BMI Fawkham Manor 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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Fawkham Manor Hospital is operated by BMI Healthcare Limited. The hospital has 30 beds. Facilities include two operating theatres, one of which has laminar flow, seven consulting rooms, X-ray, outpatient and diagnostic facilities.

Fawkham Manor Hospital provides surgery, medical care and outpatients and diagnostic imaging core services. This inspection was a focused, follow-up visit, and we inspected the surgical core service.

We previously inspected the hospital in August and November 2016 as part of our national programme to inspect and rate all independent hospitals. The 2016 inspection was brought forward because of information received, which raised concerns about the standard of governance at the location. Following our 2016 inspection, we rated the surgery core service as inadequate and outpatients and diagnostic imaging as requiring improvement. This gave the hospital an overall rating of inadequate, and we issued four requirement notices where the provider was not meeting the legal requirements of the Health and Social Care Act (Regulated Activities) Regulations 2014.

A serious incident occurred on 8 February 2017 that demonstrated to us that the safety monitoring systems in place at BMI Fawkham Manor Hospital were not effective. In March 2017 we issued a warning notice because the provider was not compliant with Regulation 12, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a time scale of one week with a date set for the provider to be compliant by 20 March 2017. The provider demonstrated compliance with the warning notice, although not within the required timeframe.

During this inspection, we reviewed surgical services only. We carried out the announced part of the inspection on 10 and 11 April 2017, along with an unannounced visit to the hospital on 5 April 2017. To give the hospital's overall rating, we have included the rating for outpatients and diagnostic imaging services in the ratings grid, which was taken from our previous inspection in 2016.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so, we rate services' performance against each key question as outstanding, good, requires improvement or inadequate. On this inspection, we did not inspect the caring domain as we found this to be good on our 2016 inspection and we had no information to suggest that this position had changed.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

We rated surgery as requires improvement. This was because:

- Medical Advisory Committee (MAC) meeting minutes showed that not all the findings and learning from root cause analysis (RCA) investigations following serious incidents were shared and discussed at MAC meetings. This meant that not all consultants might have learnt lessons from serious incidents to help prevent recurrences.
- There was a hospital risk register, which staff reviewed at monthly clinical governance committee meetings as a standard item. However, the MAC chair was not aware of any items on the risk register. When asked, the MAC chair said they felt there "were risks to the hospital, but none now". This meant the MAC was not aware of key risks to the service and demonstrated weaknesses in governance.
- Medicine fridge temperatures in theatres were not consistently recorded daily to ensure medicines remained safe to use.

