Trent Cliffs Private Healthcare Limited

# Meridian House

## Inspection report

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

## Ratings

| | |
|---|---|
| Overall rating for this location | Inadequate |
| Are services safe? | Inadequate |
| Are services well-led? | Inadequate |

# Summary of findings

## Overall summary

We rated this service as inadequate because early in the inspection process we found numerous significant concerns and issued a Section 31 Letter of Intent and a further Notice of Decision to suspend the service was issued. These notices were in relation to the safe care and treatment of patients and the management and oversight of the service. Ratings limiters were therefore considered and applied.

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

- The service did not always provide safe care. Staff did not always receive mandatory training and there was insufficient attention to safeguarding. The service did not always control infection risk well. Staff did not always assess, monitor or manage risks to people who use the service. Equipment was not always checked to ensure it was safe to use and medication was not managed safely. The service did not always recognise incidents and there was little evidence of learning following incidents.

- The service was not always well-led. Leaders did not always have the capacity to lead effectively. Risk was not always managed and oversight in relation to governance processes was not always robust. Incidents were not always investigated. Policies were not always reviewed and actions plans in relation to poor audit outcomes were not always considered or developed. The service did not always operate effective procedures to evidence that all staff employed were fit and proper persons. The service did not always engage well with patients and the community.

However:

- Post inspection, the provider demonstrated a willingness to improve.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Surgery** | Inadequate  | Our rating of services went down. We rated it as inadequate because:<br>• Mandatory training records were incomplete and did not evidence that all staff had the training to undertake their roles safely.<br>• The service did not provide induction training for bank staff when they started working at the service.<br>• Not all staff had undertaken safeguarding training in line with national guidance.<br>• The service did not control infection risk well.<br>• The service put users at the risk of harm because staff did not always have equipment they need to deliver safe care.<br>• The service did not always suitably assess the risks for all patients.<br>• Patient records were not always fully completed.<br>• Medicines were not always safely managed.<br>• Incidents were not always recognised and investigated.<br>• The service did not always have effective governance systems or have effective recruitment checks in place to grant staff practicing privileges.<br>• There were not always systems in place to ensure persons employed had undergone safe recruitment procedures and employment checks. |

# Summary of findings

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# Summary of this inspection

## Background to Meridian House

Meridian House is a private outpatient doctors' consultation and treatment centre, seeing patients via referral or self-referral on a private basis and via health insurance. It is operated by Trent Cliffs Private Healthcare Limited. The hospital provides a range of elective surgery treatments for NHS and other funded (insured and self-pay) adults in a range of surgery specialties. At the time of the inspection, the service had a registered manager in post. The service comprised of 5 clinic rooms, a patient waiting area, a dedicated endoscopy room (however not in use at the time of inspection), an endoscopy preparation room and wait area. In addition, there was a surgical pre-assessment clinic, 2 operating theatres, 2 consent rooms, a 6 bedded dedicated recovery area and 10 individual en-suite rooms for overnight stays.

We carried out an unannounced inspection of the service as part of our continual checks on the safety and quality of healthcare services. We inspected the surgery core service and rated the safe and well led key lines of enquiry only.

Following this inspection, we wrote to the registered manager to notify them of the serious concerns identified during the inspection. We issued a Section 31 Letter of Intent to the provider, to inform them of our possible intention to take enforcement action. We invited them to send us an action plan, setting out how either they had already addressed each of the concerns identified above, or how they intend to address them immediately. We reviewed this action plan and the supporting documents; however, we were not assured that the provider had taken sufficient action to ensure patients were kept safe. We then issued a Section 31 Notice of Decision to advise the provider we were suspending the service until the 16th of February 2023, as although the provider had taken some steps to improve the overall safety of the service, we were not fully assured that all action had been taken. We will plan to reinspect the service, to see if sufficient action has been taken.

## How we carried out this inspection

The team inspecting the service comprised of a CQC lead inspector, a second CQC inspector and two specialist advisors. The inspection was overseen by Jenny Wilkes, Deputy Director of Operations.

Our inspection took place on 18th and 19th December and 16th and 18th January 2023, using our comprehensive inspection methodology. The inspection was unannounced, and we rated two key questions which were safe and well led.

