the supply and top up of medicines used in the theatre area and inpatient wards. Nursing staff told us pharmacy staff provided a good service and were available and accessible when needed.
- The pharmacy team told us they carried out quarterly audits on missed dose and antimicrobial stewardship. The team would share audit results with the heads of departments for them to decide on action plans if any were needed.
- Patients were asked of known allergies during their pre-assessment. The information was recorded on the front page of their patient records. This meant the information was immediately visible to staff to reduce the risk of harm to patients. In addition, patients wore a red wristband to make staff aware they had an allergy.
- Patients were weighed and measured at pre-assessment, this information was used to accurately calculate medicine doses if needed.
- There was a small stock of 'to take out' (TTO) medicines available in the ward. These consisted of antibiotics and pain relief and could be dispensed by the nursing staff following prescription by the RMO or consultant.

- Medicines prescribed on the medicine chart were dated and signed by the prescriber. Prescriptions detailed the dose and the time the medicine needed to be administered. Nurses signed to demonstrate they had administered the medicine to the patient.
- Pharmacists carried out medicines reconciliation when patients were admitted to hospital for surgery. Pharmacy and nursing staff spoke with patients about their medicines and gave clear instructions on medication use at home prior to discharge from the ward.

**Incidents**

**The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.**

- Staff reported incidents using the electronic reporting system. Staff said they felt confident to report incidents and knew what constituted as an incident. Not all staff we spoke with had reported an incident. Agency staff who regularly worked at the hospital had been given additional training and access to the electronic reporting system which meant they could report incidents.
- From October 2017 to September 2017 there had been 215 incidents reported relating to the surgery service. 35% of incidents were rated as no harm, 46% rated at low harm (minimal harm – patient required extra observation or minor treatment) and 8% rated as moderate harm (moderate harm: short term harm - patient required further treatment, or procedure) and there was one incident of severe harm (permanent or long-term harm). 11% of incidents reported did not have the level of harm entered.
- There had been one never event during the same period. A never event is a serious incident which is 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.
- The never event related to a surgical complication. A root cause analysis (RCA) had been completed, a debrief held with staff and learning shared locally and regionally, with an agreed action plan. We reviewed the RCA and saw that a full investigation had been carried out.
- Staff gave us examples of when change or training was required as a result of an incident. For example, slides disseminated to the teams providing refresher training for staff on the consent procedures after a patient was found with the incorrect details on their identification wristband.
- Incidents were discussed at the monthly clinical governance meetings. We reviewed three sets of minutes and saw evidence incidents and adverse events were discussed, investigations into incidents reviewed, the actions taken to reduce risk and reduce the likelihood of reoccurrence put in place and to see if there were any trends emerging.
- Incident information from the clinical governance meeting was feedback by the heads of department to their teams. This happened in a number of ways, via team meetings, emails and during handovers. Staff we spoke with confirmed they received feedback from reported incidents, both those relating to their immediate area of work and those that had been reported elsewhere in the hospital. This promoted shared learning from incidents throughout the hospital.
- Minutes from the medical advisory committee (MAC) meetings showed incidents were discussed at these meetings. This showed that consultants had awareness of incidents being reported at the hospital.
- There were no regular mortality and morbidity meetings to discuss unexpected deaths or adverse incidents affecting patients. The hospital told us such cases would be included in the clinical governance and medical advisory meetings as required.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke within the surgical service could explain duty of candour and understood their responsibility to be open and honest with patients and their relatives

when something had gone wrong. There was a BMI Healthcare corporate being open and duty of candour. It was the responsibility of the senior management team to ensure the principles of the duty of candour had been completed.

**Safety Thermometer**

- The safety thermometer is a measurement tool for improvement in health care, which focuses on the most common harms to patients, pressure ulcer, catheter or urinary tract infections, venous thromboembolism episodes and patient falls.
- The service did not display safety information on the ward for patients and visitors to view. However, the hospital measured safety performance and submitted safety data to the BMI Healthcare corporate organisation.

## Are surgery services effective?

Good

Our rating of effective stayed the same.We rated it as **good.**

**Evidence-based care and treatment**

**The service provided care and treatment based on national guidance and evidence of its effectiveness.**

- Patient's care and treatment took account of national guidance. Policies and procedures we reviewed referenced national guidance including the National Institute for Health and Care Excellence (NICE), The Royal College of Surgeons' Standards for consultant led surgical care and the recommendations from the Association of Anaesthetists of Great Britain and Ireland (AAGBI).
- The National Institute of Health and Care Excellence (NICE) guidelines were reviewed at BMI corporate level, cascaded to the individual hospitals and shared with staff. Policies based on best practice and clinical guidelines were developed nationally and cascaded to the hospitals for implementation. These were reviewed at the quality and risk review clinical governance meeting. Staff were required to sign to say they had read the policies.
- Staff could access national and local guidelines through the hospital's intranet. Staff demonstrated to us how they could locate them easily when required.
- The hospital had a clinical audit programme, which was set corporately by the BMI Healthcare group. This meant that the hospital could benchmark the results from the audits with other hospitals of a similar size within the BMI Healthcare group. Audits included consent, resuscitation, hand hygiene, health and safety, the WHO safer surgery checklist, and medicines management.
- The service participated in national audit programmes for example: Patient Reported Outcome Measures (PROMS), National Joint Registry (NJR) and the National Diabetes Audit (NDA).
- We observed that audits and policies were a regular agenda item on the medical advisory committee meetings. This meant medical staff were kept up-to-date with hospital information and any actions required by them.

