

BMI The Park Hospital

Quality Report

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

Ratings

Overall rating for this location

Good



Are services safe?

Good



Overall summary

BMI The Park Hospital is operated by BMI Healthcare Limited. The hospital has 56 beds across two wards. Facilities include five operating theatres (one of which is allocated as endoscopy), a five-bed critical care unit with three beds allocated to level three care, a cardiac catheterisation laboratory and X-ray, outpatient and diagnostic facilities.

The hospital provides surgery, medical care and outpatients and diagnostic imaging. We carried out an unannounced focused inspection of the safe key question in surgery and medical care on 23 May 2018 in response to concerning information we had received about the safety of patient care and treatment across these services.

The main service provided by this hospital was surgery. Where our findings on medical care for example, medicines also apply to other services, we do not repeat the information but cross-refer to the surgery core service.

At our last inspection in September 2016 we rated the hospital as good overall; our rating for safe in medical services was good and surgical services was requires improvement.

Following this unannounced inspection our rating for safe in medical services stayed the same and our rating for safe in surgical services improved from requires improvement to good.

We found good practice in relation to medical care:

Summary of findings

- The service managed staffing effectively and had enough staff with the appropriate skills, experience and training to keep patients safe and to meet their care needs.
 - Arrangements to safeguard adults and children were in place and staff had received effective training in safeguarding adults and children at a level appropriate for their role.
 - Standards of cleanliness and hygiene were appropriately maintained, there were reliable systems in place to prevent infection and protect people from a healthcare-associated infection. Patient-Led Assessments of the Care Environment' (PLACE) results were above the England average and local hand hygiene audits showed 100% compliance.
 - Recording of all medical information was timely, accurate and legible. However, none of the medical records included the medical practitioner's general medical council (GMC) number.
 - Risks to patients were assessed, and their safety monitored and managed so they were supported to stay safe. Staff consistently identified and responded appropriately to changing risks to patients, including for example, the deteriorating patient.
 - The service had a good track record on safety.
 - Recording of all medical information was timely, accurate and legible. However, none of the medical records included the medical practitioner's general medical council (GMC) number.
 - When the critical care unit was in use, it was led by an intensivist. There was 24-hour immediate access to the intensivist or an on-call anaesthetist.
 - Staff adhered to policies and protocols which kept patients safe from infection. This included wearing appropriate clothing within the theatre environment.
 - Staff were encouraged to report significant events. These were used as scenarios in training sessions to inform staff of any changes in process and for sharing learning.
 - Integrated records/care pathway documentation were used to ensure all relevant information and risk assessments were documented throughout the patient journey.
 - There was a paediatric nurse available who led and coordinated the care of children (aged 12-18 years).
- Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

We found good practice in surgery:

- Protected time was allocated for staff to complete mandatory training, including safeguarding training relevant to their role. This included training on female genital mutilation (FGM).

Heidi Smoult

Deputy Chief Inspector of Hospitals (Central Region)

Summary of findings

Our judgements about each of the main services

Service

Medical care

Rating Summary of each main service

Medical care services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.

We rated this service as good:

- The service managed staffing effectively and services had enough staff with the appropriate skills, experience and training to keep patients safe and to meet their care needs.
- Arrangements to safeguard adults and children from abuse and neglect that reflected relevant legislation and local requirements were in place and staff had received effective training in safeguarding adults and children at a level appropriate for their role.
- Standards of cleanliness and hygiene were appropriately maintained, there were reliable systems in place to prevent infection and protect people from a healthcare-associated infection. Patient-Led Assessments of the Care Environment' (PLACE) results were above the England average and local hand hygiene audits showed 100% compliance.
- Risks to patients were assessed, and their safety monitored and managed so they were supported to stay safe. Staff consistently identified and responded appropriately to changing risks to patients, including for example, the deteriorating patient.
- The service had a good track record on safety. Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, incidents were investigated appropriately and lessons learned shared across the hospital services and the wider corporate provider.

Surgery

Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section.

Staffing was managed jointly with medical care.

Summary of findings

We rated this service as good:

- Protected time was allocated for staff to complete mandatory training, including safeguarding training relevant to their role. This included training on female genital mutilation (FGM).
- Recording of all medical information was timely, accurate and legible. However, none of the medical records included the medical practitioner's general medical council (GMC) number.
- When the critical care unit was in use, it was led by an intensivist. There was 24-hour immediate access to the intensivist or an on-call anaesthetist.
- Staff adhered to policies and protocols which kept patients safe from infection. This included wearing appropriate clothing within the theatre environment.
- Staff were encouraged to report significant events. These were used as scenarios in training sessions to inform staff of any changes in process and for sharing learning.
- Integrated records/care pathway documentation were used to ensure all relevant information and risk assessments were documented throughout the patient journey.
- There was a paediatric nurse available who led and coordinated the care of children (aged 12-18 years).

Summary of findings

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Good



BMI The Park Hospital

Services we looked at

Medical care; Surgery

Summary of this inspection

Background to BMI The Park Hospital

BMI The Park Hospital is operated by BMI Healthcare Limited. It is an independent hospital registered with the Care Quality Commission to provide a range of treatments and procedures to people in an inpatient and outpatient setting. It is an independent healthcare hospital in Arnold, Nottinghamshire. The hospital primarily serves the communities of Nottinghamshire but does however, accept patient referrals from outside this area. The hospital provides inpatient services to adults and children over the age of 12 and outpatient services to the whole population.

At the time of the inspection the hospital had an executive director, who was also the registered manager. From 1 June 2018 BMI The Park Hospital would not have a registered manager. A new substantive registered manager had been appointed and was due to commence 11 June 2018. In the interim, oversight of the hospital was to be managed by the senior management team.

BMI The Park Hospital is registered to provide the following Regulated Activities:

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

BMI The Park Hospital was last inspected on 6, 7 and 17 September 2016 as part of the CQC's ongoing programme of comprehensive, independent healthcare acute hospital inspections. Following the inspection in 2016, we told the provider that it must take action to comply with the regulations and issued the provider with one requirement notice that affected all clinical staff at this location. Following this inspection, we were satisfied the provider had taken appropriate action to meet the requirements of this regulation.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, a CQC assistant inspector and two specialist advisors with expertise in cardiology and theatres. The inspection team was overseen by Yin Naing, CQC inspection manager.

Information about BMI The Park Hospital

BMI The Park Hospital in Nottingham is part of BMI Healthcare. The hospital provides medical and surgical services to patients who pay for themselves, are insured, or are funded under National Health Service (NHS) contracts.

Medical services are those services that involve assessment, diagnosis and treatment of adults by means of medical interventions rather than surgery. Endoscopy or chemotherapy treatments undertaken as a day case are also included within medical care.