We looked at the quality of the environment, spoke with the registered manager, four clinical staff and one administrative member of staff. We looked at a range of policies, procedures and other documents relating to the running of the service, including staff training files and service policies.

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

# Our findings

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Surgery | Inadequate | Not inspected | Not inspected | Not inspected | Inadequate | Inadequate |
| Overall | Inadequate | Not inspected | Not inspected | Not inspected | Inadequate | Inadequate |

Inadequate

# Surgery

| | |
|---|---|
| Safe | Inadequate |
| Well-led | Inadequate |

## Is the service safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

### Mandatory training

**The service did not always provide mandatory training in key skills or made sure everyone completed it.**

The provided had developed a mandatory training needs analysis plan, which included a description of what mandatory training was required for each role within the organisation and when it needed to be completed. Mandatory training topics included moving and handling, sepsis management, resuscitation, and dementia awareness.

However, we reviewed staff training records and saw that staff had not completed this training. For example, we reviewed eight digital staff records and saw in all records checked certification of completed training was missing.

At our last inspection in June 2023, we found mandatory training records were incomplete and the provider did not have evidence that staff had the training to undertake their roles safely. This is a reoccurring breach.

Staff we spoke with told us many training modules were completed as part of induction. We requested induction training records, but these were also absent. This posed a risk to patients as staff may not have received the necessary training to deliver safe care and treatment.

Following inspection, the provider submitted a training spreadsheet. This showed two clinical substantive staff had completed the mandatory training modules however we did not receive any assurance that the majority of staff who were bank and agency staff, had completed the mandatory training. Dates shown on the spreadsheet showed the expiry date of courses, without any prior evidence of completion.

Managers told us they monitored mandatory training and alerted staff when they needed to update their training. However, the same spreadsheet submitted showed gaps suggesting staff had not completed their training when it was due.

Following inspection, the provider submitted training certificates for the staff working at Meridian House. None of the staff records we reviewed, appeared to have undertaken all modules as specified in the providers training needs analysis plan.

Therefore, we were not assured that all staff have completed all their required mandatory training to carry out their roles safely.

Inadequate

# Surgery

## Safeguarding

**Staff did not always understand how to protect patients from abuse. Staff did not always have training on how to recognise and report abuse and did not always know how to apply it.**

Staff did not always receive training specific for their role on how to recognise and report abuse. We reviewed four electronic staff records and saw only one member of staff had documented accredited safeguarding training.

At our last inspection in June 2023, we found not all staff had completed the appropriate level of safeguarding training, in accordance with their role. This is a reoccurring breach.

Staff did not know how to make a safeguarding referral and who to inform if they had concerns. We spoke with clinical staff during the inspection, but none had made a safeguard alert or knew how to raise the alert. We also asked if they knew who the safeguard lead for the service was, but they were unclear. This posed a risk to patients using the service as vulnerable adults may not be sufficiently safeguarded to protect them from abuse.

Following inspection, the provider told us they had retrained all staff with the appropriate level of safeguarding training and completed practical training sessions.

We reviewed eight electronic staff files to ensure staff had received the appropriate disclosure and barring checks (DBS). We saw six staff had no evidence of DBS checks in place and two staff had completed a DBS, however these had not been rechecked since 2012 for one member of staff and 2020 for another. This posed a risk to patients using the service, as staff may not have been safely recruited and therefore not appropriate to work within their role.

We reviewed the providers DBS policy and saw prospective employees were responsible to obtain their own DBS when appointed. Existing employees were encouraged to register with the DBS update system and undertake an update every five years. At the time of inspection, we did not see evidence that staff were checked in accordance with the providers own policy. We requested evidence of appropriate DBS checks as part of the Section 31 Letter of Intent. The provider submitted two certificates, but one certificate was incomplete and the other related to the staff members previous employment. We did not see evidence or assurance that bank and agency staff had completed the appropriate checks.

After the inspection the provider also told us they had carried out a recheck of all staff DBS as per the providers policy. We reviewed the documents submitted by the provider and saw not all staff had completed an appropriate DBS. Of the 48 staff files we reviewed, 11 records showed no DBS or an incomplete DBS certificate and 5 records showed an expired DBS date.

