BMI The Kings Oak

Quality Report

Chase Farm (North Side)
London
EN2 8SD
Tel: 020 8370 9500
Website: www.bmihealthcare.co.uk

Date of inspection visit: 25 September 2019
Date of publication: 05/11/2019

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

BMI The Kings Oak is operated by BMI Healthcare Limited. The hospital has 47 beds. Facilities include two operating theatres, one medical and surgical ward, one ward for services for children and young people, phlebotomy and minor operations room, outpatients and diagnostic imaging department.

The hospital provides surgery, medical care, services for children and young people, and outpatients and diagnostic imaging. We inspected surgical services only during this inspection.

We previously inspected surgical services in April 2019 where we rated safe as 'inadequate' and well led as 'requires improvement'. During the April 2019 inspection, we also identified a breach in regulation 12 (safe care and treatment) and 17 (good governance) of the Health and Social Care Act (HSCA) 2008. We inspected this service using our focused inspection methodology to reinspect the Safe and Well Led domains and determine if improvements had been made. We looked at processes around safer surgery, infection control, safety culture and leadership within theatres. We carried out the announced focused inspection on 25 September 2019.

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 hospital improved. We rated it as **Good** overall.

We found areas of good practice in surgery:

- Leaders understood and managed the priorities and issues the service faced. Following the CQC inspection in April 2019, leaders worked with staff to improve practices in the theatres and build a culture to support patient safety. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- Leaders in the service worked to promote an open culture where patients, their families and staff could raise concerns without fear. Improvements were made in the service so that staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.
- Staff completed and updated risk assessments for each patient and minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

We found areas of practice that require improvement in surgery:

Summary of findings

- Although the service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment, they did not always staff theatres in accordance with best practice. The service continued to have a high-dependency on agency staff in theatres, however most agency staff were familiar to the service and worked there regularly.

Following this inspection, we told the provider that it should make some improvements, even though a regulation had not been breached, to help the service improve.

Dr Nigel Acheson
Deputy chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Good

Location name here

Services we looked at
Surgery

Summary of this inspection

Background to BMI The Kings Oak

BMI The Kings Oak Hospital in Enfield, London is operated by BMI Healthcare Limited. The hospital opened in 1991. The hospital has 47 beds and is located on the grounds of Chase Farm Hospital in Enfield. Services are provided to both insured, self-pay private patients and to NHS patients through both GP referral and contracts.

The hospital has had a registered manager in post since 2010 with the current registered manager in post since 2017.

The hospital provides a range of services, including surgical procedures, surgical and inpatient care, inpatient care for children and young people, outpatient consultations and diagnostic imaging. There are two operating theatres, 12 outpatient consulting rooms, a minor procedures room, minor treatment room and a phlebotomy room.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one CQC inspection manager, and a specialist advisor with expertise in surgery. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.

Information about BMI The Kings Oak

The hospital has one ward and is registered to provide the following regulated activities:

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

During the inspection, we visited both theatres and the combined surgical and medical ward. We spoke with 16 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. During our inspection, we reviewed five 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 has been inspected five times, and the most recent inspection took place in April 2019.

Activity (April 2019 to August 2019)

- In the reporting period, there were 1,561 inpatient and day case episodes of care recorded at The Hospital; of these 49.6% were NHS-funded and 50.4% other funded.
- 15.4% of all NHS-funded patients and 22.1% of all other funded patients stayed overnight at the hospital during the same reporting period.
- 123 surgeons, 61 anaesthetists and 23 radiologists worked at the hospital under practising privileges. The hospital also employed 14 registered practitioners (including nurses), 14 health care assistants (HCAs) and 26 administrative staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- No Never events
- Clinical incidents 25 no harm, seven low harm, no moderate harm, no severe harm, no deaths
- No serious injuries

Summary of this inspection

No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),

No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)

No incidences of hospital acquired Clostridium difficile (c.diff)

No incidences of hospital acquired E-Coli

20 complaints

Services provided at the hospital under service level agreement:

- Pathology and histology
- Clinical and or non-clinical waste removal
- Grounds Maintenance
- Laundry
- Maintenance of medical equipment
- RMO provision
- Medical records storage
- Confidential waste service
- Laser protection and radiation protection
- Decontamination Unit

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

Our rating of safe improved. We rated it as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure staff completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service had improved how it controlled infection risk. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The service had improved the design, maintenance and use of facilities, premises and equipment to keep people safe. Staff were trained to use them. The service acted to improve management of clinical waste.
- The service had made improvements to minimise risks to patients through compliance with the surgical safety checklist and other safety measures. Staff completed and updated risk assessments for each patient and minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Observations during the inspection showed that patients received the right medication at the right time.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Summary of this inspection

- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

However,

- Although the service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment, they did not always staff theatres in accordance with best practice. The service continued to have a high-dependency on agency staff in theatres, however most agency staff were familiar to the service and worked there regularly.

Are services effective?

Good

The current rating displayed is from the previous inspection published on 20 August 2019, we did not re-rate this key question as part of this focused inspection.

Are services caring?

Good

The current rating displayed is from the previous inspection published on 20 August 2019, we did not re-rate this key question as part of this focused inspection.

Are services responsive?

Good

The current rating displayed is from the previous inspection published on 20 August 2019, we did not re-rate this key question as part of this focused inspection.

Are services well-led?