BMI The Park Hospital medical service consists of three separate components; oncology chemotherapy treatment, a diagnostic endoscopy service and a cardiac catheterisation laboratory.

Surgical facilities at BMI The Park Hospital includes 56 individual en-suite patient rooms divided over two wards. Rufford Ward is predominately for surgical and medical inpatients, whilst Wollaton Ward is mainly for day case and ambulatory care patients. There are five operating theatres and an eight-bedded recovery area for patients recovering immediately post-surgery.

Summary of this inspection

A critical care unit is available to stabilise inpatients whilst awaiting emergency service to transfer the patient to a local NHS trust and post-surgical patients, requiring level two or three critical care facilities.

During the inspection, we visited Rufford ward, Wollaton ward, the ambulatory unit, the theatre suite including endoscopy and the recovery area, outpatients department, chemotherapy suite and the cardiac catheterisation laboratory. We spoke with 27 staff including; registered nurses, health care assistants, student nurses, administration staff, medical staff, operating department practitioners, and senior managers. During our inspection, we reviewed 11 sets of medical records nine sets of nursing records, 10 medicine administration records and 10 observation charts.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected four times, and the most recent inspection took place in September 2016, which found that the hospital was not meeting all standards of quality and safety it was inspected against.

Activity May 2017 to April 2018:

- Total number of attendances for the cardiac catheterisation laboratory was 735; of these none were NHS-funded.
- Total number of attendances for endoscopy was 1,085; of these 37% were NHS-funded with diagnostic colonoscopy being the most common procedure carried out.
- Total number of attendances for oncology treatment was 2,610; of these none were NHS-funded.
- Total number of patients receiving a surgical procedure (excluding cardiology and endoscopy) was 8,420; of these 136 were 0-18 years and 8,284 were over the age of 18. NHS-funded patients accounted for 29% of activity.

There were 258 surgeons, anaesthetists, physicians and radiologists at this hospital working under practising

privileges. Two regular resident medical officers (RMOs) worked on a weekly rota. The hospital employed 49 registered nurses, 22 care assistants and 35 administration and clerical staff, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety May 2017 to April 2018:

- Zero never events
- Clinical incidents 318 no harm, 94 low harm, 20 moderate harm
- Two serious incidents
- Zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- Zero incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- Zero incidences of hospital acquired Clostridium difficile (c.diff)
- Zero incidences of hospital acquired E-Coli
- Total number of complaints received was 131

A radiotherapy treatment centre operates within the service.

Services accredited by a national body:

None

Services provided at the hospital under service level agreement:

- NHS Standard Contract
- Spinal treatments
- Weight loss surgery
- Eye surgery
- Pain management
- Clinical and or non-clinical waste removal
- Cytotoxic drugs service
- Interpreting services
- Maintenance of medical equipment
- Pathology and histology
- Resident medical officer (RMO) provision
- Emergency patient transport.

Medical care

Safe

Are medical care services safe?

We rated safe as **good**.

Mandatory training

- Staff received effective training in safety systems, processes and practices relevant to their role. Mandatory training was delivered either face to face or online. Online training could be accessed both at work and home. Where staff completed training in their own time they told us they were paid for this.
- Mandatory training included for example, infection prevention and control, information security, fire safety and moving and handling. For the reporting period May 2017 to April 2018 mandatory training compliance for the hospital was 83% and just below the hospital target of 90%.
- Individual staff training records were held at ward/department level. We reviewed three staff training records on the chemotherapy suite. Records were up to date and provided evidence of completion of mandatory training.
- All relevant hospital staff had received training on sepsis recognition as part of an 'in-house' four-hour session on the care and communication of the deteriorating patient. This session included a competency assessment.
- Additional training was available for staff who required necessary skills in specific areas, for example, in endoscopy four staff had completed endoscope decontamination training with a further three staff due to complete the training in July 2018. On the chemotherapy suite all the registered nurses had completed an 'administration of chemotherapy' competency.
- Consultants and clinicians with practising privileges were not required to complete training through the hospital system but the medical advisory committee checked assurance of their mandatory training undertaken through their employing NHS trust. However, a local induction to the hospital was carried out that included for example, local fire safety training.
- The resident medical officers (RMOs) received mandatory training through their RMO agency and had

access to the hospital's on-line training systems. The RMOs received advanced life support (ALS) and paediatric advanced life support training by means of the RMO agency. The director of clinical services had oversight of this training to ensure competency had been achieved. Both RMOs we spoke with had completed this training.

Safeguarding

- Staff received effective training in safeguarding adults and children at a level appropriate to their role. Safeguarding training was delivered both face to face and online.
- For the reporting period May 2017 to April 2018 safeguarding training compliance was similar to, or better than, the hospital target of 90%. Local levels of training for safeguarding vulnerable adults were in place, training compliance figures provided by the hospital (not broken down by area or staff group) were as follows; safeguarding vulnerable adults (level one) 90%, safeguarding vulnerable adults (level two) 88%, safeguarding vulnerable adults (level three) 100%, safeguarding children (level one) 89%, safeguarding children (level two) 88%, safeguarding children (level three) 91%.
- Staff we spoke with had a good understanding of how to protect patients from abuse. We spoke with staff who could describe what safeguarding was and the process to refer concerns.
- Clinical staff working on the chemotherapy suite were trained to safeguarding at level three for both adults and children. Safeguarding training included how to identify women or children with, or at risk of, Female Genital Mutilation (FGM).
- Individual staff training records were held at ward/department level. We reviewed three staff training records on the chemotherapy suite. Records were up to date and provided evidence of completion of safeguarding training.
- The lead for safeguarding adults and children was the director of clinical services in addition to, support from clinical services managers across the hospital site. Staff we spoke with were aware of the leads and told us they would approach these individuals should they need advice or need to refer a safeguarding concern to the

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local authority. Two of the supporting staff were trained to level four in line with Safeguarding children and young people: roles and competences for health care staff; Intercollegiate document (March 2014).

- On the chemotherapy suite, safeguarding adults and children flow charts were visible in the clinical area to advise staff on the process to follow should they become aware of a safeguarding concern.
- Safeguarding policies and procedures were available to all staff through the provider's intranet. This included access for bank and agency staff and those staff working under practising privileges.
- Disclosure and Barring Service (DBS) checks were carried out on all staff working at the hospital. DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children.