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- Not all waste bins were labelled indicating the type of waste to be disposed. Bulk storage bins for clinical waste were adjacent to the patient car park and unsecured. This was not in line with Health Technical Memorandum 07-01, which states bulk storage areas should be away from routes used by the public, be totally enclosed and secure, and kept locked when not in use.
- Three out of seven patient records we reviewed did not always show evidence of consultant or medical review when this was required. For example, we did not find evidence of a pre or post operation review by a consultant. This is not in line with the Royal College of Surgeons (RCS) (2014); good surgical practice, which recommends "surgeons must ensure that accurate, comprehensive, legible and contemporaneous records are maintained of all interactions with patients".
- Following concerns around poor staff compliance with the World Health Organisation (WHO) "Five Steps to Safer Surgery" checklist identified at our 2016 inspection, we found staff engagement with the WHO checklist remained inconsistent on our unannounced visit on 5 April 2017. However, we saw improvements in the way staff carried out the WHO checklist during our announced visit on 11 April 2017.
- The hospital provided subsequent assurances that improvements with the WHO checklist were being maintained. We saw an observational audit carried out by an external theatre manager following our inspection. This showed 100% compliance with all areas of the WHO checklist. The auditor commented that the WHO checklist flowed much more routinely and that it was "well ingrained". The executive team encouraged staff to report any non-compliance with the WHO checklist on the hospital's incident reporting system. The interim director of clinical services told us staff had reported two incidents of consultant non-compliance.
- We also saw a letter drafted by the MAC chair to the consultant body on 4 May 2017. This made explicit the requirement for staff to report breaches of the WHO checklist process as incidents on the electronic reporting system. We also saw an addendum to the hospital's action plan, which provided details of the action being taken in respect of consultants who failed to engage with the WHO checklist process and best theatre practice. This included a meeting with the hospital director and the MAC chair that would be recorded in consultant files. Further or persistent failure to follow policy might result in loss of practicing privileges. This demonstrated the hospital was taking action to ensure continuing compliance with the WHO checklist and the requirements of Regulation 12 (1) (2) (b), Safe care and treatment, of the Health and Social Care Act (Regulated Activities) Regulations 2014.
- However, internal hospital staff carrying out WHO checklist audits did not always have audit training. This meant the hospital might not have had assurances staff carried out WHO checklist audits correctly.
- Patients had signed four out of six consent forms we reviewed on the day of surgery. This was not in line with guidance from the RCS Good Surgical Practice 2014, which states staff should "obtain the patient's consent prior to surgery and ensure that the patient has sufficient time and information to make an informed decision".
- Patient reportable outcome measures (PROMs) data showed the hospital's patient outcomes following groin hernia repair and primary knee replacement were worse than the England averages between April 2015 and March 2016.
- The hospital did not have a robust system in place to assess the competence and record the use of external staff as surgical first assistants.
- The service cancelled 30 operations on the day of surgery, for a non-clinical reason within the last 12 months. The hospital offered only a third of these patients with another appointment within 28 days of their cancelled appointment. This was in not in line with the NHS Constitution pledge.
- The service did not always use complaints as an opportunity to learn lessons and improve.
- Staff demonstrated limited knowledge around the additional support required for patients with learning disabilities.

Summary of findings

- There was no step-free wheelchair access to baths or showers in the ward.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with five requirement notices that affected the surgical core service. Details are at the end of the report.

Professor Edward Baker
Deputy Chief Inspector of Hospitals (South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires improvement 	• Surgery was the main activity of the hospital. We rated this service as requires improvement, because there were gaps in assurance about safety. • The prevention and control of infection required improvement. Infection prevention and control in theatres, while better than on previous visits, was in need of further work to bring it fully up to the required standard. The ward bedrooms still lacked hand washing sinks. Storage remained a problem with clean items stored in areas that were not appropriate. • The management of controlled drugs in the operating theatres had improved but the ward staff were not signing for the receipt of controlled drugs and the CD book was scored through multiple times, in contravention of the guidance. • There was no record of consultant review in some patient records. • Some patient outcomes were worse than expected compared with similar services. Primary knee replacement outcomes were significantly worse than other similar hospitals. It is noted that primary hip replacement outcomes were better than average. • Consent was not always obtained in advance of the day of surgery in line with relevant guidance and legislation. Some consent records were poorly completed with abbreviations and were difficult to read. • There was insufficient assurance about the suitability of surgical first assistants. • The arrangements for governance and performance management did not always operate effectively, although we saw significant improvements in this area since our last inspection in 2016. However

Summary of findings

- Incident reporting had improved since our previous inspection visits and there was evidence provided that demonstrated that non-compliance with the WHO checklist was now being monitored through the incident reporting processes.
- The hospital provided subsequent assurances that improvements with the WHO checklist were being maintained.
- The service took the needs of different people into account when planning and delivering services, for example, patients living with dementia and patients who did not speak English as a first language.
- Safeguarding training had improved and was now delivered face to face rather than online.
- The theatre staff were now monitoring the patients temperature throughout surgery.

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Background to BMI Fawkham Manor Hospital

Fawkham Manor Hospital is operated by BMI Healthcare Limited. The hospital opened in 1980 and has been a part of BMI Healthcare Limited since 1989. It is an independent hospital in Longfield, near Dartford in Kent. The hospital primarily serves the communities of the Kent area. It also accepts patient referrals from outside this area. The hospital provides services to NHS and private patients. Some insurance providers stopped funding treatments at the hospital in February 2017.

The hospital only treats adults aged 18 and over, and stopped treating children and young people as inpatients in August 2016 following serious concerns identified at our previous inspection in the same month. The hospital subsequently suspended all services for children and young people. The hospital has no plans to reintroduce children's services until they have achieved full regulatory compliance.