Therefore, we are not assured that all staff have the appropriate DBS in place to ensure patients were protected from potential harm.

## Cleanliness, infection control and hygiene

**The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection.**

We requested to review cleaning schedules for the service across all areas of the building. Staff told us that the cleaning records were digital and they were not able to access them.

Inadequate

# Surgery

The arrangements for the emptying of sanitary bins for inpatients were provided through a third-party contract. We saw these bins had not been emptied following discharge of the last patient, two days previously. Staff told us the current contract meant sanitary bins were only emptied once a week.

We also saw patients were not provided with handwashing liquid at their individual sinks. Following inspection, the provider told us patients were provided with individual bars of soap.

We checked disposable theatre curtains and saw these had not been replaced since 2022. We also saw no evidence of deep cleaning in place. We spoke with staff and asked how they were able to check which rooms required cleaning, but they were unsure. This posed an infection risk to patients, as the theatre environment was not sufficiently clean to reduce the risk of infection through transmission of potentially pathogenic microbial agents from patient to patient. Following inspection, the provider submitted plans to increase the daily reporting of deep cleaning processes.

At our last inspection in June 2023, we found similar concerns relating to a lack of deep cleaning and general infection prevention and control processes. This is a reoccurring breach.

We requested a copy of the providers infection prevention and control policy but saw it had not been reviewed annually as stated. The policy did not outline any guidance to staff in relation to how infections were monitored or reported and it was not clear what cleaning processes were in place for the service.

We reviewed IPC audits for the last six months and saw compliance results were high. However, there were no action plans in place, where concerns were noted to be found.

Sharps bins were over full, with needles seen protruding from the top of the bins. This posed a needle stick risk to staff working within the service.

We brought our concerns to the immediate attention of the provider and issued a Section 31 Letter of Intent, in which the provider was made aware of our potential to take enforcement action.

Following inspection, the provider took immediate steps to address some of the concerns that were raised. This included replacing sharps bins, revising cleaning contracts and reintroducing paper-based cleaning schedules.

### Environment and equipment

**The design, maintenance and use of facilities and premises did not always keep people safe. Staff did not always carry out daily checks of specialist equipment or store COSHH chemicals safely.**

Staff did not always carry out daily safety checks of specialist equipment. We saw the resuscitation trolley in theatre was untagged and no visual checks were evident to ensure stock was replaced and appropriate for use. We also saw out of date paediatric equipment on the same trolley.

We brought this to the immediate attention of the provider whom submitted resuscitation trolley equipment checks and audits, however tag numbers did not correspond with the dates submitted on the documentation sent to us.

We also saw staff did not always manage chemicals subject to the Control of Substances Hazardous to Health Regulations 2002 (COSHH) in line with national requirements, in relation to storage and use. We reviewed the cupboard in which these chemicals were stored and found it to be unlocked.

Inadequate

# Surgery

Portable electrical appliances had not been checked as part of an annual maintenance programme with stickers in place to show testing had taken place. We reviewed servicing stickers on the patient hydraulic beds and saw that only two of the ten beds had stickers in place. Those which did have stickers were shown to be out of date.

In the sluice and in theatre we found medical gases stored inappropriately. These gas cylinders were not stored securely as required for medical gases.

We also found many out-of-date clinical supply items in theatre and recently used items which had been left out following the last theatre procedures. We saw theatre equipment including leg and arm supports were also inappropriately stored on the floor and not in a secure and sterile location.

The service had only a single wheelchair, which had also not been serviced.

We saw no evidence of anaesthetic machine checks.

We saw not all patient recovery trolleys had oxygen cylinders or suction. At our last inspection in June 2023, we found the service did not always have sufficient equipment. This is a reoccurring breach.

We brought our concerns to the immediate attention of the provider and issued a Section 31 Letter of Intent, in which the provider was made aware of our potential to take enforcement action.

Following inspection, the provider took immediate steps to address some of the concerns. For example, completed servicing of the hydraulic beds and improving the storage of medical gases and theatre equipment. The provider also submitted daily anaesthetic machine audit checking processes to confirm compliance.