**Nutrition and hydration**

**Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other preferences.**

- Nursing staff asked patients about any food intolerance or allergies as part of their pre-assessment. This also included specific dietary or cultural requirements, such as vegetarian or halal. This information was passed to the catering team who prepared the meals.
- Patients were advised about pre-surgery fasting times (that is omitting food and fluids except water before operation) during the pre-assessment process. Fasting guidelines were found in the BMI Healthcare corporate fasting before anaesthesia policy. The service followed the Royal College of Anaesthetists guidance about pre-operative fasting to ensure patients fasted for the safest minimal time possible. Written information about pre-surgery fasting times was also sent to the patient which reminded patients that fasting included smoking, chewing gum and sweets.
- If required, the hospital provided support to diabetic patients prior to their operation.

- Staff used the Malnutrition Universal Screening Tool (MUST) to assess, monitor and record patient's nutrition and hydration needs. Fluid balance charts were used to monitor patients' fluid intake. We reviewed patient records and saw that these were consistently completed.
- We saw jugs of water within reach patient's reach on the inpatient wards, which meant patients had access to water.
- The Patient-Led Assessment of the Care Environment (PLACE) audit results for 2018 showed a score of 91.7% for the ward food score. Patients we spoke with all reported that the food was enjoyable, there was adequate choice, and they had sufficient food to meet their daily requirements.
- Nausea and vomiting was formally assessed and prescribed treatment was given appropriately.

**Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain.**

- Nursing staff discussed pain and pain relief with patients during the pre-assessment process. This was documented in the patient's care record. We observed a pre-assessment appointment and heard pain and pain relief post-surgery discussed with the patient.The nurse also discussed and documented the patient's current pain level. This meant there was a baseline pain score prior to the procedure occurring.
- Patients were given written information about pain control before they were admitted to the hospital. Information about pain and pain relief was included in the patient's 'your visit to our hospital booklet'. Patients were also given an in-depth booklet entitled 'your guide to pain'. These booklets covered all aspect of pain including, information on pain before and after surgery, pain and nausea information, the questions to ask before going home and the types of medication that might be prescribed. The booklet also reminded patients to tell clinical staff if they were in pain at any time during their treatment.
- We reviewed patient care records and saw that pain was assessed, documented and managed throughout the patients care. Staff used a nationally recognised tool, a visual analogue scale for assessing pain.
- The resident medical officer (RMO) could prescribe additional pain relieving medication or if there were significant concerns nursing staff said they would speak with the patient's consultant.
- Patients we spoke with said their pain was managed well and pain relief was available to them when they needed it.
- Information on pain management was part of the patient's discharge process. Pharmacy and nursing staff would speak with patients about their pain medicines and gave clear instructions on its use at home.
- Pain audits were carried out six monthly to identify that pain was being assessed, recorded and appropriate action taken to minimise the patient's pain. Information provided post inspection showed the hospital had a 94% compliance rate in the July 2018 pain audit.

**Patient outcomes**

**Managers monitored the effectiveness of care and treatment and used the findings to improve them.**

- BMI The Princess Margaret participated in the BMI hospitals corporate audit programme. This included audits of patient health records, infection prevention and control, resuscitation, controlled drugs, consent, safeguarding, hand hygiene, medicines management and consent.
- Results on patient outcomes were compared with other locations within the region and across BMI Healthcare through the corporate clinical dashboard, which used data from the incident and risk reporting database. The service was able to review their data and compare it with hospitals of a similar size within BMI Healthcare.
- The hospital participated in national audit programmes for example: Patient Reported Outcome Measures (PROMS), National Joint Registry (NJR), the National Diabetes Audit (NDA) and the Patient Led Assessment of the Care Environment (PLACE). We reviewed data submitted to the NJR which showed from April 2017 to March 2018 the hospital was submitting data better than the national average and the hospital's patient outcomes were as expected for mortality and revision rates.
- From October 2017 to September 2018, there had been five returns to theatre and six unplanned transfers of

patients to NHS hospitals. The hospital reported 12 unplanned readmissions within 28 days of discharge in the reporting period. No trends had been identified with regards to, for example, types of surgery or surgeon.

