BMI Healthcare Limited

BMI The Esperance Hospital

Quality Report

Hartington Place
Eastbourne
BN21 3BG
Tel:01323 411188
Website: www.bmihealthcare.co.uk/esperance

Date of inspection visit: 23rd June 2015
Date of publication: 06/08/2015

This report describes our judgement of the quality of care at this hospital. 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.

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an unannounced, focused inspection at the BMI Esperance Eastbourne on the 23rd June 2015. The inspection was triggered by information of concern we received relating to infection control arrangements, standards of cleanliness and the maintenance of the fabric of the buildings. Concern was also raised about the way a complaint about these issues had been handled by the hospital. Our inspection focussed on key lines of enquiry that had relevance to these issues of concern.

Are services safe at this hospital/service in relation to infection control, cleanliness and hygiene, and the environment and equipment?

Systems, processes and standard operating procedures are not always reliable or appropriate to keep people safe. Monitoring safety systems, were not robust. There were some concerns about that not all staff had received relevant training in food safety. We found that cleaning and some decontamination processes, and the systems for monitoring them did not always meet national guidance. Some aspects of the physical environment, such as flooring, did not meet national standards and that the theatre area was in a poor state of repair in places. Systems for monitoring the maintenance of equipment in theatres were not sufficiently robust. Essential monitoring of water and air handling systems had not been performed consistently for six weeks. However, in other aspects we found that there were systems and measures to prevent the spread of infection and that these were closely monitored with good compliance demonstrable through a programme of audit.

Are services effective at this hospital/service in relation to infection control, cleanliness and hygiene, and the environment and equipment?

Patient's care and treatment in relation to infection prevention and control was planned and delivered in line with current national guidance. However, patients do not always receive care from people who have the skills and knowledge that is required for them to do their job.

Are services caring at this hospital/service

We did not assess the quality of caring at this inspection.

Are services responsive at this hospital/service in relation to the management of complaints and patient facilities

In general, patient facilities were appropriate for the service delivered. It was easy for patients to complain. Complaints and concerns were treated seriously, investigated and responded to in a timely way. Staff are made aware of complaints and actions are taken as a result of complaints to improve the service.

Are services well led at this hospital/service in relation to infection control, cleanliness and hygiene, environment and equipment and management of complaints

The hospital had the processes and information to manage current and future performance and risk. However, there had been some instances where the management team has been unaware of some significant safety issues.

Our key findings were as follows:

- Complaints were generally handled appropriately to the satisfaction of those who raised concerns.
- Generally, here were systems to manage the prevention and control of infection that followed national guidelines. However, the monitoring of cleanliness was not based on national specifications and there was a risk that the arrangements for the decontamination of endoscopes would not meet national guidelines.
- Food hygiene and safety practice did not meet best practice recommendations.
- There were elements of the clinical environment that did not meet national specifications or required attention.

Summary of findings

- Systems for checking safety systems and equipment were not sufficiently robust.
- There were arrangements to enable senior staff to receive appropriate assurance, although these had not been fully effective in identifying and managing risks.

We found some areas of poor practice where the provider needs to make improvements.

Importantly, the provider must:

- Take urgent action to ensure that water safety monitoring is carried out in line with national guidance.
- Take urgent action to ensure that the required planned preventative measures in relation to air handling in theatres are performed.
- Take urgent action to ensure staff involved with the preparation and service of food receive appropriate training to do this.
- Take urgent action to ensure all food safety and hygiene legislation is complied with.
- Ensure that endoscope decontamination processes meet national guidance.
- Assess its flooring materials and ensure they are appropriate for a clinical environment with adequate cleaning regimes.

In addition the provider should:

- Review its training programme in relation to complaints.
- Ensure that complaints receive an appropriate risk assessment.
- Tell complaints how to escalate their complaint if they are unhappy with the management or outcome.
- Review its room audits to meet the requirements of the National Specifications of Cleanliness.
- Review its monitoring of cleaning in theatres.
- Take steps to ensure that theatre services are provided in an environment that is fully fit for purpose.
- Review its processes for monitoring the planned maintenance of medical equipment.
- Ensure that there is appropriate discussion of complaints at clinical governance, departmental and Medical Advisory Committee meetings.
- Ensure that control measures identified as part of its risk management processes are robust and implemented.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Patient's care and treatment in relation to infection prevention and control was planned and delivered in line with current national guidance. However, patients do not always receive care from people who have the skills and knowledge that is required for them to do their job, for example food hygiene training.

Are services effective?

Patient's care and treatment in relation to infection prevention and control was planned and delivered in line with current national guidance. However, patients do not always receive care from people who have the skills and knowledge that is required for them to do their job, for example food hygiene training.

Are services caring?

We did not inspect caring as part of this focussed inspection.

Are services responsive?

In general, patient facilities were appropriate for the service delivered. It was easy for patients to complain or raise a concern and are supported when they do so. Complaints and concerns were treated seriously, investigated and responded to in a timely way. Staff are made aware of complaints and actions are taken as a result of complaints to improve the service.