Good

Our rating of well-led improved.We rated it as **Good** because:

- Leaders in the service worked to promote an open culture where patients, their families and staff could raise concerns without fear. Improvements were made in the service so that staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.
- Leaders understood and managed the priorities and issues the service faced. Following the CQC inspection in April 2019, leaders worked with staff to improve practices in the theatres and build a culture to support patient safety. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Summary of this inspection

- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Leaders operated effective governance processes throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. Improvements were made to identify and escalate relevant risks and issues and identify actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.
- Leaders and staff actively and openly engaged with patients, staff to plan and manage services.
- Staff were committed to continually learning and improving 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 improved. We rated it as **good.**

Mandatory training

The service provided mandatory training in key skills to all staff and made sure staff completed it.

The hospital set a target for 90% for completion of all mandatory training courses. Overall, mandatory training completion rates were 97% for staff in theatres and 90.3% completion for staff on the ward. Completion rates had improved since our last inspection in April 2019. The hospital mandatory training programme included equality and diversity, fire safety training, immediate life support (ILS), infection prevention and control, consent, dementia awareness, waste management and safeguarding.

Staff received and kept up-to-date with their mandatory training. Six months before mandatory training courses expired, staff received monthly reminders of upcoming training to complete. Training was delivered through e-learning and face-to-face training. Staff told us they were given enough time to complete mandatory training and that the quality of mandatory training was good.

The mandatory training was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Following our inspection in April 2019, managers in the service met with all staff whose mandatory training was below 90% completion. Staff were allocated protected time to complete training. The service aimed to have 100% of staff complete mandatory training unless they were new starters.

Temporary staff were required to provide evidence of mandatory training compliance from their employers. During our inspection, we reviewed that an agency staff member in theatres was up to date with all their mandatory training. Resident medical officers (RMOs) were managed by an agency to complete mandatory training and had access to the hospital online training system.

The medical advisory committee (MAC) checked that consultants and clinicians with practising privileges had completed their mandatory training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff and medical staff received training specific for their role on how to recognise and report abuse. In theatres, there was 100% staff compliance for safeguarding training completion. There was 95.7% compliance of safeguarding training for staff on wards where surgical patients were treated.

The service had access to staff who completed level 3 safeguarding vulnerable adults training. Most staff (93.3%) had completed female genital mutilation (FGM) training across surgical services.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew what processes to take to make a safeguarding referral and who to inform if they had concerns.

Cleanliness, infection control and hygiene

The service had improved how it controlled infection risk. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

At our previous inspection, we noted there was no sluice in the recovery area which meant staff had to walk across the entire theatre department for the closest sluice. This had been on the risk register and was regularly discussed at clinical governance meetings. Following our inspection in April 2019, executive leaders of the hospitals explored possible solutions and had put a plan in place to resolve this issue. There was an approved business case and the work to create a door from recovery to the dirty corridor and the sluice room was to be completed in the months following our inspection.

The service was working to address issues we found around staff not always being bare below the elbow in clinical areas. Some actions implemented were to remind staff to remove warm up jackets and ensure staff challenge anyone who enters theatres or the ward and is not bare below the elbows. Staff were also encouraged to report any non-compliance. We saw improvement during our inspection and observed compliance from staff to be bare below the elbow. Staff we spoke with told us that they felt supported by managers to challenge any other staff member, including consultants.

Ward areas appeared clean and had suitable furnishings which were clean and well-maintained. Nursing staff were responsible for cleaning specific areas of the ward. We reviewed cleaning records for the last six months which were fully completed, and days were marked when cleaning was not completed because the ward was closed.

The service had improved cleanliness in theatres following our inspection in April 2019. Actions put in place to improve cleanliness included, develop weekly, monthly and quarterly cleaning plans, include store room cleaning quarterly, allocate cleaning to specific staff daily, discuss cleanliness at staff meetings and revisit the correct use of 'I am clean' green sticker labels. Staff used new checklists to monitor IPC. These were audited monthly as well as discussed at theatre and infection prevention and control (IPC) meetings.

There were quarterly IPC committee meetings. We reviewed three sets of IPC committee meetings from January 2019, April 2019 and July 2019. Attendees included senior leaders of the hospital, pharmacy staff, quality and risk manager, a microbiologist consultant, the IPC lead nurse, representatives from hospital departments and housekeeping. Standard agenda items included water safety committee feedback, surveillance report for the reporting period, progress on the IPC annual work plan, reviews of action plans, audits, air flow reports, antimicrobial stewardship, and occupational health.

On our previous inspection we saw that staff did not always follow appropriate IPC procedures; at this inspection we saw this had improved and observed good hand hygiene in theatres, recovery and the ward. We also observed good compliance with bare below the elbows best practice. The hospital undertook hand hygiene audits regularly. In June 2019, the service reported hand hygiene compliance of 84% in theatres and 100% on the ward. Following the results from the June 2019 hand hygiene audit, the service created an action plan acknowledging that staff still needed reminding of hand hygiene after patient care. The action plan included target dates and named individuals responsible for completed actions. The service planned to audit again at the end of September 2019.

The hospital and its nearby sister hospital had an infection and prevention control (IPC) lead with link nurses in surgical services. This meant that staff could get advice from the link nurse or IPC lead for any questions.

Staff followed infection control principles including the use of personal protective equipment (PPE). The service provided staff with PPE to prevent and protect people from healthcare-associated infections.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. The service used green 'I am clean' stickers to indicate when

equipment was cleaned. Along with cleaning equipment between patient use, nursing staff told us that night shift staff took responsibility to do regular cleaning of equipment.