- Results from audits were monitored and discussed at the hospital's clinical governance and medical advisory committees on a monthly basis as well as at a regional and corporate level. If actions were required this would be fed back to the departments.

**Competent staff**

**The service made sure staff were competent for their roles.**

- Permanent and bank staff had to provide evidence of their registration as part of their pre-employment checks and at their annual appraisals. Agency nurses provided evidence of their registration, level of safeguarding and life support training to their employment agency.
- We saw that new hospital staff undertook an induction, which included a corporate introduction and a local orientation. New staff were required to complete e-learning and face-to-face training.
- There was a brief induction for agency staff, which covered the layout of the department, emergency procedures and where to find essential information. However, we did not see any completed induction checklists for agency staff. Therefore, the provider could not confirm these checks occurred and agency staff had received all relevant information to enable them to work safely in the department.
- Staff completed competency training depending on their role and the area they worked in. This included clinical skills, medicine management, governance, infection prevention and control and record keeping. A training booklet detailed the competences needed for each role within the hospital. For example, theatre nurses were required to complete competencies in all areas including recovery, anaesthetic, and scrub techniques.
- Competency training was based on the Benner'sstages of clinical competence that says to learn a skill you pass through five stages of development, novice, advanced beginner, competent, proficient and expert. Staff were signed off as competent, by the appropriate trainer, as competent once they had completed stage 3. During the inspection we did not review any staff competency booklets for completeness.
- Learning and development needs were identified during appraisal. We were told the BMI Healthcare group provided a wide range of courses that staff could access. Staff could also undertake external training courses, if they were relevant to the needs of the hospital. We were told of two members of the surgical team undertaking additional training to become surgical first assistants. However, ward staff told us obtaining permission to attend training courses was not as easy as it used to be which they thought was due to staffing and financial reasons.
- The theatre manager had developed a monthly half day training session, open to all theatre staff, where development sessions were delivered. These included, for example, training on equipment and instruments used in theatre by external trainers.
- There was a BMI Healthcare corporate practising privileges policy. This document provided details of the criteria and conditions under which licensed registered medical practitioners would be granted authorisation by the hospital to undertake care and treatment of patients.
- All consultant staff were required to provide evidence of their accreditation, validation and appraisal before the hospital granted them practising privileges. The hospital medical advisory committee (MAC) and the hospital director were responsible for granting and reviewing consultants practicing privileges every two years to ensure the consultants were competent in their roles.
- The hospital, on an annual basis, also ensured consultants had appropriate professional indemnity insurance in place; GMC registration and current licence to practice; an appraisal and personal development plan; infectious disease immunisation status; and their mandatory training was up-to-date.
- We reviewed four consultant files and found they all had the relevant information such as up to date disclosure and barring service (DBS) checks, annual appraisal and indemnity insurance.

- RMOs had their mandatory training and annual appraisal provided by the external agency provider. They worked against agency and BMI guidelines to ensure they were working within their sphere of knowledge. Consultants were available to provide advice and guide their daily practice.
- Staff told us they received annual appraisals. Staff we spoke with said appraisals were useful to identify progression and training opportunities. Data provided by the hospital showed from October 2017 and October 2018, 94% of theatre clinical staff and 95% of ward clinical staff had received an appraisal.

**Multidisciplinary working**

**Staff of different roles worked together as a team to benefit patients.**

- During the inspection we observed effective multidisciplinary working between different teams involved in patient care and treatment. There was clear communication between staff from different teams, such as the anaesthetist and operating department assistant, theatre and ward staff. Staff from all disciplines described the team as supportive and felt their contribution to patient care was valued.
- The hospital had introduced a daily communications cell meeting, which took place every morning and was attended by the senior management team and a representative from each department in the hospital. This included theatres, wards, pharmacy, outpatients, the catering department and patient services. All staff contributed to provide an overview of the hospital's activity. This included sickness, staffing levels, cancellations for theatre, patient admissions, any medical alerts, complaints, incidents and risks. Staff on call for emergencies were highlighted. Compliments and complaints were also discussed. Any relevant information was taken back to each department and cascaded to the team. Management and staff described the meeting as an opportunity for different teams to come together and to discuss the hospital as a whole.
- Physiotherapists and the pharmacy team gave support to patients and clinical staff pre and post operatively.
- Throughout the inspection, our observations of practice, review of records and discussions with staff confirmed good multidisciplinary working between the different teams involved in a patient's care and treatment. We observed safe and effective handovers of care, between the ward, theatre and recovery staff.
- The hospital had various service level agreements (SLAs) with the local trusts and other organisations to access some of their services. For example, microbiology and pathology services. Hospital staff did not raise any concerns about contacting or using these services.