Are services well-led?

In general, the hospital had the processes and information to manage current and future performance and risk in relation to the environment, complaints infection prevention and control. However, there had been some instances where the management team has been unaware of some significant safety issues.

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Surgery		We did not rate this service.

BMI The Esperance Hospital

Detailed findings

Services we looked at
Surgery

Detailed findings

Contents

Background to BMI The Esperance Hospital

The Esperance Hospital, part of the BMI Healthcare Limited, is an independent hospital situated in Eastbourne, East Sussex. The hospital offers a range of surgical treatments with overnight facilities. Services provided at the hospital include; In-patient surgery, Fertility Services, Oncology services, Diagnostic Endoscopy and Imaging, and General and Physiotherapy out-patient services. The hospital is registered for a maximum of 38 in-patient beds. The registered manager has held the position since January 2005.

We carried out a focussed inspection at the Esperance in response to information of concern we received in relation to surgical services. We focussed our inspection on the management of complaints, the suitability of the environment including maintenance and cleaning, and in the management of infection prevention and control with an emphasis on the surgical care services.

Our inspection team

Our inspection team was led by Shaun Marten, Inspector, Care Quality Commission.

The team included CQC inspectors, a specialist nurse in infection control and an expert in estates management.

How we carried out this inspection

We analysed all the information we held about the hospital prior to our inspection, and this included the information of concern that had triggered this inspection.

We carried out a visit on the 23rd June 2015. We gave the registered manger less than 24 hours' notice of our visit. This short notice was to enable them to ensure that relevant people would be available to be interviewed.

We spoke with managers, staff and patients and looked at a wide range of documents. We observed practice and examined the hospital environment.

Detailed findings

Facts and data about BMI The Esperance Hospital

The Esperance Hospital is registered to provide the regulated activities (as defined by the Health and Social Care Act) of Diagnostic and Screening procedures, Family Planning, Surgical Procedures and Treatment of Disease, Disorder or Injury.

In total there are about 88 consultants with practising privileges at the hospital, and about 25 of these are consultant surgeons. On average, per month the Esperance Hospital sees about 39 in-patients, 250 – 300 day cases, 50 - 60 'walk-in, walk-out' cases and 1 100 out-patient attendances.

Five local Care Commissioning Groups (CCG's) commissioned NHS services at the hospital. The registered manager estimated that about 50% of patients were treated by the NHS under these arrangements.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The hospital was registered with the CQC for 38 beds, and about 29 were in use at the time of our visit. There were four beds closed for refurbishment works. Surgical services were ranged across two wards, one of 12 and one of 17 beds.

BMI Esperance Hospital provided a broad range of surgical services. Specialities covered included Orthopaedics, Ear, Nose and Throat, Urology, Cosmetic Surgery Ophthalmic Surgery, Breast and General Surgery. Services were provided on an in-patient, day-case or 'walk-in, walk-out' basis. About 25 consultant surgeons had practising privileges at the hospital. The registered manager told us the hospital treated about 480 in-patients, 3 500 day cases and carried out about 600 'walk-in, walk-out' procedures per year.

We received information of concern from a member of the public relating to the suitability, cleanliness and maintenance of the clinical environment, infection prevention and control procedures and the management of formal complaints relating to surgical care services at the Esperance Hospital. We carried out a focussed inspection in response to these concerns, specifically looking at these aspects of the service. A comprehensive inspection of The Esperance Hospital will be carried out in due course.

Summary of findings

We found that systems, processes, operating and monitoring arrangements in relation to the environment and equipment did not keep patients safe enough because they were not always followed or implemented, or did not meet national guidance.

We saw that practice in relation to food safety and hygiene presented risks to patients and others.

Overall, we found that complaints were managed well. We also found that there were arrangements to prevent the spread of infection with good compliance and outcomes demonstrated through a system of audit.

Surgery

Are surgery services safe?

Systems, processes and standard operating procedures are not always reliable or appropriate to keep people safe. Monitoring safety systems, were not robust There were some concerns about the consistency of understanding and the number of staff who are aware of them.

We found that cleaning and some decontamination processes, and the systems for monitoring them did not always meet national guidance. Some aspects of the physical environment, such as flooring, did not meet national standards and that the theatre area was in a poor state of repair in places. Systems for monitoring the maintenance of equipment in theatres were not sufficiently robust. Essential monitoring of water and air handling systems had not been performed consistently for six weeks.

However, in other aspects we found that there were systems and measures to prevent the spread of infection and that these were closely monitored with good compliance demonstrable through a programme of audit.

Incidents

- There was an electronic system for staff to report safety incidents and staff we spoke with were aware of these arrangements. We reviewed the reports of safety incident for the period January – May 2105. We saw that 82 safety incidents were reported, including those relating to equipment defects and those were there was potential to breach infection control procedures.