Cleanliness, infection control and hygiene

- The hospital participated in 'Patient-Led Assessments of the Care Environment' (PLACE). PLACE are a self-assessment of non-clinical services, which contribute to healthcare, delivered in both the NHS and independent healthcare sectors in England. The programme encourages the involvement of patients, the public and stakeholders, both nationally and locally, who have an interest in healthcare and assessing providers. The assessment of cleanliness for this hospital from May 2017 to April 2018 demonstrated a compliance level of 99%, which was better than the England average of 98%.
- Hand hygiene audits were undertaken to measure compliance with the World Health Organisation's (WHO) 'Five Moments for Hand Hygiene.' These guidelines are for all staff working within healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients. Hand hygiene audit data provided by the hospital for the period May 2017 to April 2018 showed 100% compliance.
- Throughout the oncology, endoscopy and cardiology areas we observed all staff to be compliant with best practice regarding infection prevention and control policies. All staff were observed to wash their hands or use hand-sanitising gel between patients. There was

access to hand washing facilities and a supply of personal protective equipment, which included gloves and aprons. There were antimicrobial gel dispensers available on entry to the clinical areas.

- Patient equipment appeared visibly clean and we saw use of 'I am clean' stickers in the clinical areas to indicate where staff had signed to say equipment had been cleaned and was ready for patient use.
- Precautions were taken in the cardiac catheterisation laboratory and endoscopy when seeing people with suspected communicable diseases. Information received during our inspection stated these patients would receive their procedure at the end of a list.
- Reusable medical devices were decontaminated in accordance with manufacturers' instructions. This included for example, endoscopes. In endoscopy, log books were in place as a means of providing a 'track and trace' process for all endoscopes used. Log books we observed identified for example, the cleaning and sterilisation method used, a record of the decontamination equipment and cycle, the identity of the person(s) undertaking decontamination at each stage of the cycle and the patients on whom they have been used and details of the procedures involved.
- Patients who had a urinary catheter had their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the catheter and its removal as soon as it was no longer needed. Our review of nursing records showed where specified procedures had been documented once carried out.
- Patients who had a vascular access device had their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the device and its removal as soon as it was no longer needed. Our review of nursing records showed where specified procedures had been documented once carried out.
- Infection prevention and control policies and procedures were available to all staff through the provider's intranet. This included access for bank and agency staff and those staff working under practising privileges.

Environment and equipment

- Appropriate resuscitation equipment was available and staff demonstrated that they knew how to use the equipment. Training on the use of emergency

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equipment, for example, the automated external defibrillator (AED) was carried out as part of life support training. An AED is a portable device that checks the heart rhythm and can send an electric shock to the heart to try to restore a normal rhythm.

- All AEDs had a manual override function. This allowed the user to manually determine the voltage and timing for an electrical shock.
- Resuscitation equipment was safe and ready for use in an emergency. Single-use items were sealed and in date and emergency equipment had been serviced. Records indicated resuscitation equipment had been checked by staff.
- Patient equipment was appropriately maintained. Across medical services we observed all equipment to have a visible safety tested sticker in place and all equipment to be in service date.
- The management of single-use consumables was effective, single-use consumables were in date and mostly stored appropriately. However, in the chemotherapy suite we found a number of single-use consumables inappropriately stored within the dirty utility room. This was raised at the time of our inspection with senior managers who assured us the items would be removed.
- Following a serious incident in the cardiac catheter laboratory and concerns raised anonymously with the Care Quality Commission, significant improvements had been made with stock control processes in this area ensuring appropriate equipment and single-use consumables were available for each procedure.
- The endoscopy suite was within the theatre suite and shared a waiting and recovery area. There was no male / female separation within this area except the curtains. One toilet for both male and female patients was available outside the waiting area for endoscopy patients. Senior managers told us there were plans in place to upgrade this area in preparation for an assessment to be carried out by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) in April 2019.
- Sufficient equipment was available in all the areas we visited. Maintenance of equipment was carried out either 'in-house' or provided by an external contractor. For example, in endoscopy maintenance of endoscopes and equipment was managed by an external company

with regular servicing of equipment carried out on a three-monthly and annual basis. Staff we spoke with told us they had access to this external company 24 hours a day, seven days a week.

- Arrangements were in place for managing waste and clinical specimens. During this inspection we observed clinical waste, including cytotoxic waste, to be disposed of appropriately and in line with hospital policy.
- Hazardous cleaning fluids and flammable liquids were not always stored in line with guidance from the Control of Substances Hazardous to Health Regulations (2002). We found hazardous cleaning fluids and flammable liquids stored in an unlocked cabinet in the dirty utility room on the chemotherapy suite. This was raised at the time of our inspection with senior managers who assured us the items would be locked away.

Assessing and responding to patient risk

- The hospital had an admission policy setting out safe and agreed criteria for admission of medical patients. In addition, specific exclusion criteria were in place for the cardiac catheter laboratory and the endoscopy area. Exclusion criteria for the cardiac catheter laboratory included for example, procedural limitations such as, primary percutaneous coronary intervention (PPCI) and clinical limitations such as, bariatric patients and any patient who required renal dialysis support. Exclusion criteria for endoscopy included those patients with a body mass index (BMI) more than 40, those with an unstable mental health condition and patients under 19 years old.
- The hospital did not accept urgent or unplanned medical admissions (admitted without being first seen and assessed by a consultant at the hospital).
- Staff identified and responded appropriately to changing risks to patients, including deteriorating health and wellbeing, medical emergencies or behaviour that challenges. Two on-site resident medical officers (RMOs) were available for immediate support and consultants were available by telephone and able to return to the hospital within 30 minutes. In addition, there was access to on-site level two and three critical care facilities supported by an on-call consultant intensivist from a local NHS trust.
- The hospital had a service level agreement (SLA) with the local NHS acute trust, ambulance service and the local critical care network. This meant patients could be transferred to the nearby NHS acute trust for care and

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treatment should their condition deteriorate with the emergency ambulance service providing transport. This agreement included the transfer of a patient to an appropriate area within the trust other than the emergency department. For example, endoscopy or the cardiac catheter laboratory.

- Nursing staff used a national early warning scoring system (NEWS) to record routine physiological observations such as blood pressure, temperature, and heart rate. NEWS was used to monitor patients and to prompt support from medical staff when required. During our inspection we reviewed five sets of patient observations. We found nursing staff adhered to hospital guidelines for the completion and escalation of NEWS. NEWS scores were correctly calculated, frequency of observations correctly set and the correct escalation response requested.
- Staff had received appropriate training in sepsis recognition including the use of sepsis screening tools and use of sepsis care bundles. None of the five observation charts we reviewed indicated the patients should have been screened for sepsis.
- The hospital was in the process of implementing training on NEWS2; the latest version of the NEWS, first produced in 2012 and updated in December 2017. NEWS2 has received formal endorsement from NHS England and NHS Improvement to become the early warning system for identifying acutely ill patients, including those with sepsis, in hospitals in England. All staff on the chemotherapy suite had completed this training.
- On the chemotherapy suite nursing staff used a triage log sheet based on the United Kingdom Oncology Nursing Society (UKONS) for all calls from patients who were concerned they may have neutropenic sepsis. When required, nursing staff asked the patient to return to the hospital for assessment and contacted the patient's consultant for advice. Neutropenic sepsis is a life-threatening complication of anti-cancer treatment.
- For endoscopic and cardiac procedures staff used a document based on the World Health Organisation (WHO) safety procedures: the WHO surgical safety checklist to ensure each stage of the patient's journey was managed safely. At the time of this inspection there were no procedures being undertaken in either the

cardiac catheter laboratory or endoscopy. As such, we were unable to observe the WHO process taking place. However, through speaking with staff we were assured sufficient priority was given to this process.

