Mount Stuart Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an unannounced inspection at The Mount Stuart Hospital on 11 March 2016 in response to concerns raised relating to surgery practice. During the unannounced inspection period of ten days following our visit, we spoke with the interim matron and the theatre manager by phone, on 14 March 2016, as they were not on site at the time of the inspection. The purpose of the inspection was to gain assurance around the concerns raised. This was a focused, unannounced inspection, which looked at surgery services. As such, we focused on specific aspects of four out of the five domains to assess whether surgery services were safe, effective, caring and well led. We did not examine the responsive domain to assess whether the service was organised in a way that met people's needs.

The service has not yet been rated using our new inspection methodology. As such, surgery services at Mount Stuart were not given a rating.

Our key findings were as follows:

Overall we found that the service was not always protecting people from risk of harm because:

- The routine management of infection control was on-going with audit tools to monitor the infection prevention practice. However, prior to and during the building work, minimal expert advice was sought and we saw that areas of the theatre department were not monitored to ensure good infection control practice during the project.
- Reliable systems were not in place to protect staff and patients from the risks associated with inappropriate waste storage.
- The security of the hospital and theatre areas during the day could not be assured and fire safety and storage of equipment was not consistently safe.
- Arrangements for managing medicines, which included handling and storage, did not always keep people safe. Staff pre prepared syringes for use and were seen to leave them unattended for periods of time. Medicine audits had not been completed to provide the service with assurance about their medicine systems.
- Not all entries in people's individual care records were consistently written and managed in a way that keeps people safe.
- The systems used to assess if a patient was deteriorating (National Early Warning Scores) were not fully completed and placed the patient at risk.
- Theatre staff were seen to engage fully in the World Health Organisation checklist (WHO) to ensure safe practice in theatre. However audits of records were not well maintained for the provider to assure themselves that this practice was consistent.
- Staff we spoke with said their competencies had not been assessed by line management.
- We were not assured staff received a regular appraisal. In 2014, 75% of staff received an appraisal. The appraisal system was changed in 2015 and it was difficult to assess how many staff had received an annual appraisal.
- The hospital did not give due regard to providing an environment in which patients' privacy and dignity could be maintained at all times during their care and treatment in theatre. The positioning of theatre windows in theatres one and two meant that staff could see into theatre from the main theatre corridor. Other staff could see into theatre from the rear access corridor.
- There was an annual audit programme in place in which a variety of outcomes and data were audited to monitor quality and safety. However, some audits identified areas that were not performing well, and there were no actions to show how the hospital were going to make improvements in these areas. A number of these audits were not completed at all, and some were not completed in line with their schedule

However:

- There was a governance structure in place to support the provision of good care. Staff understood who to report to and how information was shared to improve performance.

Summary of findings

- The hospital promoted a culture of reporting and learning from incidents.

There were also areas of poor practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure each patient's privacy and dignity is maintained at all times in the operating theatre.
- Ensure the arrangements for managing and disposing of waste protect staff, patients and visitors from risk of harm and are in line with hospital policy.
- Ensure all premises used by patients are secure.
- Ensure all parts of the premises are clean and sterile items are stored appropriately to prevent contamination with dust and debris.
- Ensure medicines are consistently managed and secured in a way to keep people safe and this is monitored effectively.
- Ensure deteriorating patients are recognised, treated quickly and are monitored effectively.
- Ensure audits used to assess, monitor and improve the safety and quality of services, and to mitigate risk to the patient are acted upon.
- Ensure mandatory training levels are achieved so that staff are adequately trained to carry out their role.
- Ensure that persons providing care or treatment to service users have an annual review in order to ensure they have the correct competencies, skills and experience to do so safely.

In addition the provider should:

- Ensure all staff are able to report incidents and monitor they are doing so.
- Ensure the hospital's incident reporting policy is up to date.
- Ensure all entries in patient's individual care records are consistently written and managed in a way that keeps people safe.
- Ensure medical supplies such as needles and dressings are kept locked and are not accessible to patients on the ward.
- Ensure fire doors are closed at all times and evacuation areas are not compromised
- Ensure there is adequate resuscitation equipment in the post-operative recovery area and that this equipment is accessible to all staff when needed.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Overall summary

This was a focused, unannounced inspection, which looked at surgery services. As such, we focused on specific aspects of four out of the five domains to assess whether surgery services were safe, effective, caring and well led. We did not examine the responsive domain to assess whether the service was organised in a way that met people's needs.

Overall we found that the service was not always protecting people from risk of harm because:

- The routine management of infection control was on-going with audit tools to monitor the infection prevention practice. However, prior to and during the building work, minimal expert advice was sought and we saw that areas of the theatre department were not monitored to ensure good infection control practice during the project.
- Reliable systems were not in place to protect staff and patients from the risks associated with inappropriate waste storage.

Summary of findings

- The security of the hospital and theatre areas in the day could not be assured and fire safety and storage of equipment was not consistently safe.
- Arrangements for managing medicines, which included handling and storage, did not always keep people safe. Staff pre prepared syringes for use and were seen to leave them unattended for periods of time. Medicine audits had not been completed to provide the service with assurance about their medicine systems.
- Not all entries in people's individual care records were consistently written and managed in a way that keeps people safe.
- The systems used to assess if a patient was deteriorating (National Early Warning Scores) were not fully completed and placed the patient at risk.
- Theatre staff were seen to engage fully in the World Health Organisation checklist (WHO) to ensure safe practice in theatre. However audits of records were not well maintained for the provider to assure themselves that this practice was consistent.
- Staff we spoke with said their competencies had not been assessed by line management.
- We were not assured staff received a regular appraisal. In 2014, 75% of staff received an appraisal. The appraisal system was changed in 2015 and it was difficult to assess how many staff had received an annual appraisal.
- The hospital did not give due regard to providing an environment in which patients' privacy and dignity could be maintained at all times during their care and treatment in theatre. The positioning of theatre windows in theatres one and two meant that staff could see into theatre from the main theatre corridor. Other staff could see into theatre from the rear access corridor.
- There was an annual audit programme in place in which a variety of outcomes and data were audited to monitor quality and safety. However, some audits identified areas that were not performing well, and there were no actions to show how the hospital were going to make improvements in these areas. A number of these audits were not completed at all, and some were not completed in line with their schedule

However:

- There was a governance structure in place to support the provision of good care. Staff understood who to report to and how information was shared to improve performance.
- The hospital promoted a culture of reporting and learning from incidents.