Cleanliness, infection control and hygiene

- We found there was structure and systems for managing infection prevention and control (IPC) at the hospital. The Director of Nursing was the designated Director of Infection Prevention & Control (DIPC). There was lead nurse for IPC with responsibility for implementing the infection control programme. They were supported by link nurses from each clinical department.
- The Infection Prevention & Control (IPC) Committee met quarterly and attendees included the microbiologist, occupational health doctor, pharmacist, health & safety representative, pathology, clinical department leads and support services lead. This attendance demonstrates that all departments were involved in the IPC programme. The minutes of the last meeting on the 2nd June were reviewed and the agenda covered a wide variety of IPC matters including surveillance, training, audits, antimicrobial stewardship, pathology issues, decontamination, water safety and waste. BMI have introduced a corporate template for the IPC Committee to ensure consistency in the IPC monitoring programme.
- The IPC lead provided an IPC update for the Medical Advisory Committee bi-monthly and the reports for January, March and May 2015 were reviewed. These updates included progress on matters such as policies, training, infections and audits. The DIPC annual report 2013/14 was reviewed and this report gave an overview of IPC progress against the IPC plan throughout the year.
- We reviewed the IPC annual plan for 2014/2015 for the hospital. We noted actions had been completed for quarters 1, 2 & 3 with 4 to be completed by September 2015 in line with BMI's year. This showed the plan was being implemented and reviewed.
- There were systems to audit the environment in relation to IPC. Environmental audits were carried out using an adapted Infection Prevention Society (IPS) quality tool called the "Care Setting Process Improvement Tool". The outcomes of these audits for 2013/14 were reviewed and the score varied between 92% and 100%. This was better than the benchmark score of 90%. The audits for the current year were progress however the score is now entered onto a database and this could not be reviewed at our visit; however the IPC nurse confirmed that practice had improved further this year.
- Housekeeping audits were carried out by department link nurses. There was a schedule of audits for 2015, identifying which department is required to be audited and when. The audits for January through to May 2015 were reviewed and demonstrated that actions were identified for any shortfalls and these were implemented.
- There were arrangements to monitor specific practice in relation to IPC and we found practice met current guidance. We found pre, intra and post-operative actions to prevent surgical site infections were monitored. Audit results for the previous three years and 2015 to date demonstrated improvement in practice, with pre and intra operative actions resulting in 100% compliance. The post-operative actions scored between 90 and 100% until Mid-2014 however since then, all scored 100%.
- Hand Hygiene observational audits were undertaken by departments using a BMI tool and the results since 2013 were reviewed. The results identified better compliance

in 2015 than 2014/2013 demonstrating improvement year on year with all departments scoring 100% in 2015. We saw there were supplies of hand sanitizer readily available in all clinical areas. We also saw supplies of personal protective equipment such as disposable gloves and aprons. We spoke with three patients who reported that staff used the hand gel when entering and leaving their rooms.

- We found there was system of monthly surveillance of infections which included surgical site infections; MRSA wound infections, Bacteraemia and urinary tract infections. An analysis of the data identified 12 infections of various types since October 2013 to current date. There were no serious life threatening infections or bacteraemia. Each infection was investigated in line with hospital policy and reported at IPC, Medical Advisory Committee (MAC) and Governance meetings. Additionally the hospital was required to provide monthly quality metric data to the NHS Commissioners for NHS patients. This data included IPC surveillance, compliance against national guidance.
- Risk assessments in relation to IPC formed part of the pre-admission process. We saw that patients were screened for MRSA & c difficile in line with hospital policy.
- Every year there were sessions arranged for IPC week in October. The training programmes for the last three years was made available and demonstrated that "hot topics" were presented for example, Ebola in 2014.
- All staff took part in IPC training both on-line and face to face, according to their role. The records of staff training for 2013/14 and 2014/15 were reviewed. Training included hand hygiene, waste, occupational health, antimicrobial resistance, water safety, theatre cleaning, aseptic non-touch technique, catheters and dressings. It was not possible to gain an overview of the numbers of staff trained as the spread-sheet did not provide a score but it was evident that staff training was being managed and monitored for BMI staff.
- However, we found that food handling training for staff employed by sub-contractors in catering and support services was not current. Regulation (EC) No. 852/2004 states, "Food business operators are to ensure that food handlers are instructed and/or trained in food hygiene matters commensurate with their work activity". Of the four members of support services staff handling patient food only one had received food hygiene training at the time of our inspection. In the main kitchen we spoke with the chef supervisor. We asked when they had received food hygiene training. We were told that they had completed the training last month however they were unsure which level they were trained to. The other chef in the kitchen told us that they had completed training but were unable to evidence this as they had taken their training certificates home for safe keeping.
- We found that waste management was in line with - Safe Management of Waste 2011 (DOH) in relation to segregation, labelling, handing, storage and disposal. We observed that sharps management complied with "Health and Safety (Sharp Instruments in Healthcare) Regulations" (2013).
- Decontamination of surgical instruments was contracted to an accredited Sterile Services Unit off site.
- We found the hospital had a linen management policy which was in date and available to staff through the hospitals intranet. The hospital laundry service was managed through an external company who collected dirty and soiled linen and returned clean linen to the hospital. If the hospital was dissatisfied with the cleanliness of linen it was rejected and returned to the company. There was an audit trail outlining where this had occurred. During our visit we looked at the linen in five patients rooms and found it had been cleaned to a satisfactory standard.
- During our inspection we looked at ward areas including patient rooms, en suite bathrooms, corridors, stairwells, public toilets, treatment rooms, dirty utilities and patient waiting areas. We found these areas to be generally clean although we found attention to detail with high dusting in OPD areas required some improvement.
- In the BMI Patient Satisfaction Survey May 2105, for the previous quarter 94% of respondents reported room cleanliness as good or excellent, and 93.5% reported bathroom cleanliness as good or excellent. We spoke with three patients who said that they felt their rooms were very clean. This showed a high level of patient satisfaction with regards to cleanliness.
- The BMI operational cleaning manual referenced the "National Specification of Cleanliness" (NSC), and stated that each area of the hospital should be categorised into very high risk, high risk, significant risk and low risk. When questioned, the cleaning manager was unaware of this and had not assigned risk categories to areas of the hospital. Hospitals should audit against the NSC, or have a robust system in place to evidence they are