The hospital has been registered with CQC to carry out the following regulated activities since May 2011:

• Diagnostic and screening procedures

• Surgical procedures

• Treatment of disease, disorder and injury

The hospital has also been registered to provide Family Planning services since April 2014.

At the time of our inspection, the hospital had a registered manager, who had been in post since November 2016. The registered manager was also the interim executive director at the time of our inspection. BMI Healthcare Limited has a nominated individual.

Fawkham Manor Hospital provides surgery, medical care and outpatients and diagnostic imaging core services. This inspection was a focused, follow-up visit, and we inspected the surgical core service only.

We previously inspected the hospital in August and November 2016 as part of our national programme to inspect and rate all independent hospitals. The 2016 inspection was brought forward because of information received, which raised concerns about the standard of governance at the location. Following our 2016 inspection, we rated the surgery core service as inadequate and outpatients and diagnostic imaging as requires improvement. This gave the hospital an overall rating of inadequate, and we issued four requirement notices where the provider was not meeting the legal requirements of the Health and Social Care Act (Regulated Activities) Regulations 2014.

On 13 March 2017, we served the provider with a Section 29 Warning Notice against Regulation 12 (1) (2) (b), Safe care and treatment, of the Health and Social Care Act (Regulated Activities) Regulations 2014. This related to repeated failure to follow the correct checking process as part of the World Health Organisation (WHO) "Five Steps to Safer Surgery" checklist. We identified concerns in this area at our 2016 inspection, which the provider had not sufficiently addressed at the time of the warning notice. This led to a patient being put under general anaesthetic for surgery without the surgical site being marked.

We found the provider was now meeting the conditions of the warning notice served on 13 March 2017. However, improvements in staff compliance with the WHO "Five Steps to Safer Surgery" checklist were not yet fully embedded. Our routine engagement processes will be used obtain assurances of ongoing compliance in this area.

We also found the provider was compliant with two of the four requirement notices issued following our previous inspection in August and November 2016. These were Regulation 13 (2), Safeguarding service users from abuse and improper treatment; and Regulation 15(1) (a), Premises and equipment, of the Health and Social Care Act (Regulated Activities) Regulations 2014. Regulation 15(1) (a), All premises and equipment used by the service provider must be clean, specifically related to cleanliness.

However, the provider had not yet achieved full compliance with the other two requirement notices relating to Regulation 12, Safe care and treatment, and Regulation 17, Good governance, of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because the provider was still in breach of Regulation 12(2)(g) the proper and safe management of medicines, and Regulation 17(2)(c), the requirement to maintain

securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Our inspection team

The inspection was led by Terri Salt, Inspection Manager, Care Quality Commission

The team comprised of three CQC inspectors, and four specialist advisors with expertise in theatre management, anaesthetics, governance and safeguarding.

Information about BMI Fawkham Manor Hospital

Surgery was the main activity at the BMI Fawkham Manor Hospital. Surgical services cover a wide range of specialities, including Orthopaedic, General Surgery, Gynaecology, Urology, Pain Management, Ophthalmic, ENT, Gastroenterology, and Plastic Surgery.

The hospital has 30 beds and six ambulatory chairs, split across two wards. During our inspection only Mulberry ward was in use, with 22 beds available used for a mixture of inpatients and day cases. There were three double rooms (usually used by NHS patients) and the remaining 16 beds were in single rooms. All patient bedrooms have en-suite facilities, a television, and free Wi-Fi. The hospital was open seven days a week to care for patients after their surgery that needed to stay in hospital overnight or at the weekend.

The theatre suite has two operating theatres, two recovery bays, and two anaesthetic rooms. Theatre one has laminar flow (a system that circulates filtered air to reduce the risk of airborne contamination). This is best practice for ventilation within operating theatres, and particularly important for joint surgery to reduce the risk of infection. During our inspection, only Theatre One was in use. The operating theatre is used Monday to Friday 7am to 8pm and Saturday 7am to 6pm.