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Background to Mount Stuart Hospital

The Mount Stuart Hospital Torquay is an independent hospital, which is part of the Ramsay Healthcare group of hospitals. It provides care to both private and NHS patients. We carried out an unannounced inspection on 11 March 2016 as a result of concerns received in relation to surgery services. During the unannounced inspection period of ten days following our visit we spoke with the interim matron and the theatre manager by phone, on 14 March 2016, as they were not on site at the time of the inspection.

The hospital provided routine, non-urgent surgery for adults. This included general surgery, vascular surgery, gynaecology, urology, ophthalmology, ear nose and throat surgery, and cosmetic surgery. The hospital had an admission policy which set out safe and agreed criteria for the admission of people using the service. Surgery at Mount Stuart was not deemed appropriate for patients who were risk assessed with the potential to require high dependency recovery facilities.

The facility has two laminar flow theatres and a minor surgery and endoscopy unit. There are both inpatient and outpatient services and a 27 bedded ward with single occupancy, en-suite rooms. The hospital has diagnostic facilities including x-ray, ultrasound, and MRI. Treatment facilities included an onsite physiotherapy department and gymnasium. The physiotherapy department provided a continence service, acupuncture and electrotherapy.

An extensive development project was underway at the hospital which started 2 March 2015 and was due to finish on 4 April 2016. A third, new theatre had recently opened and plans were nearing completion to increase the number of ambulatory care beds from four to twelve.

The registered manager had been in place since October 2009.

We visited the theatre areas, which included the theatres, the recovery area and the ward. We spoke to staff and reviewed a sample of patient records.

Our inspection team

Our inspection team included three Care Quality Commission Inspectors and an Inspection Manager.

How we carried out this inspection

We used a range of information we held about the service as well as information provided to us by the hospital.

This was a focused, unannounced inspection, which looked at surgery services. As such, we focused on specific aspects of four out of the five domains to assess whether surgery services were safe, effective, caring and well led. We did not examine the responsive domain to assess whether the service was organised in a way that met people's needs.

We spoke with staff of different levels of seniority from around the theatre department, which included the registered manager, matron, theatre manager, a consultant, nursing and support staff.

Information about Mount Stuart Hospital

Services are provided to private and NHS patients.

Surgery

Safe	
Effective	
Caring	
Well-led	

Are surgery services safe?

We found that patents were not always protected from the risk of harm because:

- Expert advice had not been consistently sought throughout building work and there was a lack of evidence of environmental monitoring to ensure good infection control practice.
- Reliable systems were not in place to protect staff and patients from the risks associated with inappropriate waste storage.
- The security of the hospital and theatre areas during the day could not be assured and fire safety and storage of equipment was not consistently safe.
- Arrangements for managing medicines, which included handling and storage, did not always keep people safe. Staff pre-prepared syringes for use and were seen to leave them unattended for periods of time. We raised this with the provider during our inspection. Medicine audits had not been completed to provide the service with assurance about their medicine systems.
- Not all entries in people's individual care records were consistently written and managed in a way that keeps people safe.
- The systems used to assess if a patient was deteriorating (National Early Warning Scores) were not fully completed and placed the patient at risk.
- Theatre staff were seen to engage fully in the World Health Organisation checklist (WHO) to ensure safe practice in theatre. However audits of records were not well maintained for the provider to assure themselves that this practice was consistent.

However:

- The hospital promoted a culture of reporting and learning from incidents.
- The management of infection control was ongoing with audit tools to monitor infection prevention practice.

Incidents

- Systems were in place to report incidents and staff were supported to report incidents of concern. There had been 131 incidents recorded on the hospital's electronic incident recording system between 11 March 2015 and 11 March 2016.
- Staff we spoke with demonstrated their understanding of the need to report an incident and said they received learning from incidents reported. For example, a member of theatre staff reported an incident relating to the failure of a piece of theatre equipment which was recorded onto the electronic incident reporting system. Other members of staff were informed and the engineer notified.
- However, in the senior management team meeting minutes dated 15 February 2016, the hospital's matron raised concerns that the level of incident reporting was low. Actions were being taken to address this, which included: further training for heads of department with subsequent learning to be passed on to theatre and ward staff. This was still being arranged according to the minutes from the subsequent, and most recently provided senior management team meeting, dated 29 February 2016. This meant the hospital was not assured all staff were effectively recording incidents that should have been reported onto the hospital's incident recording system.
- Staff in the theatre department reported incidents in two ways. They either recorded them directly onto the hospital's incident reporting system or to the theatre manager who recorded them in the same way. Staff told us learning from incidents was shared individually or through team meetings and handovers.
- The hospital's matron completed a monthly incident report, and sent this to Ramsay UK for scrutiny. This provided further assurance in relation to safety.
- The hospital's incident reporting policy stated incidents should be reported both internally and externally. Senior leadership informed us they investigated all incidents. The severity of the incident was categorised

automatically when staff entered the incident onto the incident reporting system, this informed staff of the next action to take. It used a rating of one to four with one being the most serious. The policy was created in 2012, was last reviewed in August 2014 and was due for review in August 2015. This meant the current policy was out of date. For incidents which were classed as categories one and two, policy stated a root cause analysis should be carried out. There were nine incidents of grade one and two reported between 11 March 2015 and 11 March 2016. These included complications during surgical procedures, an accident involving staff and patients being transferred to the acute hospital etc. We reviewed a number of category three and four incidents, which included incidents such as missing equipment, extended stays in hospital, patient readmissions, accidents involving staff or patients etc. Incidents were investigated and remedial actions planned and taken as a result.