**Seven-day services**

- The management team operated a 24-hour, seven day a week on-call rota system. Staff could access them for advice and support as needed.
- The hospital only undertook elective surgery, with operating lists planned in advance.
- Patient pre-assessment was available Monday to Friday 9am to 5pm.
- Routine surgery occurred Monday to Friday, 9am to 5pm with some late finishes until 8pm. The service ran occasional theatre sessions at the weekend depending on clinical need.Theatre staff were on-call should there be any unplanned returns to theatre.
- Consultants were on call 24 hours a day for patients in their care. The resident medical officer (RMO) was based on-site at the hospital and provided a 24 hour a day, seven days a week service. The RMO provided clinical support to consultants, staff and patients.
- Consultants were required to provide details of cover arrangements should they not be available for their patients post-surgery. This was a requirement of their practising privileges.
- Nursing cover was available on the wards when the hospital was open both during the day, and overnight for patients who required an overnight stay.
- The physiotherapy department was staffed Monday to Friday, 8am to 8pm. There was a weekend rota to provide physiotherapy to inpatients as required. This was planned in advance and staff only worked at the weekends if there was an identified need. There was on-call physiotherapy service available outside of these hours.

- The pharmacy was open Monday to Friday, from 8.30am to 5pm and Saturday 9am to 12pm. Outside of these hours the RMO and nursing staff dispensed medications which had already been prescribed, with access to an on-call pharmacist as needed. Staff told us that the process generally worked well and could not describe any concerns.
- Imaging department was open Monday to Friday 8am to 8pm and Saturday 8.30am to 5pm offering general x-ray, fluoroscopy, interventional radiology, ultrasound, mammography, bone densitometry, orthopantomography, MRI and CT.

**Health promotion**

- Patients attended pre-operative assessment appointments where their suitability for surgery was checked. This included the completion of a health questionnaire, and an opportunity for the nurse to provide advice or refer patients on to other appropriate services if they required these services.
- Physiotherapy staff saw patients who were to undergo orthopaedic surgery in a pre-operative joint clinic. These appointments provided health promotion opportunities, including how to maintain mobility by performing certain exercises.
- BMI The Princess Margaret offered free health talks to the public.These included talks on focused treatment area, for example, orthopaedics, men's health and there was an opportunity for people to have their questions answered.
- BMI Healthcare had a website where the public could access information on many aspects of health promotion via their online magazine, called 'health matters'. On this site people could find information on healthy living news and research and interviews with fitness and well-being experts. For example, heart-healthy recipes from the cardiologist's kitchen and six tips for sleeping better with chronic pain.

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

**Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.**

- There was a BMI Healthcare corporate consent for examination and treatment policy (April 2018). This included, the training required to take consent, whose responsibility it was to obtain consent and when to use implied, verbal and written consent.
- Patients were given information about their procedure both verbally and in writing by the consultants and nursing staff to make an informed decision about their procedure. Patients said doctors fully explained their treatment and additional information could be provided if required.
- We were told that patients who were booked for cosmetic surgery were given a two-week cooling off period before undergoing the procedure in case they wanted to change their mind. This was in line with national guidance from the British Association of Aesthetic and Plastic Surgeons.
- Consent forms we reviewed within the patient's records were fully completed and detailed the procedure planned and the risks and benefits of the procedure. The hospital consent forms complied with Department of Health guidance.
- We observed staff asking patients' verbal consent prior to examinations, observations and delivery of care.
- The hospital had an up to date policy regarding the Mental Capacity Act 2005 and deprivation of liberty safeguards. Staff could access this via the hospital intranet.
- Staff told us the majority of admitted patients had the capacity to make their own decisions. Patients who lacked capacity were identified during the pre-operative assessment process to determine whether they could be admitted for treatment at the hospital. Patients were risk assessed on an individual basis and adjustments put in place to deliver safe care to the patient.
- All staff received MCA and DoLS training within their safeguarding level 2 training and could tell us their responsibilities in relation to gaining consent from people who lacked capacity to consent to their care and treatment.
- Staff we spoke with could describe how DoLS might be required and how they would contact the director of

clinical services and involve the consultant and relatives as appropriate. However, none of the staff we spoke had had the need to apply for a DoLS or complete a mental capacity assessment.

- The resident medical officer told us they had not completed MCA or DoLS training. This meant we were not assured they had the necessary skills if these assessments were required.