auditing to the required standard and at the frequency determined by the risk level. Therefore, the hospital were not auditing to the required frequency according to the risk associated with that area. For example, patient single rooms were audited a maximum twice per year. The NSC states that ward areas are classified as high risk areas and should be audited monthly, and achieve a percentage pass of 95% or over. We found the hospital was not scoring their audits in percentage terms which made comparison and performance difficult to monitor and judge.

- The audits that were carried out did not audit against the 49 elements requiring attention as defined in the NSC. This meant that the cleaning auditing system used by the hospital did not meet with required standards.
- Decontamination of endoscopes took place on site within the endoscopy decontamination unit. The layout of the washroom and clean room and equipment was in line with guidance (Choice Framework for local Policy and Procedures 01-06 – Decontamination of flexible endoscopes: Operational Management revised 2013). However, some areas of practice did not meet this guidance, for example temperature monitoring of water in the sink, levels in the sink to be marked for detergent use. This meant there was a risk of incomplete decontamination of endoscopes with a risk of cross-infection.
- The operating theatres cleaning team reported to the theatre manager rather than the hospital house keeper. They cleaned in the evening for approximately three hours. The cleaning schedule used was a simple document identifying the area to be cleaned with a signature and date. The current practice was for the cleaners to audit their own cleaning and the results of this were not communicated to either the housekeeping or IPC meetings. This schedule was being revised and a draft document was reviewed. This draft did not provide guidance for cleaning in line with current best practice the NHS Cleaning Manual and Specifications; for example the equipment to be cleaned is identified, and the materials to be used for the process. The theatre staff were not trained in facilities management and cleaning and did not have the relevant expertise to develop cleaning procedures. This meant that cleaning standards in theatre did not meet national specifications and that the audit process was not objective nor the results scrutinised as part of the hospital's IPC governance systems.
- We had concerns in relation to some aspects of food hygiene and safety. On Devonshire Ward we found that the fridge temperatures had been recorded daily, however when fridge temperatures went out of range staff had not raised this through their reporting mechanisms. For example, on 20th May 2015 the temperature of the fridge was recorded as 6oC which was outside of the safe range, with no actions recorded.
- We bought this to the attention of the member of support staff. They told us that the 'fridge had never been outside of safe ranges'. On further inspection of the documentation they saw that the signature recorded, on the day against the reading outside of range, was their own. They then proceeded to change the documentation from a six to a five which put the recorded temperature back within range. They did this in front of the CQC inspection team and the Ward Sister.
- We placed an independent probe into the fridge and left it for fifteen minutes. When we checked the probe inside the fridge after this time it was recording a temperature of 15oC. The fridge reading on the door showed a temperature of 5oC. When discussing the fridge temperature with the support services manager we watched the temperature go out of range between 5oC and 9oC over a period of five minutes. Therefore, we could not be sure that the fridge thermometer was in full working order.
- We found a prawn jacket potato in the fridge which was unlabelled, and undated; this meant that it had been stored without using the hospitals guidance on safe food storage. We were told the food had been left over from the previous evening's supper service and was being saved for a member of staff to eat at lunchtime. It was likely that the prawns on the potato had been through the danger zone (temperature range from 8oC to 63oC) which meant that the product had been in the optimum range for bacteria multiplication on two occasions. This meant that this food product would potentially be unsafe to eat. We reported this to the Ward Sister who disposed of the food. This demonstrated unsafe food hygiene practices.
- We asked the support services team member whether this food was safe to be consumed. They told us that they didn't know. They told us they had not received any food hygiene training despite having responsibility for heating and serving patients' food. They had worked for the hospital for two years. The support services

manager told us that the hospital required staff to obtain food hygiene training within three months of employment for the service. This had not been achieved in this instance.