Staff worked effectively to prevent, identify and treat surgical site infections. The hospital participated in the surgical site infection surveillance service coordinated by Public Health England (PHE). Between September 2018 to August 2018, there were 3,597 surgical cases performed in the service. The service reported three surgical site infections during the reporting period which occurred in hand surgeries. Hand surgery was not covered by PHE therefore, these rates were not reported to PHE.

Environment and equipment

The service had improved the design, maintenance and use of facilities, premises and equipment to keep people safe. Staff were trained to use them. The service acted to improve management of clinical waste.

There continued to be good security of the theatres and recovery area. Theatres and recovery were accessible through a secured keypad-controlled door.

There were two theatres suites which covered a variety of specialties, including orthopaedics, urology, gynaecology and cosmetic surgery. One of the theatres was equipped with laminar flow which safely filtered air away from the operating area and helped to prevent any bacterial contamination being recirculated. All orthopaedic operations and most operations requiring implants were done in the theatre with laminar flow to help prevent surgical site infections. Both theatre suites had an attached anaesthetic room.

Staff tested the defibrillator on the resuscitation trolley in theatres and recovery and on the ward daily and we saw records that indicated this. The service had an easily accessible difficult airway trolley which was checked regularly and was well-stocked. Staff could easily and quickly access a spillage kit and transfer bag (to enable quick transfer of patient to hospital in case of emergency) if needed.

Staff carried out daily safety checks of specialist equipment. In our last inspection, we found that the anaesthetic machine was not always checked or documented when theatres were closed. The service acted to improve this practice and we found that now there was daily surveillance by the theatre coordinator and senior anaesthetic staff. We observed the anaesthetic log book to be fully completed. During the daily safety huddle, a member of staff was allocated the responsibility to do safety checks of the anaesthetic machine.

Patients could reach call bells and staff responded quickly when called.

Most of the design of the environment followed national guidance and where there were gaps, the service worked to make improvements. On the ward, there was no longer any carpet present in clinical areas; all clinical areas had a wipe clean flooring. The service completed their improvement plan to have hand washing facilities available in each patient room. Theatres had wipe clean flooring, however we found that not all cabinets in theatres area were wipe clean.

The service had enough suitable equipment to help them to safely care for patients. There were processes in place to procure the appropriate equipment for surgical cases.

The service worked with their equipment servicing contractor to ensure good oversight that all items on site were up to date from a service point of view and were labelled, dated and logged. Managers in the service worked to clear out pieces of equipment that were not used or needed to avoid them going past their service date.

Staff disposed of clinical waste safely. Sharps bins were easily accessible throughout surgical services, all were sealed and dated, and none were found to be overfull. During our inspection in April 2019, we found that some clinical waste in theatres was disposed of in the general waste bin. During this inspection, we found the service had removed general waste bins in theatre suites to avoid any improper disposal of clinical waste.

There was appropriate emergency equipment on the ward and theatre and recovery areas. This included resuscitation equipment, fire extinguisher cylinders, fire blankets, defibrillator, emergency eye wash and oxygen cylinders. We checked a range of consumable items from the resuscitation trolley, including syringes, airways and nasogastric tubes and emergency medicines and noted they were all in-date. Resuscitation trolley drawers were secured with a tamper evident tag.

Storage space availability continued to be an issue for theatres, however we found that some improvements were made from our last inspection. Previously, we found that due to storage of the paediatric resuscitation trolley in a recovery bay, the recovery bay was cramped. This meant that if a patient needed resuscitation efforts, it could be difficult to access the patient. Following our inspection in April 2019, the service found an alternate area outside of theatres to store the paediatric resuscitation trolley. Now, the paediatric resuscitation trolley was only brought into theatres when paediatric patients were having a surgical procedure.

During our last inspection, we found the anaesthetic room to be cluttered and disorganised. The service had made improvements in this area by checking stock levels, removing boxes from the work surface and appropriate removal of old documentation ring binders. This was now monitored daily by the theatre coordinator and discussed and monitored at staff meetings and was now part of the monthly IPC audit.

Assessing and responding to patient risk

The service had made improvements to minimise risks to patients through compliance with the surgical safety checklist and other safety measures. Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

During our inspection in April 2019, we observed that staff did not always adhere to the World Health Organisation (WHO) surgical safety checklist and '5 steps to safer surgery'. Following our inspection, the service undertook considerable work to improve the culture amongst staff to challenge poor or unsafe behaviours in theatres. During this inspection, we observed staff actively participated in the WHO checklist. Managers in the service redesigned the observational audit for the WHO checklist so that any staff member (clinical or non-clinical) could undertake the audit confidently. During this inspection, we reviewed the observation WHO checklist audit from September 2019. The audit showed 98% compliance over 13 surgical cases. The service was working to ensure consultant compliance with the WHO surgical safety checklist as well, and staff were supported to escalate any non-compliance to executive managers who would discuss with the MAC chair.

We were told by staff that BMI had a colour-coded hat system to identify specific staff roles during theatre, for example yellow for the team leader. This system was to help all staff quickly identify everyone in theatre and know what their responsibilities were in theatre. During our inspection in April 2019, this system was not being used and not all staff were aware of the system. The service acted to re-implement this system and we found on this inspection that all theatre staff were aware of the colour-coded system and that it was now well-embedded. The hat code was displayed in all changing rooms with the colour code and photos attached.

During our inspection in April 2019, we found that although there was good attendance at the theatre team briefing, there was limited to no discussion of the patients' past medical history, allergies and American Society of Anesthesiologists (ASA) physical status classification (a system used to assess the fitness of patients before surgery).