In addition, the provider had also ordered a number of items such as additional oxygen cylinders and suction equipment for the patients trolleys in recovery. These remained on order, at the time of inspection.

### Assessing and responding to patient risk

**Staff did not always complete and update risk assessments for each patient and remove or minimise risks.**

Staff used a nationally recognised tool to identify deteriorating patients. Staff were required to make a professional judgement as to when to escalate manually to medical staff. We reviewed the providers transfer out policy which did not include guidance for staff regarding care of the deteriorating patient. We also saw this policy has not been reviewed since 2021. We saw no information for staff regarding escalation tool scoring and when to seek urgent medical assistance.

We spoke with a clinical member of staff regarding emergency escalation processes, and they told us arrangements were still in discussion. Following inspection, the provider submitted a further version which had been reviewed in January 2024 and provided escalation processes for staff.

Staff did not always complete risk assessments for each patient during pre-assessment, arrival, and admission. We reviewed eight digital patient records and saw gaps in 100% of the documentation that we reviewed. We also saw potential risks such as mental health issues and respiratory issues such as asthma were not flagged as possible risks. In one record we saw a patient who was prescribed anti-depressant medicine was not identified and we saw no evidence of discussion regarding this, as part of the pre-assessment. The records relating to mental health were not completed.

Inadequate

# Surgery

We saw in four of the eight records we reviewed, patients received a different recorded procedure to those that they were booked for. Staff told us this was due to a lack of digital coding for the correct procedures.

In 100% of the records we reviewed, we saw no venous thromboelism (VTE) had been completed at any point, in the patient's journey. Following inspection, we reviewed VTE provider audits which showed high compliance; however, we did not see any VTE assessments completed in the records.

In another record we found a patient admitted for gynaecology procedures, had not had a pregnancy test taken. The absence of testing to confirm pregnancy posed a potential risk to both the patient.

We saw some patients requiring continuous positive airways pressure (CPAP) were admitted following a detailed scope of practice process. The provider told us that ITU staff employed at a neighbouring NHS trust were booked as bank staff, to support high risk patients.

We also saw the provider contracted with a third-party provider to support paediatric surgery. None of the staff files we reviewed included paediatric training.

The provider did not use a sepsis bundle or similar screening tool. Although some staff had received sepsis training.

We saw no evidence of face-to-face pre-assessment prior to theatre. Staff told us this was carried out over the telephone. We saw evidence of health care assistants undertaking these assessments in the records we reviewed. This was not in line with the providers own policy which stated registered nurses complete these assessments.

In addition, some risks may not have been understood and again missed due to a lack of registered nursing input at pre-assessment stage. These concerns posed a risk to patients as essential clinical information throughout the patient's journey was not comprehensively recorded and therefore potential risks to patients could be missed.

Following inspection, the provider outlined a detailed pre and post operative assessment process, which they said they would ensure was followed.

Consent was obtained on the day for the procedure, with no cooling off period to support patients who may decide not to go ahead with the surgery. The provider told us that initial consent would be first sought by the referring clinicians prior to the day of surgery.

We saw no recorded documentation of handover to clinical staff when patients required care overnight.

The inpatient areas did not have a high visibility point, in which particularly high-risk patients could be observed. Both inpatient areas were side rooms along single line corridors without a nursing observation bay.

We brought our concerns to the immediate attention of the provider and issued a Section 31 Letter of Intent, in which the provider was made aware of our potential to take enforcement action.

Following inspection, the provider took immediate steps to make improvements regarding some of the concerns raised. For example, pre-assessments to always be undertaken under the supervision of a registered general nurse and training to be refreshed for all clinical staff regarding sepsis. The provider told us that side rooms were for stable and well patients after four hours in central recovery. Sepsis training had been reintroduced and refreshed for those staff who required it.

Inadequate

# Surgery

The provider also submitted evidence to confirm the termination of contract, for the provision of paediatric surgery.

## Staffing

**The service had enough nursing and support staff and managers reviewed and adjusted staffing levels. However, bank and agency staff did not always receive an induction and skills and training to safely undertake their roles were not always completed.**

The service employed a small number of clinical staff, with the entirety of theatre and recovery staff provided through bank arrangements or external agency.