- We noticed that the chef supervisor had two jewelled rings on her hands and a jewelled nose piercing. This presented food safety hazards as jewellery may be a source of harmful micro-organisms and the possibility that pieces of jewellery, or the whole items may fall into the food being prepared.
- We inspected the dry food store and found cardboard outside packaging had been used for the base of the shelves. This meant that there was potential for cross contamination as the cardboard could not be cleaned to the required standards. We found tins of soup, fresh onions, bottles of drink, and a plastic tub of gravy mix had been stored on the floor. This meant that there was a potential risk of cross contamination with cleaning products used to clean the floor and the onions.
- We also found foods that were out of their best before end date (BBE). We found three tins of soup BBE 01/2015, two tins of soup BBE 11/2014, two 500g tubs of curry powder BBE May 2015, 17 packets of crisps BBE 20/06/2015. We also found undated bananas (six) which were over-ripened and rotting bananas that appeared to be unfit for use. We also found two bottles of opened wine on the shelf one which was covered with cling film the other with no cover. These could have been contaminated with insects. This meant that the kitchen did not have adequate processes in place to ensure that food was discarded when it was unfit for use.

Environment and equipment

- The hospital was undergoing a plan of refurbishment and we were shown areas that had been improved.
- We found examples were flooring did not meet relevant guidance and presented a potential risk. We saw that many areas including patient ward areas were carpeted. The Department of Health (DOH) "Health Building Note 00-09: Infection control in the built environment" 3.115 states that, "Carpets should not be used in clinical areas. This includes all areas where frequent spillage is anticipated. Spillage can occur in all clinical areas, corridors and entrances". Risk assessments including infection prevention control (IPC) input from the provider's microbiologist must be in place for all carpeted areas. The Support Services Manager was aware that carpets caused a potential infection control risk. However, the carpeted areas were not risk assessed and were not on the hospital risk register. We were told that the hospital had a carpets cleaning programme, however we did not see the documented evidence of this during our inspection.
- We were told that the new flooring being laid during refurbishments would be butt finished against the skirting board. HBN00-09 section 3 examples of design principles designed to facilitate cleanliness and cleaning states, 'run hard flooring up the walls for a short distance to provide an easy to clean coving'. This meant that the flooring being laid during refurbishment did not meet with this requirement.
- We were also told that the en-suite bathroom flooring was not going to be replaced. We saw in room 203 that there was an unsealed gap in the flooring by the threshold strip and where the vinyl met the skirting it was not sealed. This meant that microorganisms could be under the floor as the surface is not impervious. HBN00-09 section 3 states that, "use finishes that are impervious smooth and seamless as far as practicable".
- The operating theatre environment was observed to be in a poor state of repair. The IPC environment audits had identified areas of concerns over a period of years and some refurbishment work had been carried out in recent months. Storage areas such as the anaesthetic store had peeling paint and damaged walls behind the shelving; debris on the floor had not been cleaned up and appeared to have been there for some time. Other areas, such as the anaesthetic rooms, had exposed wood on the work surface and cupboards rather than a laminate finish which was capable of being cleaned. The scrub areas had exposed plaster behind the sinks; other store areas had damaged walls and flooring. The main corridor had damaged flooring and exposed wood on door frames and doors. The sterile store recently refurbished had sash windows which were sealed but not in accordance with "Health Building Note 26 Operating Theatre Department". Staff explained that the building was listed. However, we were aware that other listed hospitals have used internal glazing to meet the standard. The method of sealing these windows does not meet with Health Building Note (HBN 26) guidance for sterile storage areas. This meant there was a risk that sterile products in this area were not stored appropriately.
- The management of theatre storage areas was unsatisfactory. We observed fluids and pharmacy

products were stored alongside sterile consumable items. There were also cardboard boxes containing sterile consumables on the floor in all three general stores. This meant there was a risk of contamination.