- For the reporting period January 2017 to December 2017 WHO checklist and observational audit results were better than the hospital target of 95% for 10 out of 12 months. For January 2018 to April 2018 audit results showed 100% compliance in endoscopy however, audit results for the cardiac catheter laboratory for March 2018 showed 80% compliance (8/10 patients) with the 'sign in' moment and 70% compliance (7/10 patients) with the 'sign out' moment. We discussed these results with the lead for this area who told us and we saw where actions had been put in place to improve these results. Actions included for example, strengthening the 'huddle' moment prior to the procedure commencing.
- A major haemorrhage policy and protocol was in place, including access to blood and blood components, at this hospital. This provided a rapid, focused approach to the urgent provision of blood for life threatening haemorrhages.

Nurse staffing

- The hospital used a corporate nurse dependency and skill mix planning tool when planning staffing in line with National Institute for Health and Care Excellence (NICE) staffing guidance.
- Patient admissions were known in advance and staffing levels calculated using an electronic staff rostering tool, this ensured safe staffing numbers were planned according to the number of patients. The tool could be manually adjusted to take account of individual patient needs, for example additional health care assistants (HCA) were allocated when patients with dementia were to be admitted. Additional qualified members of staff were allocated from the bank during busy periods to ensure staffing levels were safe and patient needs could be met. Staffing levels were reviewed daily by a senior nurse to ensure correct staffing and skill mix.
- The hospital used bank staff and wherever possible agency staff who had worked there before. Bank staff are those staff employed by the hospital to cover unfilled shifts due to sickness or annual leave. The average use of bank nurses between May 2017 and April 2018 was 14%. For the same reporting period average agency use was 0.9%.

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- A corporate induction policy and procedure was in place for bank and agency staff new to an area.
- Staffing in the cardiac catheterisation laboratory was heavily reliant on bank staff. Concerns raised before our inspection indicated bank staff working in the cardiac catheterisation laboratory had not received an appropriate induction to this area. As a result, these concerns had been investigated and actions put in place. Actions included for example, completion of an induction for all staff within this area, the appointment of a lead nurse and use of a 'core' group of bank staff primarily from a local NHS trust. Senior staff told us, the provider was consulting the British Cardiovascular Intervention Society (BCIS) for recommendations regarding nursing staffing levels.
- Endoscopy was not a 'standalone' unit and was staffed by theatres. Concerns had been raised before our inspection regarding the lack of staff specifically trained to work within endoscopy. As a result, an endoscopy lead nurse was now in post. The new endoscopy lead told us of their plans to develop a core group of staff who would work in endoscopy.
- The chemotherapy suite was fully established with five registered nurses, one health care assistant (HCA) and one administration assistant. Nursing staff we spoke with felt there was not always enough staff in this area especially when they had to go to the ward to administer cancer medicines. However, they did not feel this impacted negatively on patient care.
- A pathway was in place, and staff were aware of it, for referring patients to NHS services if their acute condition deteriorated and was unable to be managed locally in the hospital's critical care unit.
- Arrangements were in place for patients who became ill between visits to the hospital. For example, with neutropenic sepsis.

Medical staffing

- There were 258 surgeons, anaesthetists, physicians and radiologists that worked at the hospital under practising privileges. Practising privileges refers to medical practitioners being granted the right to practise in a hospital after being approved by the medical advisory committee (MAC). The medical advisory committee (MAC) monitored outcomes of individual consultants.
- Consultants visited inpatients at least once every 24 hours and were contactable by telephone 24 hours a

day, seven days a week whilst they had patients in the hospital. If they planned a period of absence a fellow consultant would be identified to cover and the hospital informed.

- Nursing staff on the chemotherapy suite told us they had good access to the oncologist who, if required, would be able to attend the suite within 30 minutes.
- Two resident medical officers (RMOs), trained in advanced life support, provided medical cover 24 hours a day, seven days a week for all patients. RMOs worked a seven-day roster and were on call for emergencies 24 hours a day, seven days a week. The RMOs worked at the hospital regularly and knew the hospital and its routine well. RMOs were advised of cover arrangements for any consultant on leave. The RMO we spoke with told us they had good access to the consultants at all times. Nursing staff told us they had good access to the RMOs and had confidence in their medical practice.
- RMOs were provided by an agency. Mandatory training for the RMOs was the responsibility of the agency. The clinical experience, qualifications and record of mandatory training was checked by the hospital before they commenced working and monitored on an annual basis.
- An on-call consultant intensivist, from a local NHS trust, was available 24 hours a day, seven days a week as support to the RMO for those patients requiring level two or three care.

Records

- Patients' individual care records, including clinical data were written and managed in a way that kept patients safe. Records were paper-based, nursing notes were held at the patient's bedside and medical notes were stored in a locked room.
- During this inspection we reviewed six medical records and four nursing records. Records were legible, accurately completed and up to date. However, none of the medical records included the medical practitioner's general medical council (GMC) number. The GMC is a public body that maintains the official register of medical practitioners within the United Kingdom and endorses the use of a practitioner's unique GMC number in medical records.

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- Nursing care records included risk assessments for example, pressure ulcers, malnutrition and falls. All clinical risk assessments followed national guidance, for example, the use of a recognised score for the prevention of pressure ulcers.
- Integrated care records were in use in endoscopy and the chemotherapy suite. In endoscopy, care records included for example, pre-operative assessment, the five steps to safer surgery checklist, operating notes, observations and recovery records.
- Our review of five medicine administration records, where patients were prescribed an antimicrobial (antibiotic), demonstrated they had the clinical indication, dose and duration of treatment documented in their clinical record. This was in line with best practice guidance.
- Diagnostic imaging and endoscopy were available on-site. As such, results were available in a timely manner.
- Care summaries were sent to the patient's general practitioner (GP) on discharge to ensure continuity of care within the community. Summaries included, where appropriate, any medication changes. A copy of the care summary was also given to the patient.

Medicines

For our detailed findings on medicines please see the Safe section in the surgery report.