The theatre lead at the time of inspection had been asked to oversee the running of this provision, due to staff sickness.

The provider utilised a standard staffing tool to calculate the numbers of staff required, depending on patient lists. It was not evident how skills of staff were assessed, due to the lack of training records and certification.

The registered manager told us that bank staff held substantive contracts in neighbouring trusts and were employed in those trusts as theatre, intensive therapy or recovery unit staff. We saw no record of induction for bank and agency staff. This concern was also found in the June 2023 inspection and is a reoccurring breach.

The service did not employ doctors, however medical staff were managed through practicing privileges arrangements.

We saw there was a resident medical officer for inpatient stays, which was managed through a rota.

Following inspection, the registered manager told us that all contracts for staff were currently being reviewed and it was not possible to determine the number of substantive staff, bank and agency staff utilised by the service.

A number of appointments had also been made, which included a Registered Manager, Deputy Medical Director and several clinical leads. Following inspection, the provider also submitted some training certificates for bank and agency staff, demonstrating how the skill mix was managed in accordance with patient need.

## Records

**Staff did not always keep detailed records of patients' care and treatment. Although records were stored securely.**

We requested to review eight patient records. Staf told us that patient information was stored digitally. We saw records were password protected and secure. In 100% of the records we reviewed, gaps were noted in several areas including pre and post op assessment, recovery and consultant review. We also found no evidence of care planning in place for fundamental aspects of care and treatment. For example, post operative management, personal hygiene and medicines management.

We also saw patients were not provided with a copy of their consent form.

We brought our concerns to the immediate attention of the provider and issued a Section 31 Letter of Intent, in which the provider was made aware of our potential to take enforcement action.

Inadequate

# Surgery

Following inspection, the provider told us they had commenced an audit of 100 patient files for review and action. The provider also outlined a process for both preoperative checking, post operative review and discharge. The provider acknowledged that patient records should be reflective of the patient journey and advised of a number of audits to be completed both weekly and monthly to ensure ongoing compliance.

The provider also introduced new log in processes to ensure patients would be sent a copy of their consent form electronically.

## Medicines

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

Staff did not always follow systems and processes to administer medicines safely.

We reviewed the controlled drugs register for the service and saw second check signatures were missing for three recent dates in September. The National Institute for Health and Care Excellence (NICE) guidance in relation to controlled drugs administration, states that administration must also be witnessed and both signatures evident.

Staff did not always store and manage all medicines safely. We found Lidocaine in the resuscitation trolley (separate to emergency drugs box) and IV fluids were stored on the floor.

We also found out of date medicines on the spinal trolley.

We saw no evidence of medicines management training for staff or training in relation to take out medication (TTO).

Some staff we reviewed had completed medical gases training.

None of the clinical staff had been provided with medicines management training by the service, despite administering medication as part of their role. We reviewed the providers medicines policy and saw that only pharmacy staff were required to undertake this training. We reviewed the pharmacists training records and saw no evidence of this training.

We brought our concerns to the immediate attention of the provider and issued a Section 31 Letter of Intent, in which the provider was made aware of our potential to take enforcement action.

Following inspection, the provider took immediate steps to make improvements and introduced daily checking processes for staff to undertake. The provider also told us they had commenced a training and compliance regime regarding medicines training for all staff and were we provided with training certificates for some staff.

## Incidents

**The service did not always manage patient safety incidents well. Staff did not always recognise and reported incidents and near misses. Managers did not always investigate incident and share lessons learned with the whole team and the wider service. We saw no recorded evidence of duty of candour.**

The service had reported no never events.

Inadequate

# Surgery

We reviewed the providers incident policy and saw there was no original version date to show when the policy was introduced. We also saw there were no defined timescales, in which incidents should be investigated and actions taken, in which to mitigate further incidents.

Staff did not always know what incidents to report and how to report them. We spoke with staff and asked them to articulate how to log an incident, but they were not sure of the process. We asked for examples of the most recent incidents, but staff were not able to articulate this.

We reviewed the most recent incidents submitted by the provider and saw they varied with no associated themes or trends.