## Are surgery services caring?

Good

Our rating of caring stayed the same.We rated it as **good.**

**Compassionate care**

**Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.**

- It was evident from our observations staff throughout the hospital put patients at the centre of what they did.
- During the inspection we saw pleasant interactions between staff and patients. Staff spoke with patients and relatives in a friendly manner, using supportive language.
- Staff understood and respected the personal, cultural, social and religious needs of people and how these may relate to care needs. For example, they checked how patients preferred to be addressed and recorded this in the patient's care records.
- We saw theatre staff offered caring and compassionate care, safeguarding the patients' dignity including when they were not conscious. For example, we saw theatre staff ensure that patients were not left exposed unnecessarily.
- The wards displayed 'thank you' cards, staff had received from patients and relatives. Patients we spoke with during the inspection spoke highly of the care and treatment they had received.
- The hospital monitored patient feedback from their Patient Satisfaction Survey and the NHS Friends and Family Test (FFT). The FFT is a tool that gives people that use the service the opportunity to highlight both good and poor patient experience.
- We were not supplied with the individual FTT performance data for the surgical service. However, from September 2017 to August 2018 the overall hospital had received an average recommend rate of 96%. We were not given the percentage response rate.
- Staff at the hospital encouraged patients to complete patient satisfaction questionnaires to review and improve patient experience. We saw questionnaires in the pre-operative assessment area and on the wards. Feedback cards were also included in the patient's discharge information pack. The results of the questionnaire were collated by an external company and a monthly report provided to the hospital for view and analysis. The monthly report showed patient response rates and ranking against all BMI hospitals.
- The Patient Led Assessment of the Clinical Environment (PLACE) privacy, dignity and well-being score was 87.9% which was higher than the BMI healthcare average of 86.5%.

**Emotional support**

**Staff provided emotional support to patients to minimise their distress.**

- Patients were given appropriate and timely support and information to cope emotionally with their care, treatment or condition. This could be in the form of talking with staff, being provided with information leaflets, or being signposted to other support services.
- The pre-operative assessment including consideration of patient's emotional well-being.
- Staff told us they had time to spend with patients and their families to provide the emotional support they needed. They understood that each patient was an individual and took time to get to know their patients. This meant they could give the right emotional support for that patient and their families when needed.
- Staff in all areas showed sensitivity and support to patients and understood the emotional impact of them

having surgery. Theatre staff told us if needed they would give additional reassurance to a patient if they were anxious about their surgery. We observed this during the inspection.

- Patients told us staff regularly checked on their well-being whilst on the wards and in theatre prior and post treatment.
- The hospital had extended visiting hours of 9am to 9pm. This meant relatives and carers could visit during the day and evening to offer support.

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

**Staff involved patients and those close to them in decisions about their care and treatment.**

- Patients told us they felt involved in the planning of their care. They told us they had received full information about their diagnosis and treatment and the care and support which would be offered following the procedure. Staff provided written information to support the verbal information given.
- Patients told us that staff clearly explained the risks and benefits of treatment to them before admission. Patients we spoke with told us they had opportunity to ask questions about their treatment. This meant that patients were involved in making shared decisions about their care and treatment.
- Staff told us that costs and payment methods were discussed with patients before admission. Patients we spoke with confirmed this and said written information was provided to them.
- Patients told us consultants visited them following their operation and answered any questions they had.

## Are surgery services responsive?

Good

Our rating of responsive stayed the same.We rated it as **good.**

**Service delivery to meet the needs of local people.**

**The service planned and provided services in a way that met the needs of local people.**

- The services provided reflected the needs of the population they served and ensured flexibility, choice and continuity of care.
- The hospital had an admission criteria which meant that the hospital only admitted patients whom the hospital had facilities to care for. A variety of surgical procedures were available within the service, including orthopaedic surgery, general surgery and urology.
- Most patients who attended the BMI Princess Margaret hospital were privately funded or insured patients. However, the hospital also worked with local commissioning groups to support NHS patients.
- Between November 2017 and October 2018 86.7% of surgical patients were non-NHS funded and 13.3% were NHS funded.
- The booking system was conducive to patient needs in that where possible, patients could select times and dates for appointments to suit their family and/or other commitments.
- Consultants had planned and dedicated theatre lists which enabled patients to be booked onto these lists in advance.
- Theatre lists for elective surgery were planned with the theatre manager and bookings team. This ensured all aspects of the patient's requirements were checked and considered before booking a patient on to the list and ensured that operating lists were utilised effectively.
- The hospital had free Wi-Fi which patients and their families could access.
- Patients and relatives attending the hospital had access to free car parking within the hospital grounds
- The hospital offered physiotherapy for both inpatients and outpatients. Physiotherapists were involved in the pre-assessment of orthopaedic patients, and provided patients with advice and education about exercise and walking aids before their operation.
- The hospital could complete simple blood tests on-site. This meant results could be obtained quickly. For more complex blood tests, samples would need to be sent to an external local laboratory.