- In the operating theatres the hospital had a contract with Electrical Medical Equipment (EME) services at Eastbourne District General Hospital for the planned preventative maintenance of most clinical equipment. Some specialist equipment was serviced by the manufacturer for example, microscopes and operating tables. The theatre manager was able to provide evidence of servicing of equipment although there was no robust system for planning, monitoring and gaining assurance in relation to equipment maintenance. For example, we saw a box file with various service records within it, in no particular order. The theatre manager was unable to demonstrate how they were assured that all theatre equipment was maintained as there was no spread-sheet/calendar in place identifying all the equipment, who it was serviced by and when. There were service records from EME and other manufacturers but no means of checking that all equipment had been serviced.
- In the recovery area we found there was equipment such as compression boots and warming blankets. This equipment was on loan from a company and was not maintained, if it developed a fault it was returned to the company and they provided another machine. This equipment provides compression to limbs to increase blood flow and warmth via the blankets and there is a risk harm to a patient should the equipment be not be properly maintained.
- The specimen hood has not been serviced since April 2014 but had been maintained yearly prior to this. The maintenance record was recorded on the hood. This meant this service was overdue and could pose a risk to staff.
- In theatres, there was a policy for the monthly checking of emergency equipment such as malignant hypothermia and difficult intubation equipment and that the check should be recorded. We found the difficult intubation equipment was checked In July, August, Sept 2014 and April 2015. The malignant hypothermia equipment was checked in July, August, September 2014 and April & May 2015. This equipment is rarely used and there is a risk that it would not be ready for immediate use should it be urgently required.
- We noted anaesthetic equipment was checked in line with Association Anaesthetists Great Britain & Ireland, "Checking Anaesthetic Equipment" (2012). We saw daily theatre checking lists were generally completed.
- The specimen hood where specimens were prepared for pathology was within a storage area for sterile consumable items. Specimens such as body fluids or tissue were brought into this area, put into containers of preserving fluid and then stored until taken to the laboratory. This process would usually take place in a dirty utility area, and this arrangement represented a risk of cross contamination of sterile items.
- The Operating Theatres had specialist ventilation which needed to be maintained in accordance with Health Technical Memorandum (HTM) 03-01 "Specialist Ventilation for Healthcare Premises (2007)". The newly appointed hospital engineer confirmed that there was a contract in place for the annual revalidation of the ventilation with an external company but the day-to-day maintenance and periodic testing was carried out by the hospital engineers. The engineer could not find the annual maintenance documents and confirmed that they had not been involved in any day to day maintenance or periodic testing. A file for the day to day maintenance showed the last entries were for March 2015. It would appear that the on-going maintenance and monitoring of the system had not been recorded since March 2015. It would also appear that the day-to-day maintenance had not been carried out since the former employed engineer left six weeks previously. The engineer explained they were learning the job, that they worked alone and had only had a four hour handover from previous engineer. We found that the engineer had a limited understanding of what planned preventative measures and monitoring were required, how this was performed or recorded because they had not been adequately trained or made aware of their responsibilities by the hospital management. This meant there was a risk that the quality of air supply in theatres could have been compromised.
- Providers must comply with Water Safety guidance and regulations such as the Health & Safety Executive's, "The Control of Legionnaires' Disease in water systems Approved Code of Practice and guidance on regulations, L8", to protect patients from the risk of serious infections such as Legionella. The organisation should have a

written scheme for preventing and controlling the risk of Legionella. We found these were not being followed and this presented a risk to patients, staff and the general public.

- We asked to review the required temperature checks on the hot and cold water system. The newly appointed engineer was unable to identify or provide the log book where the various tasks identified in the written scheme, such as monitoring the temperature of hot and cold water, were recorded.
- The engineer we spoke with did provide a piece of paper where he had measured the water temperature in various patient rooms and recorded the results although this was not dated or systematic. They told us that there was a software programme which alerted them when to undertake these measurements but they did not have the time to record them in the appropriate log. They were unable to confirm that all such temperature measurements had been carried out since their appointment six weeks previously. They explained they had not had an adequate induction and that an engineer from another hospital had been helping periodically and he may have recorded some measurements in his note book.
- The IPC nurse had identified in the third quarter of the IPC plan that the engineer had not had water safety training. The current practice in relation to water safety is not in accordance with Health and Safety (H&S) guidance (L8) or BMI's own policy "BMI has a Control of Legionella procedure" dated 2012. We noted that the hospital risk register contained an entry relating to the risk of cold water tanks storing water above the safe, approved temperatures.

However, we were provided with documents that showed housekeeping staff flushed taps in both used and unused rooms in accordance with the hospitals standard operating procedure.

- It was not possible to identify if the hospital had robust arrangements for checking the function of the generator which provided a power supply in the event of a mains power failure. The engineer was able to explain that they had carried out such a test with a colleague, however they could not provide the records for review or identify which day or how often the generator testing took place. Staff were able to confirm that the generator was tested but could not identify exactly when. This meant there was a risk that the hospital generator could malfunction if the power supplied failed with serious consequences for patients dependent on electrical equipment.

Records

- We found that relevant records in relation to the monitoring and maintenance of water safety systems, air handling systems and generator tests could not be supplied when requested.
- We noted that records of equipment checks in theatres were inconsistently completed.
- Records of fridge temperatures were not consistently recorded.
- Records of complaints could be provided when requested.

Mandatory training

- We found that there was a system of mandatory training in relation to IPC.

Are surgery services effective?

Patient's care and treatment in relation to infection prevention and control was planned and delivered in line with current national guidance. However, patients do not always receive care from people who have the skills and knowledge that is required for them to do their job, for example food hygiene training.

Evidence-based care and treatment

- We found that infection control polices, plans and audit tools were benchmarked against relevant national guidance, for example Department of Health's "Code of Practice for health and adult social care on the prevention and control of infections and related guidance" (Dec 2009).
- We saw audit data that demonstrated pre, intra and post-operative actions to prevent surgical site infections in line were in line with national guidance from the National Institute for Care and Health Excellence (NICE CG74 – Surgical Site Infections).

Competent staff

- We found that the mandatory training programme in infection prevention and control ensured that staff received training appropriate to their role in this area.