In theatres there was improved monitoring of safety systems which was now being delivered in a robust and consistent manner by staff. For example, there was now ownership of monitoring the warming fluid cabinet and processes were embedded for monitoring temperatures and expired fluids. Staff were now engaged during the WHO checklist and improvements were made so the anaesthetic room checklists were always completed.

The service was working to make improvements around the surgical instrument checklists. During our inspection in April 2019, we observed instrument checklists were being marked as complete before they were being done. The service worked with staff reminding them to ensure instrument checklists were done as per policy and were completed line by line at the time of the check. We observed good practice by staff during this inspection.

We found improvements were made in theatres concerning best practice for safer surgery. For example, it is best practice for theatres to have a standardised dry wipe count board which states all relevant items used. During our previous inspection in April 2019, we found that this was not always the case. However, staff in theatres said this was now an embedded practice for all cases and that the dry wipe count board was always used.

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

The service used the National Early Warning Score (NEWS), designed to allow early recognition and deterioration in patient by monitoring physical parameters, such as blood pressure, heart rate and temperature. We reviewed five sets of patient NEWS observations where they were all filled out to a high standard and escalated appropriately. Staff we spoke with described the process of escalating elevated scores or where they felt patients were deteriorating. Staff were positive about the relationship between ward staff, the RMO and surgeons when needing to escalate a deteriorating patient.

On the wards, there was a daily resuscitation huddle to delegate staff members tasks in case of an emergency. For example, a staff member would be delegated to do compressions or administer medications. Staff we spoke with said there were regular mock resuscitation learning activities and said that they had attended one within the past month.

Staff completed risk assessments for each patient and updated them when necessary and used recognised tools. Risk assessments were considered during the pre-operative assessment and we saw evidence that some were filled out prior to admission. Other risk assessments were filled out on admission and records reflected that risk assessments were updated regularly.

Staff knew about and dealt with any specific risk issues. Staff received training on sepsis and staff of all grades were aware of what actions to take if sepsis was suspected. Staff had early detection of sepsis reference cards they could refer to if a patients' observations were outside of normal range. We saw evidence that the service used sepsis six which was for management of sepsis involving three treatments and three tests.

Staff shared key information to keep patients safe when handing over their care to others. Staff used the situation, background, assessment and recommendation (SBAR) tool for escalation and handover of patients.

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

We saw evidence that patients had risk assessments completed during their pre-operative assessment, for example a fall risk assessment, moving and handling assessment, malnutrition risk assessment and pressure ulcer risk assessment. This meant that the service considered patients' individual needs prior to their admission and made sure they could safely meet their needs.

The service followed National Institute for Health and Care Excellence (NICE) recommendations for pre-operative testing. This meant that the service considered the patient's risk factors when evaluating and preparing the patient for elective surgeries.

In theatres and recovery, the service held regular emergency response scenarios for training purpose. Cardiac simulations were done bimonthly and a major haemorrhage scenario was done biannually.

Staff in theatres and recovery had access to the urgent provision of blood in cases of life-threatening haemorrhage. There was a blood refrigerator within the surgery department. There was a major haemorrhage policy visible by the blood refrigerator.

Although there continued to be no formal on-call anaesthetic rota, there was an on-call theatre staff list in case of an emergent return to theatre. There continued to be an informal agreement that anaesthetists in charge of the list were responsible for patients up to 48 hours post-operatively. Staff we spoke with told us they were able to contact the consultant surgeon or anaesthetists when they needed them. Consultants were required to be within a 30-minute commute to the hospital in case of an emergent return to theatre. Between April 2019 to August 2019, there was one unexpected return to theatre and five unplanned transfers out-of-hospital. Staff tracked unplanned admissions and transfers and discussed these incidents at monthly clinical governance meetings.

Nursing and support staffing

Although the service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment, they did not always staff theatres in accordance with best practice. The service continued to have a high-dependency on agency staff in theatres, however most agency staff were familiar to the service and worked there regularly.

The service had enough nursing staff of relevant grades to keep patients safe. On the wards, a corporate nursing

staffing planner tool was used to determine staffing levels. The normal staff to patient ratio was 1:6. Senior staff used the tool to allocate staff in advance based on pre-determined nursing demand and acuity of patients. The day unit staffing requirement was determined by the number of hours each patient would be in the unit. The ward sister prepared the staff roster two weeks in advance and it was reviewed daily at the daily communication meeting. Staff we spoke with said there was enough staff to meet acuity.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. We saw that the required and actual staffing numbers were displayed at the entrance of the surgical ward. The ward manager could adjust staffing levels daily according to the needs of patients.

Theatres and recovery continued to be reliant on bank and agency staffing. There continued to be difficulties in recruiting to the department. Although the service was reliant on bank and agency for staffing, we were told most temporary staff regularly worked in the service and were familiar with practices and standards. Between March 2019 to August 2019, theatres used bank staff for 12.6% of shifts and agency staff for 13.3% of shifts. During the same time, the surgical ward used bank staff for 6% of shifts and agency staff for 0.2% of shifts.

There was enough staff in each theatre as recommended by the Association for Perioperative Practice (AfPP) and the Association of Anaesthetists of Great Britain and Ireland (AAGBI) which included, two scrub nurses, one healthcare support worker, one anaesthetic practitioner and one recovery practitioner. The service was able to provide a surgical first assistant in the case that they were needed.

However, we observed on occasion, the surgical first assistant and the scrub practitioner were the same person which was not in line with best practice. AfPP guidance advocates that the practitioner should be a defined surgical first assist or scrub practitioner, not both. The service's theatre manager told us that if the same staff member was assigned to both roles (as a scrub practitioner and surgical first assist) that the case is risk assessed for suitability for the staff member to undertake both roles simultaneously.