**Meeting people's individual needs**

**The service took account of patients' individual needs.**

- Surgical patient's individual needs were discussed during booking and pre-admission assessment. This information was used by staff to provide safe care and treatment and mitigate any possible risk to the patient. If during pre-admission assessment staff identified the service could not meet the patient's needs, staff would not treat the patient at the hospital and refer the patient to an alternative health care provider who could support the patient. The hospital did not have the facilities to support the care of patients with high complex needs. Therefore, this patient group was not admitted to the hospital. However, patients who had a learning disability or dementia could be admitted but only after the appropriate risk assessments had been carried out.
- Dementia awareness training was part of the corporate BMI Healthcare mandatory training. Most staff we spoke with told us they had completed dementia training but rarely treated parents living with dementia. However, we were not provided with a breakdown of individual mandatory training rates for staff.
- The resident medical officer (RMO) told us he had not completed dementia training. Therefore, we were not assured he had the necessary skills to provide care to this group of patients.
- The Patient-Led Assessment of the Care Environment (PLACE) audit results for 2018 showed a score of 90.4% for how the environment supported patients living with dementia and 84.6% for patient's living with a disability.
- Patients received information letters and leaflets explaining about their surgical procedures and what to expect throughout their hospital visits. These leaflets were designed to address patient's questions about their forthcoming procedures. Information included details on preparing for hospital, what to bring with you and what to expect following the treatment.
- Nurses gave patients detailed explanations about their admission and treatment in addition to written information. We observed clear explanations being given during pre-assessment appointments and reassurance being given to patients who were anxious about their care treatment.
- Staff told us hospital leaflets were available in other languages for patients whose first language was not English or provided in large print.
- The service had access to an interpreting service for patients whose first language was not English. This meant staff were assured patients fully understood the information that was provided to them. The patient's need for interpreting services would be established at booking and pre-assessment appointment.
- The hospital used care pathways for surgical patients. These pathways promoted effective evidence based patient care which ensured that individual patient's needs were recognised.
- The hospital provided suitable meals and drinks for their patients. The patients and staff we spoke with talked highly of the service offered by the catering team. Facilities were available for special diets including cultural dietary needs as required. Patients expressed a high degree of satisfaction with the food and drinks and said they were offered choices.

**Access and flow**

**People could access the service when they needed it.**

- The hospital followed corporate and local policies and procedures for the management of the patient's journey, from the time of booking the appointment until discharge and after care. Staff we spoke with were aware of these policies and procedures.
- The hospital offered a flexible service that included variable appointment times and choices regarding when patients would like their treatment, subject to consultant and nurse availability.
- The hospital had established a clear booking process for appointments and hospital admissions. Patients we spoke with told us the hospital had a good and efficient booking process.
- The surgical service could conduct their patient pre-assessment either over the telephone or face-to-face dependent on the type of surgery they were having.
- BMI The Princess Margaret hospital offered either day-case or inpatient surgical procedures. Day-case surgery did not require an overnight hospital stay, inpatient surgery required the patient to remain overnight or longer after thesurgery was completed, for care or observation.

- Day-case patients were told to bring an overnight bag with them just in case they were required to stay overnight. For example, if the patient was nauseous after surgery or had no support at home. We were given examples by staff when this had happened.
- There was no formal monitoring of referral to treatment time (RTT) for private patients. Therefore, the service could not identify if there were problems relating to procedure delays and the reasons for them. However, none of the patients we spoke with or feedback we reviewed from patients, had complained of long wait times for appointments. We were told they had been seen quickly and without delay.
- As per NHS guidelines, NHS patients attending the hospital had their RTT recorded. Information provided by the hospital post inspection showed there was a RTT of 98.6% for NHS surgical patients. This meant the hospital met the target of 92% of NHS admitted patients beginning treatment within 18 weeks of referral.

**Learning from complaints and concerns**

**The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with staff.**

- The hospital followed the BMI Healthcare corporate complaints policy. We saw 'please tell us' complaint leaflets in the hospital. The BMI Healthcare website had a section detailing how to make a complaint. Complaints could be made in person, by telephone, and in writing by letter or email.
- The complaints policy stated that complaints would be acknowledged within two working days, and routine complaints investigated and responded to within 20 working days. Where the complaint investigation took longer than 20 working days, a holding letter was sent to the patient, explaining why the response was delayed. If the complainant remained dissatisfied with the response, stage two of the complaints process was instigated and BMI Healthcare would review the complaint.
- The executive director had overall responsibility for the management of complaints. Complaints were logged on the electronic reporting system. This alerted staff that there was a new complaint and heads of department would investigate the complaint as appropriate. Complainants were offered a face-to-face meeting or a telephone call with the executive director and appropriate staff such as the director of clinical services.
- From October 2017 to September 2018, there had been 24 complaints relating to the surgical service, 18 from the ward and six from theatre at the BMI The Princess Margaret hospitalThis was a rate of 0.36% of all surgical admissions at the hospital. None of these complaints had been referred to the ombudsman or the Independent Healthcare Sector Complaints Adjudication Service (ISCAS). Complaints content varied from lack of communication to private room conditions. Most complaints were resolved in the 20 days' timeframe.
- All staff we spoke with were aware of the complaints procedure. Clinical staff told us they always tried to resolve any issues or complaints at the time they were raised. If this was not possible, patients could be referred to the nurse in charge in the first instance.
- We spoke to ward staff about complaints and were told most related to the environment, continuity of care and catering. Staff said learning from complaints would be communicated to them mainly at handovers. However, staff we spoke with could not give us examples of any change of practice that had occurred due to a complaint received.
- We reviewed meetings minutes from the hospital governance meeting, heads of department (HODS) meeting, medical advisory committee (MAC) and department meetings. We saw that complaints were discussed during these meetings. However, we were not assured that learning from complaints cascaded to all staff at the ward level.