Of the 16 incident forms we reviewed, 100% had no investigation outcome or next steps required to mitigate a further incident. The provider had developed an overview of the incidents, but we saw no evidence of learning shared within the service.

In addition, we requested specific incident documentation regarding a 'transfer out' patient, following a complication during surgery. This episode had not been classified as an incident as it was felt by the provider that all processes had been followed by staff involved. Therefore, there had been no investigation as to why the incident had occurred and no learning to ensure patients were protected from further events in the future.

The providers own policy defines an incident as 'An event or circumstance that could have resulted or did result in unnecessary harm to a patient'. Therefore, we are not assured that incident reporting systems and processes were robust and effective.

We brought our concerns to the immediate attention of the provider and issued a Section 31 Letter of Intent, in which the provider was made aware of our potential to take enforcement action.

## Is the service well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate.

### Leadership

**Leaders of the service on surgical list days, were visible and approachable for patients and staff. However, local managers did not always have the capacity to lead effectively.**

The registered manager for the unit held significant experience in surgical services and was Chief Executive, Registered Manager and the accountable officer for controlled drugs.

A hospital governance and leadership team were appointed and reported to the board of directors. The team consisted of clinical operations staff as well as pharmacy, IT governance and administrative personnel.

A Medical Director held responsibility for the governance and oversight of surgeons working under practising privileges and the resident medical officer.

Inadequate

# Surgery

At the time of inspection, the appointed Director of Nursing was not in post, due to a period of absence and there was no deputy provision in place during periods of the managers absence. A theatre lead had recently been appointed in November 2023 and worked flexible hours, depending on the surgical lists and general capacity.

At the time of inspection, the Registered Manager was out of the country and staff onsite were required to seek instruction remotely to assist inspectors on site.

Some staff within the organisation provided some additional oversight and support during particularly busy periods and provided some leadership support in the absence of a deputy manager. For example, senior nursing staff.

All staff we spoke with considered the leadership team to be approachable and contactable, even when staff were off site.

The Registered Manager recognised the need to appoint a dedicated member of staff, to support day to day operational service delivery and governance responsibilities, due to their own lack of capacity. Following inspection, a new Registered Manager for the service was appointed. In addition, the provider made a number of senior lead appointments to specifically support theatre, recovery, medicines management and general governance oversight.

## Vision and Strategy

**The service had a vision for what it wanted to achieve and a mission statement underpinned by values.**

The providers vision statement was to be the best in class at a reasonable and fair price. The mission was to keep people healthy by working with local and regional partners to establish and develop a first-class patient centred hospital that delivers world class health care over a variety of specialities. The provider states that integrity, trust and excellence are at the heart of what they do. The vision statement however was not supported with the detail, as to how the service would achieve its mission. The provider did not have a strategic plan in order to fulfil service objectives.

We reviewed governance meeting minutes for August and November 2023 and saw strategy and values were not agenda items and therefore we are not assured what outcomes the provider monitored, to ensure service practice was aligned to the overarching vision and values of the service.

## Culture

Staff we spoke with during our inspection told us they enjoyed their role. The provider was reviewing staff contracts at the time of inspection, and it was not possible to speak with additional staff offsite, whilst this process was in progress.

We requested the results of the last staff survey carried out in October 2023 and saw a 100% response rate from staff, however it was not clear how many staff had responded. The findings were positive and we saw the provider had developed a number of actions to drive specific focus areas. Thes included great leadership, great teams, building an inclusive workplace, values and behaviours and wellbeing.

The provider planned to undertake a deep dive twice yearly on staff engagement which would be reported to people management and leadership development, EDI and wellbeing.

## Governance

**Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not always clear about their roles and accountabilities and did not always have regular opportunities to meet, discuss and learn from the performance of the service**.

Inadequate

# Surgery

We saw the provider held regular governance meetings and had recently combined the Private Medical Advisory Committee meetings (MAC) with the monthly governance meetings. The MAC reported to the governance board. We reviewed governance meeting minutes, but it was not clear when MAC discussions ended and general governance discussions commenced.

A nursing board was also in place consisting of the director of nursing and a number of clinical leads. Discharge lead and care navigators and administrative support were also part of the nursing board.