The number of nurses and healthcare assistants on all shifts on each ward matched the planned numbers. On the day of our inspection the needs of the ward were met with three nurses, and two health care assistants.

There was a dedicated fulltime physiotherapist on the ward who worked Monday to Friday, 9am to 5pm. The hospital also had a part time physiotherapist that covered weekend shifts.

The hospital also had two receptionists that covered the inpatient wards and one receptionist that covered theatres.

Medical staffing

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

Patient care was consultant led. Consultants worked under practising privileges agreements in the service. Under practising privileges, a medical practitioner is granted permission to work within an independent hospital. The medical advisory committee (MAC) was responsible for granting practice privileges and was overseen by the medical director.

Nursing staff found the consultants to be supportive and responsive when contacted for advice. Nursing staff told us it was easy to contact consultants.

Between October 2018 to September 2019, there were 310 doctors employed or working under practicing privileges in the service for six months or more. During the same reporting period, three doctors had their practicing privileges suspended.

The service had enough medical staff to keep patients safe. The RMOs were provided under contract with an external agency that provided them with training and support. The RMOs provided 24-hour 7 day a week service on a two-week rotational basis. Senior staff told us RMOs were selected specifically to enable them to manage a varied patient caseload and requirements. The hospital had two inpatient RMOs who rotated for at least six months to ensure continuity of care. The resident medical officer (RMO) provided day-to-day medical service and dealt with any routine and emergency situations in consultation with the relevant consultant. Out of hours, consultants provided either telephone advice or attended in person.

While consultants had patients under their care in hospital, they were required to be within 30 minutes journey to the hospital or to have a suitable stand-in to provide cover. This was in line with best practice for emergency surgery standards.

Records

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

The hospital used a paper and electronic system to record patient needs and care plans, medical decision-making, reviews and risk assessments. The hospital kept and maintained health records for both NHS and private patients.

Consultants in the service would send a letter to the patient's GP with information and the outcome of a consultation. All patients admitted to the service would have a discharge summary sent from the hospital and consultant to the patient's GP.

Staff told us they did not have issues getting records and that any record needed could be requested by administrative staff and retrieved in a timely manner. All patient notes were kept securely in the hospital following discharge. Doctors could have copies of the patient discharge letter.

Records were stored securely. When electronic systems were not in use, staff logged off or locked their computer.

We reviewed five patient records and their prescription charts. Of the records we reviewed, we found improvement from our last inspection with all clinic notes being signed by the consultant. Notes from the multidisciplinary team staff were signed, dated and timed. There was evidence of good communication and MDT working with patients and their families.

The hospital undertook monthly audits of patients' health records, which included monitoring of risk assessments, such as for falls, pressure ulcers and nutrition. The health record documentation audit in June 2019 showed an overall compliance of 93% of four standards audited. This was an improvement from our last inspection where compliance in the December 2018 audit was 81%. The audit also showed improvement in all areas of the four standards audited: 99% compliance on the WHO checklists, 90.6% on the general standards, 98% on the clinical risk assessments and 94% on the pharmacy prescription chart on allergies and weight standard.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. Observations during the inspection showed that patients received the right medication at the right time.

The service had robust systems in place for the management and reconciliation of medicines in line with national guidance. The service undertook biannual antimicrobial stewardship audits and regular medicine management audits. Audits were undertaken to identify and address safety issues, patient outcome or identify areas of support for patients. Antimicrobial stewardship audits were discussed at the IPC committee meeting for further oversight of antimicrobial use.

All clinical staff we spoke with were clear about arrangement in place for safely managing medicines, including controlled drugs (CDs). Controlled drugs are medicines which require additional security to prevent them being misused, obtained illegally or causing harm. On inspection, we observed staff followed systems and processes for safely prescribing, administering, recording and storing medicines. CD log books we reviewed in theatres, recovery and the ward were signed and had daily checks completed.

Controlled drug audits were completed every other month. We reviewed three controlled drug audits on the ward where compliance was 100% in March 2019, 96% in June 2019 and 96% in September 2019. We reviewed four controlled drug audits in theatres where compliance was 100% in April 2019, 100% in June 2019, 96% in September 2019 (theatre 1) and 88% compliance in September 2019 (theatre 2). We reviewed one controlled drug audit in recovery where compliance was 88% in September 2019. Following audit results in September 2019 in theatres and recovery, action plans were developed to improve compliance with controlled drugs. Actions included revising the stock list and changing minimum stock levels for medications not regularly used and reminding staff to record time medications were administered.

Staff reviewed patients' medicines regularly and provided patient-specific advice to patients and carers about their medicines. There was a pharmacist available Monday to Friday between 9am to 5pm. Nursing staff said pharmacy staff were available to provide advice and do consultations with patients. Staff told us the goal was for pharmacy staff to review medication charts of each patient within one day of their arrival.

We observed staff stored and managed medicines and prescribing documents in line with the provider's policy.

On the ward, fridge temperatures and clinical room ambient temperatures were monitored and recorded daily. During inspection we saw that all fridge and room ambient temperatures were within the expected range.

Following our inspection in April 2019, the service improved oversight of the fluid warming cabinet in theatres. The theatre coordinator was responsible for completing the daily theatres checklist which included fluids in the warming cabinets. The warming cupboard was checked daily and when there were variances in temperatures, there were now clear processes for adjusting temperatures. Also, there were now clear processes to identify when fluids expired.