- Senior staff informed us learning from incidents was shared at quarterly clinical governance meetings which were attended by heads of department and also by some of the consultants. Learning from these meetings was shared with the clinical heads of department. More serious incidents were discussed at the senior management team meetings. We reviewed a number of theses meeting minutes and saw this was a standing agenda item. Learning from incidents was also shared more widely across the Ramsay group with staff telling us of an example where this happened after an incident at Mount Stuart Hospital.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Ramsay Healthcare UK Being Open Policy dated 1 October 2015, required staff to inform the relevant person as soon as reasonably practicable after an incident was identified. Staff were required to report the incident, within at most 10 working days of the incident being reported and sooner where possible. The policy stated it was not required by the regulation to inform a person using the service when a 'near miss' had occurred, and the incident had resulted in no harm to that person.
- Leaders instilled a policy of being open and honest in line with the Duty of Candour Regulation 20. Staff were encouraged to be open and honest throughout their employment and received training on this subject as part of their induction. It was the matron's responsibility when incidents occurred to check the correct parties had been informed. Senior leaders confirmed they saw staff speak openly with patients when they had made a mistake, at the time an error occurred and that staff understood the need to be honest with patients. With more serious incidents, the hospital would write to the patient and highlight their duty under Regulation 20 to keep them informed. They offered the patient the opportunity to come in and speak with them and to share the investigation report with them. For a serious clinical incident, the consultant would inform the patient and carer as soon as it was practically possible to do so. These processes ensured the hospital was meeting the requirements related to the duty of candour.

Cleanliness, infection control and hygiene

- The theatre manager oversaw the standards of hygiene and cleanliness within the theatre department. The theatre manager was responsible for the cleaning and decontamination of the theatre environment and the auditing of this process. Porters were responsible for cleaning the theatre environment and started work at 7am. We were informed they would ensure the area was fit for purpose by 8 am when the theatre area was surveyed by the theatre manager to ensure it was clean, ready for the day and no dust due to building work was present.
- Building work had been ongoing in the theatre area for some months prior to our inspection and was continuing. This included various times when builders screened off different areas with partitions. The theatre manager was satisfied with the level of partitioning work by builders who constructed partitions to cordon off areas that were under construction. The theatre manager told us of one occasion where they were not assured about this work, and took steps to ensure the building work did not take place until the matron and theatre manager agreed it. The registered manager, matron and theatre managers felt builders were very responsive to their requests in order to maintain cleanliness and safety during the expansion work.

Surgery

- The management of infection control during the building works did not ensure safe practice. We toured the theatre area and saw no evidence of dust or debris in any of the rooms or circulating areas outside of the theatres. However, we found some dust and building debris along the'dirty' corridor behind the three theatres. This is the area used for the removal of unsterile items or equipment from theatres. There were numerous items of equipment stored on shelves or directly on the floor. This did not comply with the hospital's infection prevention and control policy and this had also been identified in the November 2015 and February 2016 infection prevention and control environmental audit. There were boxes that contained IV fluids which were covered in dust and debris, and were in date. We found sterile dressings stored in this area on top of a table, which were not in date. We informed the registered manager who agreed to take action in relation to this and who said some of these items were awaiting disposal. It would not have been clear to staff which items were being stored or which were going to be discarded as they were not clearly marked as such. This meant contaminated and out of date items could have been used for patient care and treatment.
- The on-going building work did not ensure the safety of patients and staff. A wall in the main theatre area corridor was temporarily closed off using a large sheet of plaster board. The edges of the plasterboard were not sealed and could have created dust. The entrance to the theatre area was temporarily without flooring, wall coverings or lighting and there was a hole in the ceiling immediately above the entrance to the main theatre area.
- Systems, process and practices in relation to cleanliness, hygiene and infection control could not always be controlled and managed safely. In the November 2015 and February 2016 infection prevention and control environmental audit, overall scores were 96% and 97% (cool amber) and were an improvement on the August 2015 audit which achieved 91%. A small number of items were not compliant in the two most recent audits. Carpeted areas were found to have stains on them, floor coverings were not always intact, with smooth, washable surfaces and not all furnishings were visibly clean and in a good state of repair. During the inspection, we saw a number of areas in the theatre department where the floors were damaged, walls were covered with bare plaster and lacked skirting as a result of the ongoing building work. This meant these surfaces could not be effectively cleaned. We were informed by the registered manager that these areas were due to be completed imminently. It was not clear as to how long these areas had remained in this condition.
- The cleaning schedule was reported to have been increased during the building work but we were not supplied with evidence of any enhanced cleaning or a revised cleaning schedule during the work.
- The registered manager confirmed that there had been no oversight or input from the Ramsay Group's infection prevention and control team before or during the building work. It was felt this was not necessary as the registered manager felt they had the skills to manage these aspects of the project and that telephone advice from external experts was sufficient.
- Some doorways which led from the corridor surrounding the theatres were sealed using duct tape. We did not find dust or dirt in the 'clean' area in front of the theatres.
- Reliable systems were not in place to protect staff and patients from the risks associated with inappropriate waste storage. In the November 2015 and February 2016 infection prevention and control audit, it was identified that waste was stored in corridors or other inappropriate areas internally or externally. We found two bags containing clinical waste outside an exit to the corridor behind the theatres. Staff left them on the floor outside the building instead of placing them in the clinical waste bins which were nearby. Therefore, monitoring of the environment had not been successful to remove all risks.
- During the inspection, we saw two members of staff in the theatre department who did not comply with bare below the elbow policy. One of these also did not comply with hand hygiene policy. However, hand hygiene audits in July 2015 and December 2015 showed an average score of 100% and 96% compliance respectively. Actions to be taken were documented in one of the two areas which did not show 100% compliance. For example, a member of staff was asked to remove a stoned ring and to read there relevant hospital policy. A hand hygiene audit carried out in October 2015, achieved an average score of 81%. An action from this audit identified not all staff used paper

towels and two further hand washing technique posters were required. During our inspection we found a sink in a corridor at the back of the theatre area where paper towels were not available next to the sink.