During our inspection, we visited all clinical areas including theatres, ward and the pre assessment clinic. We undertook an unannounced visit on 5 April 2017 before our announced inspection on 10 and 11 April 2017.

We spoke with three patients, 16 members of staff including, nurses, health care assistants, operating department practitioners, consultants, and managers. As part of our inspection, we looked at hospital policies and procedures, staff training records and audits. We looked at seven sets of surgical patient notes and six consent forms, four prescription charts and the environment and equipment.

Activity (September 2016 to February 2017)

- In the reporting period September 2016 to February 2017, there were 1,825 inpatient and day case episodes at the hospital, with 1,787 visits to the operating theatre. NHS-funded patients represented 32% of inpatient stays and 50% of day case procedures.
- One hundred and fifty-four doctors worked at the hospital under practising privileges. Two regular resident medical officers (RMO) worked on a rotational pattern of two days working followed by two days off. BMI Fawkham Manor Hospital employed 19.9 whole-time equivalent (WTE) registered nurses, 5.7 WTE healthcare assistants and 5.0 WTE healthcare assistants and registered operating department practitioners (ODPs) in theatres. The hospital also employed 45.3 WTE other staff, such as housekeeping, reception, administration and estates staff, as well as having its own staff bank.

Track record on safety (September 2016 to February 2017)

- There were no reported never events. Never events are serious patient safety incidents that should not

Summary of this inspection

happen if healthcare providers follow national guidance on how to prevent them. 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.

- The hospital reported 179 clinical incidents. Of these, 166 were graded no harm, 12 as low harm and one as moderate harm.
- The hospital reported no serious injuries within the last 12 months.
- The hospital reported one serious incident.
- The hospital reported no expected or unexpected deaths.
- There were no reported incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA).
- There were no reported incidences of hospital acquired Methicillin-sensitive Staphylococcus aureus (MSSA).
- There were no reported incidences of hospital acquired Clostridium difficile (C. diff).
- There were no reported incidences of hospital acquired E. coli.
- The hospital received 40 complaints between January 2016 and December 2016. No complaints were referred to the Parliamentary Health Services Ombudsman (PHSO) or the Independent Healthcare Sector Complaints adjudication service (ISCAS).

Services provided at the hospital under service level agreement:

- Sterile services
- Clinical and non-clinical waste removal
- Interpreting services
- Maintenance of medical equipment
- Pathology and histology
- RMO provision
- Catering services

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as requires improvement because:

- Three out of seven patient records we reviewed did not always show evidence of consultant or medical review when this was required. This was not in line with Royal College of Surgeons (RCS) guidelines.
- MAC meeting minutes showed that not all the findings and learning from root cause analysis (RCA) investigations following serious incidents were shared and discussed at MAC meetings. This meant that not all consultants might have learnt lessons from serious incidents to help prevent recurrences.
- On the ward we saw that there was no date when controlled drugs (CDs) had been received from pharmacy in the CD register. We also saw when an error had occurred this had been crossed out with multiple lines. These practices were not in line with Nursing and Midwifery Council (NMC) Standards for medicine management.
- In theatres, medicine fridge temperatures were not consistently recorded daily to ensure medicines remained safe to use.
- There were clean items of equipment stored inappropriately in dirty areas, such as the sluice.
- Dirty items such as soiled linen skips were being kept in the corridor due to a lack of storage space.
- Staff were not always observing best practice in the use of personal protective equipment.
- There were no handwashing sinks in patient's bedrooms.
- Not all waste bins were labelled indicating the type of waste to be disposed. Bulk storage bins for clinical waste were adjacent to the patient car park and unsecured.
- Following concerns around poor staff compliance with the World Health Organisation (WHO) "Five Steps to Safer Surgery" checklist identified at our 2016 inspection, we found staff engagement with the WHO checklist remained inconsistent on our unannounced visit on 5 April 2017. However, we saw improvements in the way staff carried out the WHO checklist during our announced visit on 11 April 2017.