There were effective systems in place for staff to access medications and medication supplies out-of-hours. Clinical pharmacy services were available Monday to Friday from 9am to 5pm. The resident medical officer (RMO), along with the nurse in charge, could obtain out of stock medications in the pharmacy out-of-hours. There were labelled packs of to take away (TTA) medicines on the ward to be dispensed outside of normal pharmacy hours.

Medicines were stored in locked fridges and cabinets within locked clinical treatment rooms and only relevant clinical staff could access them. During inspection, we observed all medications stored on the ward were secured and managed safely. On the ward, there was a system to alert staff if the clinical treatment room was opened and unsecured.

There was an up-to-date antibiotic protocol which included first and second choice medicines to use, the dosage and duration of treatment. An action plan was implemented after an antibiotic audit completed in March 2019 showed that only 20% of antibiotics were prescribed according to antimicrobial sensitivity and only 30% of the antibiotic prescriptions stated the treatment duration or review date. Some of the actions implemented were for prescribers to indicate treatment duration and review date on the chart, notes and to remind the prescriber in the antibiotic rounds. Another action implemented was to switch intravenous to oral antibiotics if antibiotics were needed for more than three days which would also be flagged on the 3pm safety call to discuss antibiotic necessity. The June 2019 antimicrobial stewardship audit showed 97% compliance with local policy.

Staff told us when there were incidents with medications that they were reported through the electronic incident reporting system and with the pharmacist. If learning needs were identified, the service could offer additional training and support to staff.

We observed that in the August 2019 'Lessons Learned' brief there was an incident where medications required for use had expired. In response, staff were reminded to follow procedures for checking expiry dates of stock regularly. During our inspection, staff reported that they weekly go through all the medication cupboards to check expiry dates on medicines. Medicines that were soon to expire were marked and placed at the front of stock to be used first. All medicines we examined were within their expiry date.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. All staff were encouraged to escalate any concerns through the twice daily 'comm cell' calls which discussed surgical procedures after 4pm, staffing issues, expected admissions and discharges, equipment issues, incidents and complaints, who the on-call manager was and any other hospital business.

The service had no never events on the ward or theatres between January 2019 and September 2019. Never events are serious incidents that are wholly preventable as

guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Between April 2019 and August 2019, there were 92 incidents reported. Most incidents were reported as no harm (72.8%) or low harm (26.1%) and one as moderate harm (1.1%). The service used an electronic incident reporting system.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers shared learning with their staff about incidents that happened within the service and across the hospital. We saw evidence learning from incidents was discussed at departmental meetings and at staff handover. Staff demonstrated there was learning of incidents from the wider BMI organisation. We were told of learning from an incident where staff had to call the consultant multiple times to get in touch with them. Learning from the incident was that consultants now leave home and mobile phone numbers for better access to the consultant in case of emergency.

Staff reported serious incidents clearly and in line with policy. The hospital reported no serious incidents between April 2019 and August 2019.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. We reviewed a duty of candour letter from March 2019 which discussed the processes for investigating when things went wrong and invited patients and family to have a face to face meeting to discuss findings and give patients and family an opportunity to ask questions. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

There was evidence that changes had been made because of incidents. The hospital released a monthly 'Lessons Learned' brief to all hospital staff. We reviewed the 'Lessons Learned' brief from July 2019 and August 2019. Incidents reviewed included cases cancelled on the day because equipment not available and cases cancelled on the day when interpreters were not available. For each incident listed, lessons learned, and actions were also noted.

Hospital leaders encouraged staff to work as one team and voiced the importance that any issues or concerns were escalated as soon as possible. There was a culture that it was everyone's duty to report and by doing so, any member of staff could help prevent potential incidents, including harm to persons.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The service continually monitored safety performance. The service recorded pressure ulcers, falls, urinary tract infections in patients with a catheter and venous thromboembolism (VTE). We observed this data was displayed in hospital areas which showed information about incidents and patient satisfaction.

The service gathered information, such as hospital acquired infections and reviewed these through its clinical governance processes. There had been no incidents of meticillin-resistant staphylococcus aureus (MRSA), meticillin-sensitive staphylococcus aureus (MSSA), Escherichia coli (E. coli) or Clostridium difficile (C. diff) in the reporting period from April 2019 to August 2019.

Patients were risk assessed for VTE in pre-operative assessment or at time of admission. In a VTE audit from March 2019, 100% of patients had received a VTE assessment and the appropriate VTE prophylaxis was provided. The hospital reported no incidents of VTE or deep vein thrombosis (DVT) between April 2019 to August 2019.

Are surgery services effective?

Good

We did not re-rate this key question as part of this focused inspection. See report published on 20 August 2019 for further details around the rating.

Are surgery services caring?

Good

We did not re-rate this key question as part of this focused inspection. See report published on 20 August 2019 for further details around the rating.

Good

Surgery

Are surgery services responsive?

Good

We did not re-rate this key question as part of this focused inspection. See report published on 20 August 2019 for further details around the rating.

Are surgery services well-led?

Good

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

Leadership

Leaders understood and managed the priorities and issues the service faced. Following the CQC inspection in April 2019, leaders worked with staff to improve practices in the theatres and build a culture to support patient safety. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The hospital had a clear management structure in place with defined lines of responsibility and accountability. The hospital was led by a senior management team consisting of an executive director (ED), director of operations, director of clinical services and a quality risk manager. Surgical services had a theatre manager and ward manager who worked across sites with the nearby sister BMI hospital. Surgical services also had a deputy theatre manager at hospital location.

The executive director reported to the corporate regional director. They had a bimonthly one to one meeting and a bimonthly meeting of all regional executive directors.