- We found that staff had not received appropriate training in food hygiene and safety, even when this was a major component of their job.
- We found that the newly appointed engineer had not received adequate training and support in relation to water safety monitoring and air handling systems to enable them to discharge their responsibility in these areas and ensure the safety of patients, staff and the general public.
- There were no arrangements for managers, investigators or staff to receive formal training in the management of concerns and complaints of which staff were aware.

Are surgery services caring?

We did not inspect caring as part of this focussed inspection.

Are surgery services responsive?

In general, patient facilities were appropriate for the service delivered. It was easy for patients to complain or raise a concern and are supported when they do so. Complaints and concerns were treated seriously, investigated and responded to in a timely way. Staff are made aware of complaints and actions are taken as a result of complaints to improve the service.

Environment

- In the BMI Patient Satisfaction Survey May 2105, for the previous quarter, 67.8% of respondents rate the overall impression of accommodation as excellent, 22.8% rated it as good. 68.9% rated the room facilities as excellent and 28.8% as good. 59.2% rated bathroom facilities as excellent and 32.2% as good. This demonstrated a high level of satisfaction with the facilities provided.

Learning from complaints and concerns

- We found there were systems for receiving, investigating and responding to patient complaints.
- There was information available to inform patients how to make a complaint. We looked at the "Patient information guide for your stay" that was available in patient rooms. We noted that on page 12 there were details of how to raise a complaint or concern. We also noted that the same information appeared in a leaflet about BMI healthcare that was displayed in public areas. We spoke with two patients who although did not know specifically how to complain, felt that it would be easy for them to find out if they needed to.
- We reviewed the records of five complainants. We assessed them using a tool developed in conjunction with the Patient's Association which reflected the vision in the "My expectations" for raising concerns and complaints, produced jointly by Parliamentary Health Services Ombudsman, Local Government Office and Healthwatch in November 2014. We found that there were arrangements to support people to make a complaint and that the system was not overly-complex. However, complainants were not reassured that making a complaint would not adversely affect their future care.
- We found that complaints were not risk assessed, despite the corporate pro-forma for complaints records including a risk assessment tool. This meant that it was possible that the seriousness of the issue raised may not be fully understood.
- We saw investigation notes for three of the five records we looked at. It was evident that an investigation had taken place with reference to correspondence in the other cases, although the lack of details made it difficult to judge the adequacy of that investigation. In the investigation records we judged the investigation to be proportionate to the severity of the concern raised.
- We saw that complaints received a timely acknowledgement, and when the investigation was complete, a letter outlining the outcome. We noted that for stage 1 complaints these letters did not contain information to tell the patients what action they could take to escalate their concern if they were unhappy with the outcome. CQC guidance to providers states, "Information must be available to a complainant about how to take action if they are not satisfied with how a provider manages and/or responds to their complaint." This guidance was not being followed. However we saw this information was included in a letter from the regional office when a complaint had been escalated to stage 2 of the company's complaints process.
- We saw a complaint letter which the complainant had deemed unsatisfactory. We found that this letter did not fully address the concerns raised, or explain the findings of the investigation or the actions that were to be taken. The hospital manager acknowledged that this response

was not of a satisfactory standard and assured us that it had been a valuable learning experience. We saw that response form the regional office after the complaint had been investigated remedied these shortcomings.

- There was a database system for monitoring complains which we viewed. We saw that there had been a total of 16 formal complaints made in the past year. The reasons for complaint were recorded and we noted that four related to financial matters, seven aspects of clinical care and nine non-clinical matters. We saw that 13 of these were recorded as being upheld or partially upheld.
- From the complaints log we noted that all 16 complaints in the past year were recorded as being "resolved to the satisfaction of the complainant and closed". However, the outcome for patients was not recorded in four of the five records we looked at in detail. This indicated that complaints were being handled to the satisfaction of complainants.
- We saw that complaints generated action plans of remedial actions when appropriate. There was an electronic action planner which set out the agreed actions, time-scales, responsible person, a risk rating and evidence of future completion or assurance. We saw completed examples of trackers. These appeared on the hospital's Quality and Risk Report and remained there until they are formally reviewed and closed. This demonstrated that action resulted from complaints and that there were assurance systems to ensure action plans were fully implemented and effective.
- CQC guidance states, "Staff and others who are involved in the assessment and investigation of complaints must have the right level of knowledge and skill. They should understand the provider's complaints process and be knowledgeable about current related guidance". Managerial staff at the hospital told us that they had not received any training in complaints management or investigation. They felt that this was an unmet development need. Other staff were not aware of any training to help them manage or respond to complaints or queries. One senior nurse told us about training they had received in other organisations and how they informally used their knowledge to provide on the job training for their staff. This showed that staff were not supported to acquire skills in the handling of complaints and concerns.

Are surgery services well-led?

In general, the hospital had the processes and information to manage current and future performance and risk in relation to the environment, complaints infection prevention and control. However, there had been some instances where the management team has been unaware of some significant safety issues.