The provider told us managers completed a series of quality and compliance linked training topics. These included risk management, managing safely, completion of root cause analysis and managing a safe clinic environment and fire safety.

The provider had developed clear scope of practice guidelines for the surgical procedures offered at Meridian House. The provider told us that each scope was regularly reviewed at monthly governance meetings and all updates from national consensus bodies and NICE guidelines were incorporated. However, we reviewed governance meeting minutes for August and November 2023 and saw scope discussions were not agenda items.

A medicine management group, information governance steering group, response and safeguarding group, also reported to The Board of Directors and to the governance board.

We requested a governance structure from the provider to show senior leadership team responsibilities and we saw key areas for each role. However, not all staff were clear regarding their roles and responsibilities. Some staff were waiting to find out what their role would be and none of the staff we spoke with knew how to log an incident or raise a safeguard.

The provider told us there was a programme of audits across the service, we reviewed clinical audits such as airway resuscitation audits, daily cleaning audits and post operative notes audit. However, the providers findings did not corollate with inspection findings. For example, we saw 100% compliance in the post operative notes audit October 2023, clinical governance meeting minutes. However, during the inspection, we found gaps in 100% of the patient records that we reviewed and therefore we were not assured that audits were robust and comprehensive.

There was a policy in place for the management of consultant practising privileges. Consultants with practising privileges where required, were listed on the specialist register. We reviewed the providers spreadsheet which showed how surgeons working under practising privileges were monitored. We saw gaps where dates should have been entered, to confirm DBS and appraisals had been completed. We spoke with the Medical Director in relation to these gaps, but we were not provided with any assurance as to the reason for the missing details.

We saw the provider held only digital records for staff working at Meridian House. In all nine records we reviewed we found gaps with safer recruitment checks, mandatory training certification or professional registration checks. The provider did not have an overarching process to monitor these checks and relied on Trent Cliffs administrative staff to compile the documents.

We reviewed the sharing of learning following incidents and saw that although incidents were a regular agenda item on the clinical governance meeting agenda, learning and next steps to improve practice were not discussed.

We did not see evidence of general staff meetings to share clinical governance information.

Inadequate

# Surgery

The provider told us that policies were reviewed at every meeting and following review of the most recent meeting minutes, we saw they were included. However, again this did not corollate with the findings of the inspection, which found key policies such as the transfer out policy to be out of date. We saw some policies and procedures available for public viewing were available on the website. We reviewed 13 policies on the website and saw 11 were out of date. We found out of date policies in the June 2023 inspection therefore this is a re-occurring breach.

The provider was also without a home office licence at the time of inspection. This licence is required to be able to lawfully receive controlled medicines. The provider told us they were going to apply for this, and we saw confirmation of the application, following the inspection.

We brought our concerns to the immediate attention of the provider and issued a Section 31 Letter of Intent, in which the provider was made aware of our potential to take enforcement action.

Following inspection, the provider took immediate steps to increase the senior leadership team and strengthen oversight of governance strictures and processes. The provider also introduced additional checking systems to ensure policies, processes and practice were audited to ensure compliance was improved across the areas of concern that were raised.

### Management of risk, issues and performance

**Leaders and teams did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identified actions to reduce their impact.**

We reviewed the providers risk register and saw that it was limited in detail and did not reflect the concerns found on inspection. We saw there 9 risks on the current risk register, 3 of which were clinical risks. None of the risks identified had a review date or clearly defined timescales in which actions needed to be completed.

None of the concerns raised by inspectors were documented as a concern on the providers risk register. The Registered Manager was not aware of the concerns raised by inspectors but acknowledged a willingness to improve.

The service produced quarterly quality and performance reports. We reviewed the April – June 2022, report but the information regarding incidents, safeguarding and medicines management did not contain comprehensive detail to ensure performance and quality was measured.

We reviewed the providers audits in relation to infection prevention and medicines management, however areas of poor compliance were not flagged or escalated.

At the time of inspection, the provider did not always use systems to effectively manage and monitor risks. For example, we found that mandatory training records were incomplete for all staff we reviewed. Professional registration checks were not always completed for all staff. Safer recruitment checks were not complete for all staff we reviewed. The providers practising privileges monitoring spreadsheet, showed gaps in key areas such as DBS check date and appraisal completion.