Senior leaders in the hospital were aware of the challenges to quality and identified and acted to address them. Following our inspection in April 2019, the hospital's senior leaders created an action plan to address issues identified. Leaders coordinated an away day for theatre staff to build teamwork, refresh staff and 'get back to the basics', empower staff to challenge poor attitudes and behaviours and to educate staff on human factors training.

During our inspection in April 2019, we found that managers in theatres did not always provide support to challenge poor behaviours in theatres. We also found in April 2019 that there was a lack of nursing leadership in theatres. Where areas for improvement were identified, the hospital senior management was supportive to improve services. This meant the hospital managers worked to empower current staff to improve in management skills and to support nurses in theatres to lead the service. Staff in theatres we spoke with told us they were better supported in their roles and now had clear pathways to report poor behaviours.

Leaders were visible in the service. Staff we spoke with told us that senior hospital leaders were present and visible. Staff daily saw theatre and ward managers in the service and felt supported by them.

The executive director (ED) told us that there was good support from the Medical Advisory Committee (MAC) and its chair. Following our inspection in April 2019, where poor behaviours were identified with consultants, the MAC worked with senior leaders to improve services. For example, senior leaders in the service observed surgical lists and formally met with consultants to challenge poor behaviours. The MAC continued to have improved medical supervision since the appointment of a new MAC chair in 2018. Between April 2019 and August 2019, the MAC managed to recruit additional members and improving diversity on the committee, including now having a female consultant join.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

The hospital continued to work towards its five-year vision for 2015 to 2020. This was achieved through their eight strategic objectives and priorities and by delivering the best clinical outcomes through best practice pathways. The objectives and priorities also included patients, people, communications, growth, governance, efficiency, facilities and information. The hospital aimed at having a clear

evidence of meeting standards through integrated audit results, improving patient experience, investment in new medical technology and equipment and improving the look of the hospital through refurbishment.

In line with corporate strategy, the hospital was working on a new 5-year plan. The director of clinical services was also developing a local clinical strategy. The local strategy planned to focus on safety at the core of their work, improving on staff skills and teamwork, having effective communication between staff and leaders, and creating and improving the patient journey to deliver the best outcomes possible.

The clinical strategy encompassed the Care Quality Commission domains used to assess service provision and quality of care in healthcare organisations. Under each domain objectives stated a commitment to quality improvement and how this was to be achieved.

The hospital was committed to the BMI Healthcare corporate vision, which was to offer "the best patient experience and best outcomes in the most cost-effective way". All staff we spoke with told us they were committed to providing a positive patient experience.

Although there was no specific vision for surgical services, staff were aware of the hospital's vision and strategy and understood their role in achieving it. We observed the BMI Healthcare vision was prominently displayed throughout the hospital.

Culture

Leaders in the service worked to promote an open culture where patients, their families and staff could raise concerns without fear. The service had improved culture so that staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.

During our inspection in April 2019, we observed a culture in theatres where staff did not challenge poor behaviours. Following our inspection findings, the service undertook work to improve a culture of safe practice and openness. While hospital leaders acknowledged that it takes time for culture to improve, they were already seeing noticeable differences. For example, staff we spoke with told us they felt more supported to challenge consultant behaviour. The most recent staff survey was from November 2018. The senior leaders were dedicated to improving the safety culture and communicated to staff that if they challenged consultant behaviour they will be supported. Staff were given the director of clinical services and the deputy director of clinical services contact information, so they could call on them at any time for support.

Another way the senior leader clinical team monitored improvements in culture was through their audit programme. Some of the audit forms had been redesigned so that any staff member, clinical or non-clinical, could undertake the audits. For example, the WHO checklist audit was redesigned and although scores were similar in the March 2019 audit and the September 2019 audit, executive directors were assured that there were improvements with compliance with the WHO checklist because the audit clearer and easier for staff to use.

Our observations in theatre demonstrated there was an improved culture and commitment to safer surgery. Staff now used the dry wipe board for swab counts in theatres in accordance with best practice. During the WHO checklist, staff were engaged with the process. There was improved local leadership with the dedication of a theatre coordinator for every surgical list. Staff were also committed to wearing different coloured surgical hats for the quick identification of staff members and their responsibilities in theatre.

Senior hospital managers for the service were committed to improving culture with consultants and held meetings with consultants and the MAC when necessary.

Staff of all levels in theatres were aware of safety processes in place. Staff spoke about measures they now took to consistently put safety at the centre of patient care. For example, there were now daily safety huddles, a team brief (led by the consultant) and check-ins and debriefs, which were now consistently done as part of the WHO checklist.

BMI The Kings Oak participated in a survey for the BMI Healthcare Limited organisation which looked at workforce race equality standards (WRES). The results for the BMI Healthcare Limited organisation in 2017/18 showed that 14.5% of staff identified as black and minority ethnic (BME), 76.3% identified as white and 8.2% identified as unknown or did not answer. Across the organisation, 91.9% of board members were white and 9.1% were BME. Across all BMI sites, 65% of white staff and 55% of BME staff thought there

was equal opportunity for career progression or promotion, 13% of white staff and 20% of BME staff said they experienced bullying, harassment or abuse from staff in the 12 months prior to the survey, and 9% of white staff and 17% of BME staff said they personally experienced discrimination at work from their manager/team leader or other colleague. The BMI organisation was working with the NHS WRES team to gain feedback and ensure BMI were supporting WRES reporting within the independent providers.

Governance

Leaders operated effective governance processes throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a clear governance structure in place with a variety of committees, such as resuscitation, infection prevention and control, and health and safety, which fed into the hospital's governance meetings and ultimately reported to the BMI corporate board.