## Are surgery services well-led?

Good

Our rating of well-led improved. We rated it as **good.**

**Leadership**

**Managers at all levels in the service had the right skills and abilities to run the service.**

Good

# Surgery

- The hospital had a clear management structure in place with defined lines of responsibility and accountability. The hospital was led by an executive director, who had overall responsibility for the hospital, a director of clinical services, clinical service manager for quality and risk and the director of operations.
- The clinical service managers (CSM) of each department reported to the director of clinical services. This included the CSM for theatres and the CSM for inpatients. The CSM was also referred to as the head of department.
- At the time of the inspection the inpatient CSM position was vacant and the senior nursing staff were taking on additional duties to cover the gap.
- Senior theatre and ward staff stated that the executive director and the director of clinical services were approachable and visible, and they felt well supported by them. Staff told us that the senior managers visited each department regularly.
- Consultant medical staff told us they had a good working relationship with the staff and senior management to deliver care and meet patients' needs.
- We observed good leadership and communication amongst the theatre team. We were told by a consultant surgeon 'the theatre team was good'.

**Vision and strategy**

- The hospital was committed to the BMI Healthcare corporate vision, which was "to deliver the best patient experience in the most effective way from our comprehensive UK network of acute care hospitals". The vision had been translated into eight strategic objectives and priorities, which were entitled: The vision had been translated into eight strategic objectives and priorities, which were entitled: people, patients, communication, growth, governance, efficiency, facilities and information.
- There was a hospital strategy business plan in place which was aligned to the corporate vision and strategic priorities. Staff we spoke with were aware there was a corporate vision.
- Post inspection we asked if the surgical service had its own individual surgical service vision and strategy in place. The hospital did not supply one. Therefore, we were unsure of the departments long-term aims.

**Culture**

**The service promoted a positive culture, creating a sense of common purpose based on shared values.**

- All staff we met during the inspection were welcoming, friendly and helpful. It was evident that staff cared about the services they provided to patients.
- Staff told us they enjoyed coming to work, with many staff having worked at the hospital for many years. We were told this made teams a cohesive and supportive group. However, staff did acknowledge that it could be intimidating for new staff joining the group and therefore made sure they were inclusive of new team members.
- BMI Healthcare had a corporate Freedom to Speak up Guardian. The theatre team told us they had decided to give a member of the team the role of 'speak up guardian' for their team. With this person being the point of contact between staff and the senior management.
- Since the last inspection in 2016, the theatre team now had monthly team training half days. These meeting had helped to empower the team to raise issues of concern and challenge and change working practices if needed.
- Staff were flexible in the hours they worked to meet the needs of the service and patients. However, we were told due to staff shortages on the patient wards staff were regularly working past their shift end time or having their shifts changed at the last minute to cover ward activities. We were told this was having a negative impact on morale.

**Governance**

**There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, and sustainable services.**

- BMI The Princess Margaret hospital had a governance framework in place through which the hospital were accountable for continuously improving their clinical, corporate, staff, and financial performance.
- Patient outcomes, the audit program and hospital meetings fed into the governance framework. Each month the quality and risk manager would produce a hospital quality and risk report which was circulated to the senior management team for them to review and act on if needed.
- These reports would also be reviewed by the heads of departments to understand how their departments were performing. They could see the key quality issues of safety, risk, clinical effectiveness and patient experience for their departments. It was up to the heads of departments to disseminate this information to their teams and to act on any issues arising.
- We were told by heads of departments that information would be shared with their teams in many ways including, at handovers, on notice boards and in departmental meetings.
- There were monthly hospital and departmental governance meetings. Post inspection we reviewed minutes of these meetings and noted meetings followed a standardised format, with actions listed, who was accountable for the action and by when. The minutes of the clinical governance meetings demonstrated that staff discussed complaints and incidents, including any learning and trends related to these events. They also discussed audits, policy reviews, updates from clinical committees and any external guidance or new legislation.
- Governance was discussed at the medical advisory committee (MAC). The MAC's role was to ensure clinical services, procedures or interventions were provided by competent medical practitioners at the hospital. This involved reviewing consultant contracts, maintaining safe practicing standards and granting practicing privileges. The MAC would also discuss new procedures to be undertaken to ensure they were safe, equipment was available and staff had relevant training. The MAC chair met with the hospital executive director regularly to discuss the MAC agenda and review complaints and incidents. The MAC minutes showed discussions including key governance issues, such as incidents, complaints and practising privileges.