However:

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- The hospital had significantly improved the cleanliness and state of repair of the theatre environment since our last inspection. We found the theatre environment to be visibly clean and tidy. Floors, ceilings, and walls were all clean and intact, and met Department of Health guidance.
- We observed staff adhering to the "bare below the elbows" requirement, in accordance with corporate policy.
- Incident reporting had improved and staff were beginning to report non-compliance with the peri-operative WHO checklist as incidents.
- Safeguarding arrangements were sufficiently robust and staff were trained to the appropriate level.
- Theatre staff were no longer block signing for controlled drugs.
- Records were generally well maintained and stored securely.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Consultants did not obtain patient consent consistently in advance of the day of the procedure. This was not in line with guidance from the RCS Good Surgical Practice 2014.
- Patient reportable outcome measures (PROMs) data showed the hospital's patient outcomes following groin hernia repair and primary knee replacement were worse than the England averages between April 2015 and March 2016.
- The hospital did not have an effective system in place to assess the competence and record the use of external staff as surgical first assistants.
- Staff had received mental capacity training, however all staff we spoke with told us patients living with dementia would lack capacity. This was not in line with the Mental Capacity Act, 2005.
- Hospital data showed the hospital was not on target for ensuring all staff would receive an appraisal for the current year.

However:

- The service planned and delivered care and treatment in line with current evidence-based guidance, standards, best practice and legislation. Regular monitoring and audit ensured consistency of practice.
- Information about people's care and treatment, and their outcomes, was routinely collected and discussed at senior management team meetings.

Summary of this inspection

Are services caring?

Good

At our last inspection in 2016, we rated caring as good. We saw no evidence to suggest a change to the good rating for caring at this inspection.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- The service cancelled 30 operations on the day of surgery, for a non-clinical reason within the last 12 months. The hospital offered only a third of these patients with another appointment within 28 days of their cancelled appointment. This was in not in line with the NHS Constitution pledge.
- The service did not always use complaints as an opportunity to learn lessons and improve.
- Staff demonstrated limited knowledge around the additional support required for patients with learning disabilities.
- There was no step-free wheelchair access to baths or showers in the ward.

However:

- The service made reasonable adjustments and took action to remove barriers for patients living with dementia who may find it hard to use or access services. We saw improvements in this area since our last inspection in 2016.
- Translation services were available from an external provider to provide face to face and telephone services if required and staff knew how to access this. Menus were available in a number of different languages including Polish, Iranian and Lithuanian as well as large print.
- Access to the service was straightforward and timely.
- The hospital scored better than the England average in the Patient Led Assessment of the Care Environment (PLACE) in 2016. The results were used to improve the patient experience.
- There was clear information displayed to patients on how to make a complaint about their care or treatment.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Medical advisory committee (MAC) meeting minutes showed that not all the findings and learning from root cause analysis (RCA) investigations following serious incidents were shared and discussed at MAC meetings. This meant that not all consultants might have learnt lessons from serious incidents to help prevent recurrences.
- There was a hospital risk register, which staff reviewed at monthly clinical governance committee meetings as a standard

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item. However, the MAC Chair was not aware of any items on the risk register. When asked, the MAC chair said they felt there "were risks to the hospital, but none now". Neither the MAC Chair nor the MAC membership were aware of any items on the hospital risk register.

- Internal hospital staff auditing compliance with the World Health Organisation (WHO) "Five Steps to Safer Surgery" checklist did not always have audit training. This meant the hospital might not have had assurances staff carried out WHO checklist audits correctly.
- There was a culture of consultants persistently failing to fully engage with the WHO checklist in theatres. However, the hospital had begun to address this issue by empowering staff to report consultant non-compliance on the electronic incident reporting system and taking action against consultants that failed to comply.
- Some staff told us the uncertainty of not having a permanent executive director adversely affected morale. However, staff felt the interim executive director was supportive and approachable.

However:

- The interim executive team encouraged learning and a culture of openness and transparency. They operated an "open door policy" and encouraged staff to raise concerns.
- The hospital shared the corporate BMI Healthcare vision. This was to provide the best outcomes, the best patient experience, and the most cost-effective care. Staff we spoke with had some understanding of the goals and values of the hospital and how it had set out to achieve them.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Requires improvement

Surgery

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement

Are surgery services safe?