We reviewed six sets of clinical governance meeting minutes and saw they were well attended by the senior management team, heads of department and clinical leads. Standard agenda items for discussion included clinical incidents, complaints, audits and risks.

Departmental meetings were held monthly cross-site with the nearby sister BMI hospital. We reviewed theatre meeting minutes from July 2019 and September 2019. Regular topics at the meetings included finance, health and safety, staffing, infection control, safeguarding audit feedback, training, information security and complaints in the service. Staff also discussed findings from the April 2019 inspection and what actions were implemented following the inspection. Meetings were generally well attended and staff that could not attend were asked to review the meeting minutes.

The medical advisory committee (MAC) was held quarterly and oversaw the renewing of consultants' practicing privileges, clinical governance issues, key policies and guidance and monitored patient outcomes.

Practicing privileges were granted after submitting a curriculum vitae (CV) and two references to the executive director who then interviews along with the chairman of the MAC. Privileges were reviewed and renewed annually according to evidence of appraisal, revalidation, GMC membership, mandatory training completion, and enough evidence of good conduct.

Other meetings the service used to gain assurance were through the health and safety committee, the medical advisory committee (MAC), senior management meeting, infection prevention and control (IPC) meeting and the cross-site departmental meetings with the nearby sister BMI hospital.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. Improvements were made to identify and escalate relevant risks and issues and identify actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There were six surgery specific risks on the hospital risk register. Risks included were lack of sluice in recovery, lack of storage in theatre and reliance on agency staffing. Staff we spoke with were aware of the risks in surgical services and could name several risks on the risk register. For the most part, we found that the risks on the risk register matched the risks that we observed on inspection. Staff viewed it as a risk that there was only one c-mac video laryngoscope between BMI The Kings Oak and its nearby sister hospital. Although this was not identified on the risk register for BMI The Kings Oak, it was identified on the risk register for the sister hospital and the c-mac video laryngoscope was normally on the BMI The Kings Oak site. The service had a fully stocked and functional difficult airway trolley which meant the service adequately mitigated this risk.

Top risks for the service were displayed in the staff room for theatres and recovery. Most staff we spoke with were aware of the risks to the service. Managers continued to publish risks in the coffee room and discuss them at staff meetings.

Senior leaders of the service, including the executive director, ward manager, theatre manager and infection prevention control lead nurse attended clinical governance committee meetings monthly. We reviewed six clinical

governance meetings between February 2019 to July 2019 and at all meetings risks were discussed. Outstanding actions and updates were regularly addressed at these meetings.

Staff were able to provide input for potential risks to the service through the electronic incident reporting system. The ward manager or theatre manager reviewed the risks and investigated if they needed to be escalated to the head of the department and quality and risk manager. This meant staff could directly be a part of the system of identifying risks.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

During inspection we observed staff treated patient identifiable information in line with the General Data Protection Regulations (GDPR). 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.

As well as having access to the hospital intranet for all up-to-date policies, staff were aware that policies and pathway information was kept in paper format on the wards.

Information technology systems were used effectively to monitor and improve the quality of care. For example, the corporate risk and incident recording system provided the hospital with a platform to monitor and assess risks and assess trends.

Engagement

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

The hospital actively gathered people's views and experiences through questionnaires. Patients could participate in the friends and family test (FFT) by paper questionnaires or online. Between April 2019 to August 2019, the response rates for the FFT ranged from 50% to 60% with 98.6% recommended the service to their family and friends.

The hospital had formed a new patient experience group which involved clinical and non-clinical members of staff. The aim of the patient experience group was to improve the patient experience and services offered. The director of clinical services was in the process of creating a patient group forum inviting patients to participate in discussions with hospital staff with the goal of identifying areas for improvement.

Senior hospital managers in the service engaged with staff by being visible and walking through the ward, theatres and recovery. Senior leaders supported teams, provided an on-call role, provided a 'lessons learnt' workshop monthly and encouraged staff to attend. There was a daily 9:30am managers meeting which senior hospital managers attended to discuss concerns and address issues.

The service obtained patients feedback through various forms such as social media, NHS choices, BMI website, feedback forms, and the patient satisfaction group. The monthly patient satisfaction meeting was a cross site meeting were staff representative from each site were required to attend and meet with patients to discuss patient feedback trends.

The service continued to utilise a 'you said, we did' feedback program to improve services in the hospital. Some recent examples included, complaint of patients not knowing who staff were or who to direct concerns to. In response, staff were to introduce themselves by name and role during ward rounds and handovers. The nurse in charge was to identify themselves as the person in charge of the department and make it know if the patient or family member has any concerns to not hesitate to contact them. There were also 'named nurse' boards in the patient rooms to help inform patients of who the nurse was caring for them. Another example was from a complaint of lack of recycling bins; therefore, the service implemented recycling bins.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services.

Senior hospital managers recognised a need to support staff following the last inspection and coordinated an away day for theatre and recovery staff. The away day was an

opportunity for staff to have a 'back to basics' refresher course, build teamwork and make pledges to maintain high safety standards. Staff were given workbooks to complete and overall feedback was positive from staff.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure risk assessments are completed and risks are mitigated if a staff member is required to act as both surgical first assist and scrub practitioner.
- The provider should ensure all cabinets in clinical areas have wipe clean surfaces.
- The provider should ensure staff continue to be supported to challenge poor attitudes and behaviours.
- The provider should ensure compliance of the WHO surgical safety checklist is monitored and completed in line with best practice.