- Matron stated infection control related incidents had not increased during the year prior to the inspection, since the commencement of the building work in March 2015.
- There were 20 surgical site infections reported between 1 March 2015 and 29 February 2016. An audit to monitor surgical site infection prevention procedures before and during the operation was scheduled to take place in November 2015 and February 2016. These audits were not completed and so it was not possible to identify if surgical site infection prevention was effective.
- There were a number of wound related infections reported in the previous 12 months but hospital management felt they found nothing in their investigations of these infections to suggest they were acquired during surgery, or related to theatre cleanliness.
- There were no reported cases of methicillin-resistant bacteraemia in the previous three years.
- Personal protective equipment such as aprons and gloves were readily available and we saw staff using them when providing care and treatment to patients.
- The matron chaired the infection, prevention and control committee. There was an infection prevention and control link nurse role who carried out an audit, undertook staff training and acted to ensure that information from outside the hospital or from Ramsay UK reached the relevant department. The link nurse was a nominated person but was not an expert in infection prevention and control. The link nurse was off on long term sickness leave at the time of our inspection. However the ward manager and a nurse on the ward were continuing with these responsibilities in their absence. An infection prevention and control lead at Ramsay UK liaised with the hospital. We noted there had not been any representation from the theatre department in the January 2016 monthly Infection prevention and control meeting, and the building work was not an agenda item, nor had any update on the building and potential for risk of cross infection from this, been discussed. The hospital matron was confident any concerns in relation to theatres would have been raised at this meeting by another head of department, by the matron, in other departmental or quality and safety meetings.
- The hospital had a microbiology service level agreement with a local acute hospital and were able to seek advice from them in relation to microbiological infection prevention and control. For example, during the building works, the hospital took advice and implemented additional checks, and introduced changes to procedures in order to maintain the quality of airflow into theatres. Theatres one and three were laminar flow. Filters were checked and changed on a more regular basis and at intervals which exceeded recommendations during normal theatre activity. We observed the theatre three's air filtration systems in action during our inspection and noted them to be working.

Environment and equipment

- The design, maintenance and use of facilities and premises did not always keep people safe. The hospital did not provide a secure environment for patients on the ward, in the recovery area or in theatre. During our inspection, we were able to freely access all areas of the wards and theatres as doors to these areas were not secured. We accessed these areas on a number of occasions during the inspection and raised this with senior management on the day. From the outpatients department, it would also have been possible to access the theatre out of hours. The registered manager informed us a key fob system was due to be installed as part of the refurbishments. In an emailed update which was sent to staff by the Ramsay UK project manager dated 7 March 2016, it informed staff about the lack of security until a fob access system was installed. They were asked to be extra vigilant of visitors or patients accidentally accessing clinical areas, especially around the post-operative recovery area and ambulatory care unit.
- During the inspection, staff told us the doors to the hospital were locked at night after shift handover at approximately 9-9.30pm. Night staff would carry out final checks of the area. A panic button on the ward was linked to the reception area which would not have been manned at night. We raised concerns on the day of the inspection in relation to the security of the hospital entrance in the early evening. We saw that unless staff

watched the security camera which displayed the entrance to the hospital, it may have been possible for unauthorised persons to enter the building due to the seven second delay with the automatic doors. This would enable unauthorised people to access the ward and theatres and place patients and staff at risk. However, following the inspection, we were informed the doors to the hospital were put on the 'exit only' option when there was no receptionist on duty, at approximately 7pm to 7.30pm. In order to gain access to the building, people would need to ring the doorbell. They would then be accepted by the nurse on duty by viewing the CCTV camera. The nurse would then open the first set of doors but would need to collect the individual, prior to passing through the second set of doors.

- Fire doors on the corridor at the rear of the theatre backed onto what was previously part of the hospital's car park. This area was cordoned off with a number of metal railings, which had been placed there during building work. We found these doors to be open on at least one occasion during the inspection and at other times, staff had closed them. This posed both a security risk and a fire risk, as the doors led to the waste room which was not locked, meaning anyone could enter the theatre back corridor. The fire doors should have been kept closed.
- Storage of equipment was not consistently safe. A storage cupboard on a ward corridor was being used temporarily to store items such as needles. This did not protect the public from the risk of harm or injury as there was no lock on the cupboard, which made it accessible to patients and visitors. We informed the registered manager about this who said action would be taken to rectify this promptly.
- There were two resuscitation trolleys in use but none available in the ambulatory care area. Staff in this area would use the ward's resuscitation trolley which was not in the immediate vicinity. This could have made it more difficult for staff to access to the trolley and more time consuming during an emergency.
- We observed staff responding to a product recall. Liquid supplied in a bottle deemed as faulty was being recalled and staff took appropriate measures to ensure they removed the items from hospital stock. This demonstrated effective safety systems were implemented and staff followed safety procedures successfully.
- During the inspection, staff were receiving training for a new piece of equipment which was being used on a patient in theatre. Staff were supervised by a representative from the equipment's supplier to ensure it was being used effectively and safely.
- Leaders felt they kept staff informed about changes to the building as a result of on-going building work and discussed this monthly at staff meetings.