- Nursing guidelines were in place for the management of patients requiring conscious sedation by non-anaesthetists. We reviewed the guidelines and found these were in date and appropriate for use in for example, endoscopy and the cardiac catheterisation laboratory. In addition, we noted all appropriate equipment required, when sedation was to be administered, was readily available.
- Nitrous oxide was administered by theatre staff during some endoscopy procedures under a patient group direction (PGD). The endoscopy lead told us not all staff had completed this competency and said in the event a registered nurse was not competent the responsible medical practitioner would assume responsibility and sign for administration. In addition, we were told the medical practitioner remained in attendance

throughout the endoscopy procedure. PGDs allow some registered health professionals (such as nurses) to give specified medicines to a predetermined group of patients without them seeing a doctor.

- On the chemotherapy suite medicines, including those requiring cool storage, were stored appropriately. There was access to spill kits, skin irritation packs and a drug used when chemotherapy drugs had leaked into surrounding skin tissues. Chemotherapy was not prepared on site. A cytotoxic drugs service was provided at the hospital under a service level agreement.

Incidents

- Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From May 2017 to April 2018, the hospital reported no incidents classified as never events.
- In accordance with the Serious Incident Framework 2015, the hospital reported two serious incidents (SIs) which met the reporting criteria set by NHS England from May 2017 to April 2018.
- We reviewed the investigation report following a SI in the cardiac catheterisation laboratory in September 2017. We found a thorough investigation had taken place and learning points identified. In addition, an external review of the cardiac catheterisation laboratory had been completed by a senior member of staff from another location within the provider organisation. As a result of this incident 20 actions had been agreed. As of the date of this inspection actions had either been completed or were due for completion once there was assurance that new practices were fully embedded. One action included the development of a clinical operational policy. We saw where this had been completed and shared with five locations across the provider organisation.
- For the reporting period May 2017 to April 2018, 434 incidents were recorded by the hospital. The majority of these were graded as no harm (318 incidents). Of the remaining 116 incidents, 94 were graded low harm and 20 were moderate harm. The remaining two incidents had been classified as serious incidents.

Medical care

- An incident reporting policy which included the approach of BMI Healthcare for the management of incidents was available to staff. Incidents, accidents and near misses were reported through the hospital's electronic reporting system.
- We spoke with staff specifically about incident reporting. Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally, where appropriate. Staff we spoke with could give us examples of recent incidents they had reported.
- Staff told us incidents and shared learning from incidents was shared through a daily communication bulletin, email, through individual feedback and during patient handover.
- The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with were familiar with the duty of candour and the concepts of openness and transparency. Before our inspection we saw where the hospital had applied the duty of candour when an incident required it.

Surgery

Safe

Are surgery services safe?

The main service provided by this hospital was surgery. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section.

We rated safe as **good**.

Mandatory training

- Mandatory training was a mix of e-learning and face to face training sessions. All staff were expected to complete annual updates and protected time was provided mostly during working hours and managed by the department managers. We saw evidence of study time allocated to staff on their rostering system throughout the surgery services departments and theatre suite. Where it had been necessary for some staff to complete e-learning modules at home, they had received payment for this.
- Mandatory training included for example, infection prevention and control, information security, fire safety and moving and handling. For the reporting period May 2017 to April 2018 mandatory training compliance for the hospital was 83% and just below the hospital target of 90%.
- In addition to e-learning modules, staff also attended face to face training for a number of subjects relevant to their role. These included; safeguarding level three, immediate life support, care of the deteriorating patient, safe medicine management, medical gasses, and infection control updates which included identifying potential sepsis.
- Staff working in the theatre suite had time allocated for mandatory updates during their monthly audit day, which was also used for other training and development and team meetings.
- Sepsis management training was also included as part of the 'in-house' four-hour session on the care of the deteriorating patient. This session included a competency assessment.
- Consultants and clinicians with practising privileges were not required to complete training through the hospital system but the medical advisory committee

checked assurance of their mandatory training undertaken through their employing NHS trust. However, a local induction to the hospital was carried out that included for example, local fire safety training.

- The resident medical officers (RMOs) received mandatory training through their RMO agency and had access to the hospital's on-line training systems. The RMOs received advanced life support (ALS) and paediatric advanced life support training by means of the RMO agency. The director of clinical services had oversight of this training to ensure competency had been achieved. Both RMOs we spoke with had completed this training.

Safeguarding

- All staff were required to undertake children and adult safeguarding training at a level relevant to their role. There were senior clinical staff within each surgical department who had completed face to face training at level three. Staff told us that since our last inspection, they had received training on female genital mutilation (FGM) which had been included as part of the annual safeguarding updates.
- For the reporting period May 2017 to April 2018 safeguarding training compliance was similar to, or better than, the hospital target of 90%. Local levels of training for safeguarding vulnerable adults were in place, training compliance figures provided by the hospital (not broken down by area or staff group) were as follows; safeguarding vulnerable adults (level one) 90%, safeguarding vulnerable adults (level two) 88%, safeguarding vulnerable adults (level three) 100%, safeguarding children (level one) 89%, safeguarding children (level two) 88%, safeguarding children (level three) 91%.
- The lead for safeguarding adults and children was the director of clinical services in addition to, support from clinical services managers across the hospital site. Staff we spoke with were aware of the leads and told us they would approach these individuals should they need advice or need to refer a safeguarding concern to the local authority. Two of the supporting staff were trained to level four in line with Safeguarding children and young people: roles and competences for health care staff; Intercollegiate document (March 2014).

Surgery

- We spoke with staff in a variety of roles, on the surgical ward, pre-assessment team, ambulatory unit and theatre, and found they had a good understanding of how to protect patients from abuse. Staff could describe what safeguarding was and the process to refer concerns. All were aware of who the safeguarding lead was.
- Safeguarding policies and procedures were available to all staff through the provider's intranet.