At our last inspection in June 2023, we found the service did not have effective systems or effective recruitment checks in place to ensure persons employed had undergone safe recruitment checks. This is a reoccurring breach.

Incidents were not thoroughly investigated to avoid future events.

Inadequate

# Surgery

Equipment was not always stored or serviced appropriately, and the provider did not have processes in place to enable oversight of this.

Patient records were incomplete for all records we reviewed, and we found no formal care record audit processes.

Staff were not able to define safeguarding and incident reporting processes sufficiently, to ensure patients were kept safe.

Staff did not always have the necessary skills and training to deliver safe care and treatment.

Therefore, we were not assured that risk management processes including clinical oversight by the registered manager were sufficient to keep patients safe.

We brought our concerns to the immediate attention of the provider and issued a Section 31 letter of intent, in which the provider was made aware of our potential to take enforcement action.

Following inspection, the provider took immediate steps to make some improvements and introduced daily checking processes for staff to undertake and increasing the frequency of policy reviews. Equipment orders were made for items identified as required as part of the inspection and staff recruitment checks were revisited. Staff also underwent further DBS checks in accordance with the providers own policy. We saw mandatory training certificates were also submitted for staff who continued to work for Meridian House. However, medicines management and specialist training records were not provided.

### Information Management

We did not inspect information management.

### Engagement

**Leaders collaborated with some partner organisations to help improve services for patients.**

The provider told us they shared the scope of practice documentation with the NHS and integrated care board (ICB) and trusts to agree common clinical pathways, to deliver quality services to patients.

We requested additional information from the provider to demonstrate effective engagement with all partners, but this was not provided.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury<br>Surgical procedures<br>Diagnostic and screening procedures | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>• The service must ensure robust oversight and management of incidents and ensure incident investigation is clear and themes from incidents are shared across the speciality. Regulation 17 (1) (2) (a) (b)<br>• The provider must ensure robust oversight of medication management processes, including the regular auditing of medication administration records and review of storage and disposal. Regulation 17 (1) (2) (a) (b)<br>• The provider must have effective governance processes to ensure the safe and effective delivery of care. This must include post audit action planning and performance outcome monitoring, to improve patient outcomes. Regulation 17 (1) (2) (a) (b)<br>• The provider must ensure policies are regularly reviewed to ensure they reflect national guidance and current best practice across the speciality. Regulation 17 (1) (2) (a) (b)<br>• The provider must ensure key information is shared consistently across all staff groups, including risk and performance monitoring data. Regulation 17 (1) (2) (a) (b) |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury<br>Surgical procedures<br>Diagnostic and screening procedures | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment |

This section is primarily information for the provider

# Requirement notices

- The provider must ensure that staff continue to have the required level of training or skills to enable them to carry out their roles and responsibilities safely. Regulation 12 (2)(c)
- The provider must ensure staff have the appropriate level of safeguarding training and are able to recognise the potential risk and protect vulnerable adults and children from abuse. Regulation 12 (2)(c)
- The service must ensure equipment used for the safe care and treatment of patients is checked and records are completed regarding these checks. Regulation 12 (2)(c)
- The provider must have robust procedures in place for the identification, monitoring and escalation of patient risk. Regulation 12 (2)(c)
- The provider must have robust procedures in place for the early identification of deteriorating patients to ensure timely care and treatment. Regulation 12 (2)(c)
- The service must ensure safe medicines management in all areas, specifically in relation to controlled drugs. Regulation 12 (2)(c)
- The service must ensure that all patient records are comprehensive, accurately completed and include appropriate preoperative and post operative assessment and care planning. Regulation 12 (2)(c)

| Regulated activity | Regulation |
| --- | --- |
| Treatment of disease, disorder or injury<br>Surgical procedures<br>Diagnostic and screening procedures | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br>• The provider must have the processes in place to ensure that staff are safely recruited, suitably qualified, competent, skilled, and experienced persons to ensure |

This section is primarily information for the provider

# Requirement notices

provision of a safe service. The manager must ensure that they meet the requirements of Schedule 3 and 4 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Regulation 19 (1) (a)(b)(2)