Medicines

- Arrangements for managing medicines, which included handling and storage, did not always keep people safe. We identified medicines were not consistently managed and stored in line with the hospital's medicines management policy. Staff confirmed it was common practice to draw up a number of syringes filled with anaesthetic medicines and to leave them on the side in the anaesthetic room ready for use during the surgery list that day. Staff explained the drugs were pre-drawn due to busy workloads. They confirmed they were labelled and used for individual patients only, then discarded at the end of surgery if not used. We observed times when staff left this area unattended. The doors to this room were not secure and access to all areas of the wards, theatre and recovery area was possible due to the lack of a secure entry system.
- Staff informed us the hospital had not had a pharmacist in position since August 2015 but one had recently been appointed approximately three weeks prior to the inspection.
- Stocks of medicines in theatres were checked twice daily. Staff reported some issues in the ordering of stock. For example, a member of staff ordered 15 ampules of eye drops and received 15 boxes of eye drops instead. This meant the fridge used to store the eye drops was overcrowded. However, we checked fridge temperature and found them to be checked daily and were within the appropriate temperature range.
- Staff we spoke with were unclear as to where the spare key was kept to access controlled drugs. It was thought the engineer had a spare key in order to access the cupboards. This meant it may not have been possible to access these drugs during an emergency. Furthermore,

this practice was not in line with Ramsay UK medicines management policy which states there must be a key log in place to record who is responsible for the key at any given time.

- Controlled drugs audits were established as part of the hospital's annual audit system with three monthly audits scheduled starting in September 2015. These had not been completed so far. A prescribing audit for November 2015 was not completed and the next was scheduled for May 2016. The medicines management audit for October 2015 was not completed with the next scheduled for April 2016.

Records

- Not all entries in patient's individual care records were consistently written and managed in a way that kept people safe. Records audits starting in July 2015 were established three monthly to review ten sets of medical records selected at random. The July 2015 audit showed 78% of records were filled in correctly for which the hospital traffic light style rating system reflected a hot amber rating (next to red at 70-79%). This meant concerns were raised within the service about the quality of record keeping. The following criteria were all omitted from the records audited:
  - There is a GP referral letter and Consultant outpatient record in each set of notes
  - All record entries are dated (using day/month/year format), timed (using 24 hour format) and signed or initialled by the care giver
  - There is an entry made in the patient record by the Doctor whenever they see a patient.
  - Day case patients - a phone call to the patient has been recorded within 48 hours of admission to confirm admission and discharge plan
  - Details of Consultant letter sent to the General Practitioner according to locally agreed standards or contract guidance, but no longer than 4 weeks
- In the same audit, 40% of all entries in patients records made by non-registered practitioners (support workers, students etc.) were countersigned by the registered practitioner who had delegated that care. There were no actions documented that resulted from this audit. Staff had not completed the October 2015 medical records audit. The January 2016 audit scored 82% compliance but showed little or no improvement in the areas highlighted as poor in the July 2015 audit. However, an action was recorded in the January 2015 audit for this to be raised with staff, for results of the audit to be shared with non-medical and medical staff and responsibilities discussed. The date for completion of this was 31 March 2016.
- Staff filled in a theatre register both prior to and following an operation. It contained information about the patient and the type of operation being performed and was an audit trail of patient, procedure and staff. We reviewed registers from theatres one and three and noted omissions in the documentation of patients' allergies. There were two scrub nurse signatures missing in theatre three register and not all printed names next to signatures were legible in both books. We observed the process of filling in the log book during the inspection and saw it was completed correctly. The theatre register was not audited and so it would not be noted when the record was incomplete. However, the registered manager explained this system was a written, daily log of theatre procedures and an electronic version served as the main system for capturing this information. The electronic system captured information relating to the patient, their procedure and discharge information, etc.

Safeguarding

- Safeguarding training was a mandatory element of training for all staff at induction and then through updates every three years. Safeguarding training records showed all theatre staff had completed training in this subject. Overall, 73.5% of staff completed safeguarding e-learning level one and 100% had completed face-to-face safeguarding training. Staff reported one safeguarding incident in the 12 months prior to the inspection.

Mandatory training

- Staff did not always receive mandatory training on an annual and ongoing basis. Levels of training received often fell below the hospital's target of 90%. Staff completed mandatory training, which was a mixture of classroom and e-learning according to a report dated February 2016. Completion rates for the following modules were: basic life support 68%, immediate life support 60%, fire safety 75.5%, health and safety 81.6%, Infection prevention and control 100%.
- A theatre-specific manual handling training course was completed by seven out of a possible eight theatre staff. Blood transfusion skills training was completed by six out of a possible seven theatre staff.

- Senior leadership were aware mandatory training levels were below target, at around 60-70% and they explained they would work with the head of department if training levels were very far from target, to gain insight into why this was the case. However, mandatory training levels remained below target. The organisation would be changing its electronic mandatory training system imminently which it felt would be more conducive to the completion of training modules. During 2015, Ramsay UK linked pay award to mandatory training, so leadership felt confident training targets would be reached.

Assessing and responding to patient risk

- The hospital had an admission policy which set out safe and agreed criteria for the admission of people using the service. The hospital provided routine, non-urgent surgery for adults. Surgery was not deemed appropriate for patients who were risk assessed with the potential to require high dependency recovery facilities.
- The systems used to assess if a patient was deteriorating were not fully completed and placed the patient at risk. The hospital used an early warning scoring (EWS) system to identify and respond appropriately to changing risks to people who use services, including deteriorating health and wellbeing, medical emergencies or behaviour that challenged. The EWS is a series of physiological observations which produce an overall score. The increase in score would note deterioration in patient's condition. Audits relating to the deteriorating patient were scheduled six monthly. We reviewed an audit which took place in November 2015 which was red, amber, green rated and the audit was rated as red, with a score of 64%. This meant deteriorating patients were not always managed effectively and in line with guidance. For example, only 70% of observations were being recorded on the EWS chart overall. Respiratory rate was recorded in 10% of patients and temperature was recorded in 30% of patients. Further training was recommended as an action following this audit and it was noted some staff had started to attend a critical care study day. It was not clear as to whether this action was now fully completed as the audit was scheduled to run every six months.
- We observed the WHO surgical safety checklist performed correctly both pre and post-operatively. This is an internationally recognised system of checks designed to prevent avoidable harm during surgical procedures. Where there was a lack of clarity, staff ensured the process was paused until all staff in the theatre were clear about the patient information and operation being discussed. Staff informed us notes from the checklist which were written onto a white board were written up in each patients individual care record while the patient was still in the theatre.
- Theatre staff were seen to engage fully in the World Health Organisation (WHO) checklist to ensure safe practice in theatre. However audits of records were not well maintained for the provider to assure themselves that this practice was consistent. Surgical safety audits were scheduled from August 2015 quarterly. The August 2015 audit showed a 93% compliance with surgical safety in the 10 sets of patients surgical notes audited. The poorest achieving area was, "all areas requiring times, initials and signatures are recorded and are legible". Staff had not completed the two subsequent audits.
- Each patient had a care record completed. These included information and an audit trail of relevant information from pre-admission through to discharge. This included; previous medical history, investigative tests, current medication and known allergies. The care record included risk assessments, such as; manual handling, pressure care, venous thromboembolism (VTE), bleeding and falls risks and nutritional care. In the four care records we looked at, we saw risk assessments had been completed and re-assessed where necessary.
- Two resident medical officers (RMO) were employed by an agency through a Ramsay corporate contract. They were available on site 24 hours a day, seven days a week. The RMO was available to assist nursing staff and consultants by completing any necessary medical tests and writing prescriptions required by the lead consultant.
- The assessment and actions taken to prevent patients developing venous thromboembolism (VTE) were audited six monthly and was 91% in September 2015, 94% in February 2016 and 89% in March 2016. The lowest score related to VTE preventative treatment being reviewed by the surgeon following surgery. These scores remained consistently low in all three audits.