Cleanliness, infection control and hygiene

- Patient-led assessments of the care environment (PLACE) are a system for assessing the quality of the patient environment; patients' representatives go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness and general building maintenance.
- From May 2017 to April 2018 the hospital scored 99% for cleanliness in patient-led assessments of the care environment (PLACE). This was above the national average of 98%.
- There were infection prevention and control (IPC) policies and procedures in place that were readily available to staff on the hospital's intranet and infection prevention and control was included in mandatory training programme. Staff told us they were up to date with this training. The hospital provided us with a total compliance score for mandatory training which included infection prevention and control. For the reporting period May 2017 to April 2018 mandatory training compliance for the hospital was 83% and just below the hospital target of 90%.
- The IPC lead had recently retired and a senior nurse had been recruited to the role on a temporary basis. The senior nurse was being supported in this role and had taken action to address issues identified in an audit conducted in January 2018 which identified that improvements could be made to the segregation of waste. For example; new signage was being introduced to remind staff about correct use of waste containers. The IPC lead was also working with the hospital's learning and development lead to improve the training package for staff and plans were being made to update staff on correct use of new sharps bins that were soon to be implemented.
- We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The sharp bins were clearly labelled and tagged to ensure appropriate disposal.
- Hand hygiene audits were undertaken to measure compliance with the World Health Organisation's (WHO) 'Five Moments for Hand Hygiene.' These guidelines are for all staff working within healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients. Hand hygiene audit data provided by the hospital for the period May 2017 to April 2018 showed 100% compliance.
- Throughout surgical services we observed all staff to be compliant with best practice regarding infection prevention and control policies. All staff were observed to wash their hands or use hand-sanitising gel between patients.
- An observational audit was carried out each month to check that standard precautions were being adhered to, and on the cleanliness of patient equipment. Audit data from January 2018 to April 2018 showed 100% compliance. (Standard precautions are the infection prevention measures that should be adopted by all healthcare workers at all times.)
- The wards, theatres and recovery areas were visibly clean and tidy. This included clinical areas, corridors, bathrooms, offices and storage rooms.
- There was a system for ensuring equipment was clean, for example 'I am clean' stickers. These were clearly visible, dated and signed to indicate cleaning had taken place. We observed patient-care equipment to be visibly clean.
- Sanitising gel was available in each room, in corridors and at the entrances to wards.
- Disinfection wipes were readily available for cleaning hard surfaces and equipment surfaces in between patients, and we saw staff using these.
- There was access to hand washing facilities and supplies of personal protective equipment (PPE), for example gloves and aprons. We observed staff using PPE appropriately.
- All staff were observed to be compliant with the bare below the elbows policy which enabled effective hand washing and reduced the risk of infection.

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- Ward staff told us that they followed specified procedures for patients who required a urinary catheter and its removal as soon as it was no longer needed. We saw that this was recorded in the patients' record. This was to minimise risk of infection.
- Staff told us they adhered to specified procedures necessary for the safe insertion and maintenance of vascular access devices for patients and removal as soon as it was no longer needed. We saw that this was recorded in the patients' record. This was to minimise risk of infection.
- There was a carpeted area on Wollaton Ward which was visibly clean and free from stains. A capital bid had been put forward and the hospital were awaiting approval of funding to replace the carpeting with suitable washable floor covering.
- We observed that staff changed into surgical scrubs and theatre caps which was a requirement of all staff and visitors to theatres and the surrounding areas and corridors.
- We saw staff adhering to procedures in line with national guidance to minimise the risk of infection to patients undergoing surgical procedures, for example, skin preparation and the use of sterile drapes.
- In the theatre suite, there was a designated area and appropriate equipment available for the cleaning of endoscopic equipment. Other equipment used for surgical procedures was cleaned and sterilised off site by an external provider.
- There were cleaning schedules in use on the wards and in the theatre department and we observed that staff consistently documented when they had completed cleaning of rooms and equipment.
- Patients were treated in individual rooms apart from in the recovery area, intensive care unit and the ambulatory care unit, where disposable curtains were used to provide screening and privacy for patients.
- The provider reported zero cases of Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia or *Clostridium difficile* (C. Difficile) within the hospital for the reporting period May 2017 to April 2018. MRSA is a bacterium responsible for several difficult-to-treat infections. C. difficile is an infective bacteria that causes diarrhoea, and can make patients very ill.
- All NHS patients were screened prior to their procedure for MRSA as part of their pre-operative assessment. Non-NHS patients were screened if they met certain criteria in line with BMI Healthcare Limited policy. These

included all critical care patients, international patients, those patients scheduled for certain surgical procedures, those who had been admitted from a nursing home and those who had been in hospital within the previous three months.

Environment and equipment

- All inpatients were accommodated in en-suite private rooms, which were located off the main ward corridors, and were equipped with a nurse call bell and emergency buzzers.
- There was an eight-bed ambulatory unit which had been purpose-built and cared for patients in reclining chairs after their surgery. The unit provided all necessary facilities for patients, and had all relevant equipment easily accessible, including a resuscitation trolley.
- Appropriate resuscitation equipment was available and staff demonstrated that they knew how to use the equipment. Training on the use of emergency equipment, for example, the automated external defibrillator (AED) was carried out as part of life support training. An AED is a portable device that checks the heart rhythm and can send an electric shock to the heart to try to restore a normal rhythm.
- All AEDs had a manual override function. This allowed the user to manually determine the voltage and timing for an electrical shock.
- Resuscitation equipment was safe and ready for use in an emergency. Single-use items were sealed and in date and emergency equipment had been serviced. Records indicated resuscitation equipment had been checked by staff.
- The operating department was modern and purpose built. It included five operating theatres, three of which had laminar flow (a ventilation system which reduces the number of airborne bacteria). One theatre was equipped with digital cameras and displays. One theatre was dedicated to endoscopy and minor local anaesthetic procedures.
- The recovery area had capacity for eight patients recovering immediately post-surgery.
- There was a critical care unit (CCU) with five beds available if required. Three of these beds could accommodate patients requiring level three care, and two beds were for level two care. There were no patients being treated there on the day we visited.

Surgery

- We observed that there were adequate facilities for storing equipment throughout the hospital, including theatres where equipment was stored in a way that made it easily accessible to staff.
- We saw a safety tested sticker was attached to electrical items showing when it had been inspected. All items we checked in theatre and Wollaton ward were in date and were safe to use. On Rufford ward We observed 15 items of equipment. Of these, two items were overdue for service and two items did not have a visible safety tested sticker demonstrating when the equipment was next due for service.
- We observed that substances hazardous to health were kept in a locked cupboard in theatre and flammable substances were kept in a locked metal cupboard and complied with Control of Substances Hazardous to Health (COSHH) recommendations.