**Management of risk, issues and performance**

**The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**

- The hospital had a hospital risk register which was regularly reviewed and updated to ensure risks were monitored and appropriately managed. We reviewed the hospital risk register and the minutes from the hospital risk register review meeting which the senior management team attended. We found risks were reviewed appropriately.
- The departments had their own local risk registers which were managed by the heads of departments and fed into the hospital risk register.
- We reviewed the risk registered from the surgery service and could see risks we had been told about on inspection reflected what staff had told us during the inspection. For example, aging medical equipment and the dirty and clean utility process.
- From speaking with staff and reviewing documentation we were assured the surgical service were able to recognise, rate and monitor risk. This meant the service could identify issues that could cause harm to patients or staff and threaten the achievement of their services.
- There was a systematic corporate programme of clinical and internal audit to monitor quality, operational and financial processes in BMI hospitals. During our inspection we could see from speaking with staff and reviewing documentation that the surgery service was carrying out these audits and identifying and taking action where required.
- The hospital had a daily communication meeting held at 9am, Monday to Friday. Representatives from each department attended these meetings. The meeting covered a range of subjects including risk review, recent incidents, health and safety updates, training compliance review, and any concerns that affected the hospital. This enabled staff to gain a wider view of risk, issues and general performance within the hospital. It was up to the departmental representative to feed

information from the communication meeting back down to the members of their team. Staff we spoken with in the surgery team said this was a good way to be kept informed and they thought it had helped with communication throughout the hospital.

**Information management**

**The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**

- Staff had access to a range of policies, procedures and guidance which was available on the service's electronic system. Staff also told us that information technology (IT) systems were used to access the e-learning modules required for mandatory training.
- The hospital and service had clear service performance measures, which were reported and monitored by the BMI Healthcare corporate organisation and the local commissioners. There were systems in place to ensure that data and notifications were submitted to external bodies as required.
- All designated staff had access to patients' medical records which included assessments, tests results, current medicines, referral letters, consent forms, clinic notes, pre- and post-operative records.
- The BMI Group had policies and processes in place governing Information Governance, Security and Personal Data Protection. All data controller registrations for the processing of personal data were maintained in accordance with the requirements of the UK Information Commissioners Office and information security and governance policies were compliant with ISO/IEC27002 the Code of Practice for Information Security Management.
- Information technology systems were used effectively to monitor and improve the quality of care. For example, there was a risk management system where incidents and complaints were recorded.
- The director of clinical services was the Caldicott officer within the hospital. The corporate medical director held the position of the Caldicott guardian for all BMI hospitals. A Caldicott guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

**Engagement**

**The service engaged well with patients, staff and the public to plan and manage appropriate services.**

- The hospital actively encouraged patients to give feedback through patient satisfaction questionnaires, Friends and Family Test and via the hospital's complaint process.
- The service used the Patient Led Assessment of the Care Environment (PLACE) audits to gain feedback on patients' experiences.
- Members of the public were invited to attend open events held at the hospital throughout the year, where a consultant would speak about a particular health topic including the various treatment options available.
- The theatre and ward teams had monthly staff meetings where staff were encouraged to raise concerns or share experiences and we saw evidence of this in meeting minutes we reviewed. Senior staff told us there was a good attendance at these meetings.
- The senior management team (SMT) told us there was a monthly staff forum, which was open to all staff including bank and agency staff. The SMT used this to let staff know what was happening at the hospital and seek feedback. This made sure all staff where hearing the same information at the same time.
- Information was also cascaded to staff through newsletters, emails and staff noticeboards.
- Staff completed staff surveys to help the SMT assess how staff were feeling or knowledge of the hospital teams. We reviewed results from the staff safety culture survey and saw staff were confident of their role in patient safety and that of the SMT at the hospital.

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**Learning, continuous improvement and innovation**

- All staff had access to the BMI learn system which provided both mandatory and additional training modules. There was a process for applying for funding to attend external training, which staff told us had been successful in the past.

Good

# Surgery

- Once a month the theatre team had half a day's training as a team. We were told by the theatre staff these were invaluable days where the team could get together. They used the time for training, for example on new pieces of equipment or refreshing working practices.
- The hospital had introduced a daily communications cell meeting, which took place every morning and was attended by the senior management team and a representative from each department in the hospital and discussed the day's operational issues.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider SHOULD take to improve

- The service should follow guidelines for the safe storage of gas cylinders in the theatre areas.
- The service should make sure staff, when reporting incidents, fill out the level harm of the incident.
- The service should make sure that all theatre areas are free from dust.
- The service should make sure learning from complaints is cascaded to all staff including bank and agency staff.
- The service should make sure staff, including bank and agency staff, have training in sepsis management.
- The service should make sure agency staff have completed their induction checklist when working on the hospital wards.
- The hospital should review its policy for the training required by resident medical officers, with training to include the Mental Capacity Act, Deprivation of Liberty Safeguards and dementia.