Nursing staffing

- The hospital used an electronic rostering tool which was set to correlate rotas which reflected the skill mix requirements and staffing levels specific to patient

numbers and dependency. The hospital followed a patient dependency calculation to ensure adequate staffing levels met patients' needs. The dependency calculation was based on a ratio of one nurse to every six patients and extra staff were employed where necessary, based on patient acuity.

- In general, there were two trained nurses and one care assistant on shift during the day and two nurses on shift overnight. We reviewed staff rotas for the period of January to March 2016 and found staffing met planned levels on the wards.
- In the theatre department staffing levels were linked to key performance indicators. The theatre manager calculated the number of staff needed based on the scheduled operating lists. In theatre, there were very specific roles needed for each list and staffing varied accordingly. It was based on the complexity of the list and staff's skill mix.
- Nursing, operating department practitioner (ODP) and healthcare assistant staff (HCA) consisted of permanent employees and bank staff. The hospital had not used agency staff since 2011. The hospital confirmed it used a good amount of bank staff in its theatres who worked in the hospital's theatres two to three shifts per week. Senior managers confirmed they would convert the bank staffing hours into contracted hours if they were regularly having to use more bank staff than permanent staffing.
- A staffing tool was used to calculate staffing levels based on workload, time of day and theatre lists.
- Staff in the surgical department we spoke with said they were busy and would have preferred to have more staff. However, they were clear that safety in relation to staffing was not compromised. We heard recent examples of where theatre lists had been cancelled due to insufficient staffing. In the senior management team meeting minutes dated 2 February 2016, it was noted a theatre list was cancelled on 29 January 2016 due to staff sickness and the appropriate "safe" decision had been made.
- A range of staff said there had been increased staff turnover in recent years. The hospital was in the process of recruiting new staff to cover a number of current, recent vacancies and to employ new staff due to the increase in facilities. For example, two ODPs had recently left, two new staff were due to start in order to fill these vacancies and two further ODPs were needed to accommodate the recent changes. Staff turnover in 2013 was 9.3%, 8.1% in 2014 and 10.8% in 2015 and 18.2% in 2016. Turnover for a rolling 12 month cycle in February 2016 for clinical staff and support staff was 16% and 20.4% respectively.
- It was reported in the senior management team meeting dated 7 December 2016 there were concerns about high levels of staff sickness across all departments. This was not linked to any impact on the service and there were no actions linked to this finding. It did not appear on the risk register.

Are surgery services effective?

In assessing if surgery services were effective, we focused specifically on staffs' skills knowledge and experience to deliver effective care and treatment, and whether people's consent to care and treatment was sought in line with legislation and guidance.

- Senior management informed us staff could access training from both within and outside the hospital. However, staff we spoke with said their competencies had not been assessed by line management.
- We were not assured staff received a regular appraisal. In 2014, 75% of staff received an appraisal. The appraisal system was changed in 2015 and it was difficult to assess how many staff had received an annual appraisal.
- The hospital audited the process for seeking consent which showed procedures and processes were not consistently being followed.

However

- Staff said they felt they could approach managers if they were concerned about the competencies of other members of staff.

Competent staff

- A staff induction took place every first Tuesday of the month for new staff. This included subjects included manual handling, fire and risk management, safeguarding, infection control and customer service excellence.
- The matron informed us staff were able to access training internally and externally through the acute hospital in the area. Staff were able to discuss their competencies and training needs during one to one staff meetings and annual appraisal discussions.

Management spoke of an 'open door' policy if staff want to talk to leadership about training and development. They said clinical supervision happened by a more experienced team member supervising the member of staff until they became more competent. Staff we spoke with said their competencies had not been assessed by line managers. Therefore, we were not assured staff received a regular appraisal.