Assessing and responding to patient risk

- The hospital had an admission policy setting out safe and agreed criteria for admission of surgical patients. Exclusion criteria for surgery included those patients with a body mass index (BMI) more than 40, those with an unstable mental health condition and patients under 19 years old.
- Patients who planned to undergo cosmetic surgery received counselling at their initial appointment with the consultant and when admitted to the ward.
- Pre-operative assessments were provided for patients undergoing planned surgery to identify any co-existing medical conditions, identify the level of individual risk, optimally prepare patients for their procedure, and define the appropriate post-operative level of care. For example; inpatient, daycase, or high dependency care. The visit also gave patients the opportunity to discuss the procedure in more detail and methods of pain relief in a more relaxed state than immediately prior to the surgery.
- There was a team of pre-operative nurses based on Wollaton ward and led by a nurse manager. The team held weekly meetings with an anaesthetist to discuss the needs of forthcoming patients and to plan ahead. The meeting also enabled the team to discuss updated national guidelines with the anaesthetist and to receive clinic advice and support.
- Relevant patients were reviewed by the pre-assessment team prior to admission to ensure their health risks had been appropriately assessed. An integrated record/care pathway was used to record all risk assessments conducted, and to monitor ongoing care during the patient's journey. Each integrated record/care pathway was specific to the patient's surgical needs and enabled care to be individually tailored.
- The hospital did not accept urgent or unplanned surgical admissions (admitted without being first seen and assessed by a consultant at the hospital).
- Staff identified and responded appropriately to changing risks to patients, including deteriorating health and wellbeing, medical emergencies or behaviour that challenges. Two on-site resident medical officers (RMOs) were available for immediate support and consultants were available by telephone and able to return to the hospital within 30 minutes.
- There was access to an on-site level two and three critical care facility supported by an on-call consultant intensivist from a local NHS trust. We were told that the intensivist or an anaesthetist would remain overnight when patients were being treated there. The intensivist, RMOs and critical care staff had attended a local Critical Care Network course to enhance their knowledge and skills in managing critically ill patients. The hospital told us that there were plans to extend the development course to some theatre and ward staff which would then be cascaded in-house to other relevant staff.
- The hospital had a service level agreement (SLA) with the local NHS acute trust, ambulance service and the local critical care network. These meant patients could be transferred to the nearby NHS acute trust for care and treatment should their condition deteriorate with the emergency ambulance service providing transport. This agreement included the transfer of a patient to an appropriate area within the trust other than the emergency department. For example, a surgical ward. Ward staff told us that, although this was rarely required, any requests for urgent transfer were responded to appropriately by the ambulance service.
- Nursing staff used a national early warning scoring system (NEWS) to record routine physiological observations such as blood pressure, temperature, and heart rate. NEWS was used to monitor patients and to prompt support from medical staff when required. We reviewed five sets of patient observations and found nursing staff adhered to hospital guidelines for the completion and escalation of NEWS.

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- The hospital conducted regular audits of NEWS charts to check compliance. The most recent one conducted in February 2018 showed that the monitoring plan had not been followed in two out of five charts. We were assured that this had been addressed with staff at the time.
- We did not see evidence of a sepsis tool being used within the records we looked at, as none of the five observation charts we reviewed indicated the patients required this. However, the hospital was in the process of implementing training on NEWS2; the latest version of the NEWS, first produced in 2012 and updated in December 2017. NEWS2 has received formal endorsement from NHS England and NHS Improvement to become the early warning system for identifying acutely ill patients, including those with sepsis, in hospitals in England. The ward manager was in the process of cascading training to staff.
- All staff we spoke with told us that they knew how to use the tools provided to identify potential sepsis.
- A major haemorrhage policy and protocol was in place, including access to blood and blood components, at this hospital. This provided a rapid, focused approach to the urgent provision of blood for life threatening haemorrhages. Staff had received additional training to identify early signs of haemorrhage, which had been included in the hospital's four-hour training session on the care of the deteriorating patient.
- The WHO (World Health Organisation) checklist is a system to safely record and manage each stage of a patient's journey from the ward through to the anaesthetic and operating room to recovery and discharge from the theatre. There was a full team approach to ensuring this was completed accurately.
- We observed that the WHO safety checklist procedure had been followed correctly during a surgical procedure, and of the five sets of patient records we checked, all showed evidence that the WHO safety surgical checklist had been correctly recorded in the patient's record.
- Monthly observational audits conducted January 2018 to April 2018 showed 100% compliance with the WHO safety checklist procedure.
- We observed the accountable items board in use in theatre. There was a team approach to ensure all disposable items and equipment were counted prior to the surgical procedure and immediately after. A record was made in the patient's notes which included the surgeon's name and signature.

- We observed that pre-operative team brief was carried out with all staff present and discussed each patient's requirements, procedures, and equipment and identified any potential issues. Post-operative de-brief also included all staff and identified any areas for improvement. Both stages were documented.

Nursing and support staffing

- BMI The Park Hospital used a corporate skill mix planning tool when planning staffing in line with National Institute for Health and Care Excellence (NICE) and Association for Perioperative Practice (AfPP) staffing guidance.
- Surgical patient admissions were known in advance and staffing calculated using an electronic staffing tool which ensured staffing numbers were planned according to the number of patients. The tool could be manually adjusted to take account of individual patient needs so that additional staff could be allocated when patients with additional needs were to be admitted. In particular, Rufford ward used additional staff to enable palliative care patients to receive one to one care when required.
- Staff we spoke with told us that they usually had sufficient staff to run their ward or department, and that staff could work flexibly to assist other departments if required.
- There was a paediatric nurse available who led and coordinated the care of children.
- A member of staff trained in advanced life support (ALS) was available at all times to attend theatre recovery. Where a child was present, a member of staff trained in European paediatric advanced life support (EPALS) was available. In addition, the resident medical officer (RMO) had completed ALS and EPALS and was on site 24 hours a day, seven days a week.
- All staff we spoke with told us that they were well supported by their clinical manager within their department.
- The hospital held a register of 176 bank staff who had worked there before. Bank staff are those employed by the hospital to cover unfilled shifts due to sickness or annual leave.
- The average use of bank nurses between May 2017 and April 2018 was 14%. For the same reporting period average agency use was 0.9%.
- A corporate induction policy and procedure was in place for bank and agency staff new to an area.

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Medical staffing

- There were 258 consultants who worked at the hospital under practising privileges. These included surgeons, anaesthetists, physicians and radiologists. Practising privileges refers to medical practitioners being granted the right to practise in a hospital after being approved by the medical advisory committee (MAC). The medical advisory committee (MAC) monitored outcomes of individual consultants. We saw evidence where the MAC had reviewed a consultant's practise following concerns identified at the consultant's employing trust.
- Consultants visited inpatients each day and were contactable by telephone 24 hours a day, whilst they had patients in the hospital. If they planned a period of absence a fellow consultant would be identified to cover and the hospital informed.
- Two resident medical officers (RMOs) provided medical cover 24 hours a day. RMOs worked a seven-day roster and were on call for emergencies 24 hours a day. The RMOs worked at the hospital regularly and knew the hospital and its routine well. They were trained in advanced life support. RMOs were advised of cover arrangements for any consultant on leave. Nursing staff told us they had good access to the RMOs and had confidence in their medical practice.
- Mandatory training for the RMOs was the responsibility of the agency which employed the RMOs. The clinical experience, qualifications and record of mandatory training was checked by the hospital before they commenced working and monitored on an annual basis.
- An on-call consultant intensivist, from a local NHS trust, was available 24 hours a day as support for the RMO for those patients requiring level two or three care. We were told that an anaesthetist, working under practicing privileges, would remain on the premises overnight when there were patients being treated in the critical care unit.