Governance, risk management and quality measurement for this core service

- There were systems in place to ensure that complaints and incidents relating to infection control and prevention or estates were brought to the attention of the hospital's clinical governance meetings and Medical Advisory Committee (MAC). We saw the minutes dated May 2015 for both of these fora. We noted that in relation to complaints a brief statement of each complaint was included but there was no discussion of any underlying factor, lessons learned, or changes made recorded.
- Departmental mangers were expected to cascade information form the clinical governance meeting in their departmental meetings. We saw ward meeting minutes were there was feedback about complaints received. However, again there was no accompanying discussion recorded or any action points. This meant that opportunities for improvement and learning may not have been fully realised.
- We were told that the IPC nurse provided a report for each clinical governance meeting. In this group's May 2015 minutes we noted there a more detailed discussion recorded in relation to this agenda item. We also saw feedback form a root-cause analysis about a patient identified as developing MRSA that was not attributable to the Esperance Hospital. This meant that IPC was given due consideration and prominence as part of the hospital's governance systems.
- Information about complaints was notified through routine reporting to BMI's regional quality and risk manager. We saw the Esperance Hospital Quality and Risk Month End Report for June 2015 and noted that relevant information about a complaint escalated to stage 2 was included. This meant there were systems to ensure corporate oversight with regard to complaints.
- We noted that no problems with food hygiene and safety had been identified as part of routine

governance. For example, we checked 93 individual food service temperature records. Support service staff probed food and recorded the temperature at the point of service. Of the 93 records, 88 were above the expected temperature. One was not above the expected temperature (Risotto on the 15th May 2015) and there were no records of any corrective action taken. On four records no temperature was recorded. Consistently throughout the records there was no temperature recording of, sandwiches and salads. Regulation (EC) No. 852/2004 states that these items of food should have also had temperature recording and records kept. Similarly, we found examples that the systems on ward areas for keeping refrigerated food and drinks at the required temperature were not robust.

- We found another further example of routine governance systems not being complied with, and failing to identify food safety risks. On Hartington Ward we found that the fridge in the pantry was operating. Staff were unable to find any temperature recordings for this fridge. We were told that the fridge was not used for patient food as there had not been sufficient patients using this ward for some time. However, staff could not confirm that this fridge had never been used for patient food and the support services manager was unsure of how long the ward had experienced low occupancy. We found juice in the fridge which was unlabelled and undated. We were told that this had been left over from a hospital function and would not be served to patients. We saw the temperatures on the thermometer readings on this fridge were between 6.8oC and 8.5oC which were outside of safe ranges. This fridge had not been closed down and turned off, and staff were still able to use this fridge to store food.
- The hospital had a risk register which we noted had been updated in May 2015. We saw that risks relating to water safety and theatre equipment had been identified and also the presence of sinks in clinical areas that were not compliant with current guidance. In relation to water safety we noted that the control measures had not been carried out and we noted that the control measures for the obsolete theatre couch addressed manual handling issues but not the IPC concerns. This meant that in these examples the mitigation of identified risk was inadequate.
- We were told that that the management team had sought guidance regarding the replacement flooring and were assured their plans met current guidance. This assurance did not accurately reflect current guidance.
- We could not be sure that the governance systems had, or would have, identified the poor state of repair, storage concerns or lack of assurance around equipment maintenance in theatres. Similarly the governance systems had not identified the lack of planned preventative measures and monitoring in relation to air handling and water safety systems.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The hospital must take urgent action to ensure that water safety monitoring is carried out in line with national guidance.
- The hospital must take urgent action to ensure that the required planned preventative measures in relation to air handling in theatres are performed.
- The hospital must take urgent action to ensure staff involved with the preparation and service of food receive appropriate training to do this.
- The hospital must take urgent action to ensure all food safety and hygiene legislation is complied with.
- The hospital must ensure that endoscope decontamination processes meet national guidance.
- The hospital must assess its flooring materials and ensure they are appropriate for a clinical environment with adequate cleaning regimes.

Action the hospital SHOULD take to improve

- The hospital should review its training programme in relation to complaints.
- The hospital should ensure that complaints receive an appropriate risk assessment.
- The hospital should tell complaints how to escalate their complaint if they are unhappy with the management or outcome.
- The hospital should review its room audits to meet the requirements of the National Specifications of Cleanliness.
- The hospital should review its monitoring of cleaning in theatres.
- The hospital should take steps to ensure that theatre services are provided in an environment that is fully fit for purpose.
- The hospital should review its processes for monitoring the planned maintenance of medical equipment.
- The hospital should ensure that there is appropriate discussion of complaints at clinical governance, departmental and Medical Advisory Committee meetings.
- The hospital should ensure that control measures identified as part of its risk management processes are robust and implemented.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Monitoring of water safety, and planned preventative measures in relation to air handling in operating theatres had not be performed in line with national guidance. Flooring materials used and their maintenance did not meet national specifications. This breached Regulation 12 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff whose job role was concerned with the preparation and serving of food and drink had not received adequate training in food safety. This breached Regulation 12 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The decontamination of endoscopes did not meet national standards. This breached Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Food safety guidance was not fully implemented. This breached Regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.