- During January to 17 March 2016, 17 out of a possible 83 staff within the hospital received an annual appraisal. The hospital informed us it planned to complete all appraisals by the year end. In 2015, there had been a change to the appraisal system in planning when an appraisal would take place. This made it difficult to assess from the data provided by the hospital, how many annual appraisals were completed. However, in 2014 75% of appraisals were completed, which was below the target of 100%.
- There was a process in place for all consultants working for the hospital to receive an annual NHS appraisal or a Ramsay UK appraisal. Consultants who had not received an annual appraisal in their NHS role would be offered a Ramsay appraisal.
- A Ramsay UK academy could be accessed to support additional learning and there were good links established with a learning centre at the acute hospital nearby. For example, in recent past staff completed a 'difficult airways' course.
- Matron described the process in place for managing poor staff performance, which would follow a series of stages and began with an initial discussion with the head of department. The head of department asked for staff to be appraised by a member of the team who had witnessed the poor performance or behaviour, if they had not witnessed it themselves. Following this, human resources were involved and where appropriate formal disciplinary procedures commenced. The member of staff removed would be removed if practice was deemed unsafe.
- A number of staff said they would feel comfortable to raise concerns with management if they had concerns about the competencies of another member of staff. A recent example was given where concerns were raised about the competencies of a member of staff. Staff sought the opinions of others prior to reporting it to line management. Actions were taken as a result.
- An engineer carried out fire training for staff at the hospital. Three fire drills were conducted during 2015. We reviewed documentation filled out during these drills, which demonstrated they were performed effectively. A member of staff informed us they had practice fire drill on three occasions during 2015.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed four sets of patients' records and found consent to care and treatment was appropriately documented.
- The provider had a consent policy and the relevant 14 day cooling off period was monitored by the outpatient cosmetic department administrative team, nurses and consultants. Seniors leaders informed us the scheduling of the appointment was established in order to ensure the minimum amount of time between the initial consultation and treatment was met. Consent for the procedure was signed on the day of the procedure so that the patient had sufficient time to absorb the information in relation to the procedure. This was also the case for inpatient cosmetic procedures.
- The hospital carried out audits to monitor the process for seeking consent which showed procedures and processes were not always followed. Staff completed audits during November 2015 and February 2016 to review ten sets of patients' notes which looked at the consent form and the consent process. It was noted in the February audit, this was carried out in a different clinical area to the November audit. However, both related to surgical procedures. The November 2015 and February 2016 audits scored 91% and 84% compliance respectively. Actions to be taken as a result were outlined in both these audits. It was noted in the February audit that actions from the previous audit were completed. However, it was not possible to assess whether compliance had improved as the audit was not repeated in the same clinical area. Two of the lowest scoring areas included; all extra procedures being noted on the consent form, and a signed copy of the consent form being given to and accepted by the patient.

Are surgery services caring?

In assessing if surgery services were caring, we focused on compassionate care and specific aspects of how the provider ensured patients' privacy and dignity was maintained.

- The hospital did not give due regard to providing an environment in which patients' privacy and dignity could be maintained at all times during their care and treatment. The theatre environment was not always conducive to maintaining patients' privacy and dignity. Whilst some windows in the theatres were covered with temporary but inappropriate coverings, staff and those working in the hospital would still have been able to see through the some windows. This included during intimate, surgical procedures.

Compassionate care

- The theatre environment was not always conducive to maintaining patients' privacy and dignity. The positioning of theatre windows in theatre one and two, meant that staff could see into theatre from the main theatre corridor. Other staff could see into theatre from the rear access corridor. This meant staff, which included ancillary staff such as porters and engineering staff, would have been able to see into theatres from this corridor. The corridor was used frequently to access areas for clinical waste storage, equipment and the fire exits. Concerns were raised with us that builders had also previously been working and travelling along these corridors, although we did not see this happen during the inspection. This did not maintain patient's dignity and privacy during care and treatment which at times, would have included intimate procedures whilst unconscious. However, theatre staff had made attempts to ensure people's privacy and dignity was maintained, by using temporary materials to cover those windows in theatres. Staff placed incontinence pads up against one of two windows of both theatre one and two. The incontinence pads were unsightly and a temporary method used to occlude theatre windows. One pad was placed at a window at the rear of one theatre and at the front of the other theatre. Staff said these had been in place for a few days. One member of staff said they had informed management there was "no privacy". The windows of the new theatre, theatre three, had privacy stickers which occluded the view through the bottom half of the theatre window only. Staff said these had been put in place in the last few weeks. This meant taller members of staff would still be able to see through the window.

Are surgery services well-led?

To assess if surgery services at the hospital were well led, we focused on specific aspects of governance and leadership.

- There was a governance structure in place to support the provision of good care. Staff understood who to report to and how information was shared to improve performance.
- There was an annual audit programme in place in which a variety of outcomes and data were audited to monitor quality and safety.

However

- Some audits identified areas that were not performing well, and there were no actions to show how the hospital were going to make improvements in these areas. A number of these audits were not completed at all, and some were not completed in line with their schedule. Despite remedial actions having been taken in some areas, there was still a decline in results for some issues such as consent.

Governance, risk management and quality measurement for this core service

- The hospital had a governance structure in place from ward to board, and back to ward. Clinical governance meetings took place monthly to provide an avenue of information in both directions and provided an effective framework to support the delivery of strategy and good quality care.
- Governance, risk and quality information from all staff departmental meetings was fed through to other meetings on a monthly or quarterly basis. These included; health and safety, infection control, heads of department and senior management team meetings.
- Significant events and complaints were reviewed during fortnightly senior management meetings and were reviewed throughout all formal meetings such as heads of department meetings, medical advisory committee meetings and clinical governance meetings. There was a hospital wide risk register but no risk registers at a departmental level. The hospital risk register contained more strategic risks to the hospital, such as third party provider withdrawal from a service level agreement or recruitment concerns. Senior leaders informed us when individual wards and departments believed they had

identified a risk, they would carry out a manual risk assessment which were kept on the shared drive locally, with review dates allocated to these. For example, a recent risk related to new doors that were fitted in the theatre area, which were not remaining open long enough for staff to get a patient trolley through. This has since been addressed. Short and longer-term risks were then monitored by these departments and reviewed on an ongoing basis but were not captured on one collective document. These risk assessments were reviewed during the quarterly health and safety risk management meetings. Not all were reviewed at every quarterly meeting but new risks or those that were not being well managed were discussed. Some of these risks were informed by incidents. There was an annual audit programme in place in which a variety of outcomes and data were audited to monitor quality and safety. Staff identified actions and recorded them against each audit where appropriate. However, some audits identified areas that were not performing well, and there were no actions to show how the hospital were going to make improvements in these areas, such as in the medical records audit. A number of these audits, such as medicines management audits were not completed at all, and some were not completed in line with their schedule.