Records

- Patients' individual care records, including clinical data, were written and managed in a way that kept patients safe.
- We reviewed five sets of paper-based nursing and medical records for inpatients. Nursing records such as

prescription charts and observation charts were kept in the patient's room, and then filed in the patient's record when discharged. Medical notes were stored securely in locked trolleys at the nurses' station.

- We found that medical records were legible, accurately completed and up to date. However, none of the medical records included the medical practitioner's general medical council (GMC) number. The GMC is a public body that maintains the official register of medical practitioners within the United Kingdom and endorses the use of a practitioner's unique GMC number in medical records.
- Integrated care records/care pathway for day case surgery and long stay surgery were in use. These covered the entire patient pathway from pre-operative assessment to discharge, risk assessments, and included the five steps to safer surgery check lists, operating notes, observations and recovery records.
- We saw risk assessments were completed as part of the integrated care records. These included pressure ulcers, malnutrition and risk of falls. All clinical risk assessments followed national guidance, for example, the use of a recognised score for the prevention of pressure ulcers.
- Our review of five medicine administration records, where patients were prescribed an antimicrobial (antibiotic), demonstrated they had the clinical indication, dose and duration of treatment documented in their clinical record. This was in line with best practice guidance.
- Care summaries were sent to the patient's general practitioner (GP) on discharge to ensure continuity of care within the community. Summaries included, where appropriate, any medication changes. A copy of the care summary was also given to the patient.

Medicines

- Although surgery is the main service at this hospital, information about medicines also relates to other services, for example medical services including oncology and endoscopy.
- Medicines were managed and recorded in a way that kept patients safe.
- Medicines were stored securely in locked cupboards in each department. We checked some randomly selected medicines and found these to be in date. All were appropriately stored and stock levels checked by the pharmacist and ward staff.

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- We looked at controlled drugs (CDs) in an anaesthetic room. Controlled drugs are medicines liable to be misused and requiring special management. We checked order records, and CD registers and found these to be in order. We saw stock balances of CDs were checked daily by two members of staff. All checks were signed and dated.
- Controlled drugs were double locked (kept in a locked cupboard inside another locked cupboard). Staff told us that CDs were always checked and administered by two members of staff, one of whom was a qualified health professional.
- We observed that medicines requiring cool storage were stored appropriately and fridge temperatures monitored daily. Medicine room temperatures were also checked daily. All temperatures were within acceptable ranges. This helped to ensure medicines did not deteriorate or become less effective.
- Paper prescription pads were locked in the CD cupboard and staff kept a log to monitor their use.
- The hospital conducted medicines audits as part of their monthly audit programme. They had achieved between 93% and 100% compliance for medicines management across all departments at their most recent audit in April 2018.
- The hospital had its own pharmacy, and access to an on-call pharmacist. Staff told us that the pharmacy staff attended the ward daily to review the medicines charts to ensure medicines were being prescribed correctly.
- There was a service level agreement (SLA) in place with an NHS trust to obtain medicines in an emergency if required.
- Patients were asked to complete a pre-admission questionnaire, which included information about the medicines they were currently taking. After an incident where a patient brought some medicine into hospital that had been incorrectly administered by a pharmacy, the hospital amended their checking process so that patients' medicines were seen and checked at the pre-assessment stage. This ensured that any inaccuracies in prescribing patients' own medicines in hospital were avoided.
- We looked at five prescription and medicine administration records (MARs) on the wards and theatre. We saw administration of medicines was being recorded appropriately. These records were clear and fully

completed. The records showed patients were receiving medicines when they needed them and as prescribed. Records of patients' allergies were recorded on the prescription chart.

- All surgical implants used in theatre suite were documented in a register and included relevant patient details as well as product identifying information. This was so that patients could be provided with accurate information, if there was a problem with an implant in the future.
- Patients were given advice about any new medicines prescribed on discharge. Information about dosage and any side effects was discussed and an information leaflet provided with details of who to contact should they have any queries.

Incidents

- There were zero never events reported for BMI The Park between May 2017 and April 2018. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Although a never event incident has the potential to cause serious patient harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- Between May 2017 and April 2018 there were 434 clinical incidents reported for the hospital as a whole, of which 432 occurred in surgery. Of the total number of clinical incidents for surgery, 318 were no harm, 94 were low harm and 20 were moderate harm.
- Hospital policy stated that incidents should be reported through the hospital electronic reporting system. Staff said they were encouraged to report incidents and understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Staff described the process for reporting incidents and most staff told us they received feedback which was disseminated through the hospital's electronic reporting system, by email, meetings and team briefings.
- If staff were involved in incidents they were encouraged to write a reflective account of it which was discussed with their manager.
- Incidents and near misses were discussed in detail at monthly clinical meetings which were attended by a manager or senior team member from each department and outcomes of the meetings were cascaded to staff at

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ward or department level. The meeting structure for the ward and pre-assessment team was in the process of being changed to make cascade of this information more accessible and consistent for staff. Staff from the theatre department said that communicating information from monthly meetings could be made more consistent.

- Learning from incidents was shared with individuals and, where required all staff were made aware of any changes to policy or processes that were implemented. For example; following an incident, changes were made to enable staff to identify signs of potential deterioration in a patient's condition earlier. All staff were required to attend training which had been enhanced to include learning from the incident. Information to staff about changes to policy and processes and the learning from the incident was cascaded widely and included a display on a notice board for staff.
- Reviewing incidents was a standard agenda item on the quarterly clinical governance meetings. This ensured that any themes of incidents were highlighted and new incidents discussed. There were a total of two safety incidents reported to the quarterly clinical governance meetings during the period May 2017 to April 2018 in surgical services.
- Regulation 20 (Duty of Candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November

2014. This Regulation requires the organisation to notifying the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.

- We saw that the hospital had a duty of candour policy and that staff were aware of the terminology. The process they described in communicating with patients and their relatives reflected openness and transparency.
- Staff gave examples of how they had applied duty of candour when something had gone wrong.

Safety Thermometer

- The Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism (blood clots in veins).
- Safety thermometer data submitted demonstrated 100% harm free care had been achieved from May 2017 to April 2018.
- Data from the safety thermometer submitted in April 2018 for the preceding three months showed; There were no incidents of hospital acquired Venous Thromboembolism (VTE) or Pulmonary embolism (PE). The VTE screening rate target of 95% for each quarter was consistently achieved for the period. There were no new pressure ulcers, catheter or urinary tract infections.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should ensure patient equipment is appropriately maintained.
- The provider should ensure plans to upgrade the endoscopy area are completed.
- The provider should ensure hazardous cleaning fluids and flammable liquids are always stored in line with guidance from the Control of Substances Hazardous to Health Regulations (2002).
- The provider should ensure medical records include the medical practitioner's general medical council (GMC) number.
- The provider should consider reviewing the use of the nitrous oxide patient group direction (PGD) in endoscopy.