- A six monthly, theatre organisational management audit monitored data under the following headings; legal and ethical issues, management and human resources, equipment, risk management, the environment, infection prevention and control and education. The July 2015 audit was completed by the theatre manager and achieved 94% compliance. Two areas which scored 0% were; "There is evidence of effective communication links when incidents occur in relevant meetings minutes" and "The Risk assessments are carried out on an annual basis." There were clear actions document for areas which did not achieve 100% compliance. We could not assess if these were completed as the subsequent audit in January 2016 was not completed. However, some areas were covered in other audits which were completed, such as environmental audits.
- We reviewed consent audits dated September and December 2015 which achieved 91% and 84% compliance respectively. The September audit highlighted for example, one in five of the patients notes looked at did not contain a ticked box to confirm that they had received information about the risks, benefits and alternatives, but the patients' signatures were present. This was subsequently discussed with theatre staff at a ward meeting and was added to the medical advisory committee meeting agenda in order to update consultants. The December audit focused on a different clinical area but showed only 40% of notes reviewed had a signed copy of the consent form which was given to and accepted by the patient. Results were due to be discussed with all departments in order to address this.
- The Medical Advisory Committee (MAC) was made up of registered consultants from most specialties within the hospital. The MAC was involved in the development of clinical services within the hospital. This included accrediting and credentialing new applications from consultants who sought employment at the hospital, reviewing practising privileges and insurance indemnity. The MAC reviewed incidents, clinical effectiveness and clinical governance report, policies, new techniques and devices.
- A Ramsay UK project manager for the building works and theatre expansion was present two days per week. We were informed they liaised closely with the registered manager and contractor and held weekly meetings to review work completed during the previous week and to understand work planned for the following week, in order to maintain the safety of the service. The general manager, matron and theatre manager felt communication between the project management team, leadership and staff was good and maintained the safe running of the service. We reviewed a number of sets of minutes from fortnightly senior management team meetings and saw that progress and issues with the expansion project along with relevant actions were discussed. Heads of department were involved in the initial planning stages of the expansion project, to give them an overall understanding of the planned changes to their department. Weekly meetings maintained communication around the project during subsequent weeks.
- Heads of department were clear that the building work schedule would not compromise patient safety and would not agree for changes to take place if they felt it compromised patient care or safety in any way.
- The registered manager carried out a 'walk round' to assess the environment and progress with the ongoing building work. Senior leadership informed us they received daily updates and conversations with the building company's site manager as well as regular

communication with the Ramsay UK project manager. Any issues or concerns were then discussed directly with heads of department (HOD) and senior leaders as appropriate, with whom they worked closely in relation to the sequencing of the building work.

- The project manager was experienced in working in hospitals that were undergoing construction. Leaders were clear they felt they had the skills and knowledge in relation to infection prevention and control or consulted external experts where they felt it necessary, such as testing the air filtration system.
- We were not provided with an overall plan for the management of the project. Leaders we spoke with felt it was the responsibility of the heads of department to maintain safety, as part of their role.

Leadership / culture of service related to this core service

- An interim matron was in place at the time of our inspection, who worked at the hospital two days per week and reported to the registered manager. Heads of the ward, theatre and outpatient departments, along with a lead for physiotherapy and cosmetic services reported to matron. The finance manager and acting operational manager reported to the hospital's registered manager. The matron also worked at another Ramsay UK hospital when not at Mount Stuart and could be contacted by email or telephone during these times.
- The theatre manager and matron were not present on the day we visited the hospital, but we spoke with them following this, as part of the inspection. Staff knew who their managers and senior management were. Some staff described leaders as 'firm but fair'.

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 10 HSCA (RA) Regulations 2014 Dignity and respect **10 (1)(2)** 10(1) Service users must be treated with dignity and respect. The use of incontinence pads to occlude the view to some but not all theatre windows of theatres one and two, and the semi-occluded windows of theatre three did not maintain the privacy and dignity of patients. 10(2)(a) ensuring the privacy of the service user; Each person's privacy must be maintained at all times including when they are asleep, unconscious or lack capacity.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **12 (2)(a)(b)(g)(h)** 12(2) (a) assessing the risks to the health and safety of service users receiving the care or treatment (b) doing all that is reasonably practical to mitigate any such risks**;** The systems used to assess if a patient was deteriorating (National Early Warning Scores) were not fully utilised and placed the patient at risk.

This section is primarily information for the provider

Requirement notices

(g) the proper and safe management of medicines

Staff must follow policies and procedures in relation to the management of medicines. These policies and procedure should be in line with current legislation and guidance and address storage and administration.

The provider must ensure medicines are consistently managed and secured in a way that would keep people safe.

(h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated

In an infection prevention and control audit, it was identified that waste was stored in corridors or other inappropriate areas internally or externally. We found two bags containing clinical waste outside an exit to the corridor behind the theatres.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **15 (1)(a)(b)** 1. All premises and equipment used by the service user must be (a)clean (b)secure The theatre areas were not always clean, free from dust or building debris. Some items of equipment were stored on the floor and covered with building dust and debris.

This section is primarily information for the provider

Requirement notices

The hospital did not provide a secure environment for patients on the ward, in the recovery area or in theatre.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **17 (1)(2)(a)(b)** (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to- (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; Audits of compliance with the WHO checklist were not carried out at the designated frequency and actions were not reviewed. Audits to monitor the process for seeking consent showed procedures and processes were not always followed and improvements in audits were not seen, as audits were not repeated for the same clinical areas. The assessment and actions taken to prevent patients developing venous thromboembolism (VTE) was audited. Some scores remained consistently low in all three audits.

This section is primarily information for the provider

Requirement notices

Audits to monitor surgical site infection prevention procedures before and during the operation were not completed and so it was not possible to identify if surgical site infection prevention was effective.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **18 (2)(a)** (1) Persons employed by the service provider in the provision of a regulated activity must (a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out their duties they are employed to perform Mandatory training levels were not being met and the hospital could not assure staff always received an annual appraisal to ensure they were competent to carry out their role.