Requires improvement

Surgery services at BMI Fawkham Manor Hospital cover a wide range of specialities, including Orthopaedic, General Surgery, Gynaecology, Urology, Pain Management, Ophthalmic, ENT, Gastroenterology and Plastic Surgery. The hospital treats adults aged 18 and over and stopped providing surgical services for children in August 2016.

Between September 2016 and February 2017, there were 1,825 inpatient and day case episodes at the hospital, with 1,787 visits to the operating theatre.

The hospital has 30 beds and six ambulatory chairs, split across two wards. During our inspection only Mulberry ward was in use, with 22 beds available and used for a mixture of inpatients and day cases. There were three two bedded rooms (usually used by NHS patients) and the remaining were single rooms. All patient bedrooms had en-suite facilities, a television, and free Wi-Fi. The hospital was open seven days a week to care for patients after their surgery who needed to stay in hospital overnight or at the weekend.

The theatre suite had two operating theatres, two recovery bays, and two anaesthetic rooms. One theatre had a laminar flow system (a system that circulates filtered air to reduce the risk of airborne contamination). This is best practice for ventilation within operating theatres, and particularly important for joint surgery to reduce the risk of infection. During our inspection, only the theatre with laminar flow was in use. The operating theatre was used Monday to Friday 7am to 8pm and Saturday 7am to 6pm.

During our inspection, we visited all clinical areas including theatres, ward and the pre assessment clinic. We undertook an unannounced visit in the week before our announced inspection.

We spoke with three patients, 16 members of staff including, nurses, health care assistants, operating department practitioners, consultants, and managers.

As part of our inspection, we looked at hospital policies and procedures, staff training records and audits. We looked at seven sets of surgical patient notes and six consent forms, four prescription charts and the environment and equipment.

At our previous inspection in 2016, we rated safe as 'inadequate'. On this inspection, we have changed the rating to 'requires improvement' this reflects improvements made in how incidents were reported, a focus on learning from incidents, the improvements in the infection control, mainly with the refurbishment of the theatre environment. Although there was some improvement with compliance when undertaking the World Health Organisation "Five Steps to Safer Surgery" checklist, we found it was still not significantly embedded into practice.

Incidents

- The hospital did not report any never events in the last 12 months. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. 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.
- The hospital reported one serious incident in February 2017. This related to an absent surgical site marking. We

reviewed the patient notes and saw the hospital had not provided a written apology to the patient involved**.** This is not in line with Regulation 20 duty of candour of the Health and Social Care Act (Regulated Activities) Regulations 2014.

- The hospital reported no expected or unexpected deaths within the last 12 months.
- The hospital reported no serious injuries within the last 12 months.
- Between September 2016 and February 2017, the hospital reported 179 clinical incidents. Of these 125 (70%) related to surgery. Of the total incidents 166 (93%) resulted in no harm to the patient, 12 (7%) resulted in low harm and one resulted in moderate harm.
- The hospital followed their corporate Incident Reporting Policy, dated February 2016, which staff could access via the hospital intranet.
- All staff we spoke with said they would have no hesitation in reporting incidents and were clear on how they would report them. All incidents, accidents, and near misses were reported. Staff were able to give us examples of the type of incidents they reported.
- On our previous inspection we found, staff completed a paper clinical incident form, which they submitted to the appropriate ward or theatre manager. The personal assistant to the Executive Director entered data from the form onto the risk management system. We saw during this inspection staff entered the incident onto the electronic reporting system directly. All staff we spoke with told us they had undertaken training, in the new system, and what constituted an incident, so felt confident when reporting an incident.
- Staff who had reported incidents told us they received a response that the incident had been received, and would go to their manager for investigation. Staff told us, they received feedback from incidents they reported via their manager and incidents were discussed at team meetings. Learning was also shared via a monthly governance newsletter.
- MAC meeting minutes showed that not all the findings and learning from root cause analysis (RCA) investigations following serious incidents were shared and discussed at MAC meetings. This meant that not all consultants might have learnt lessons from serious incidents to help prevent recurrences.
- On our previous inspection, we found theatre staff were not completing the WHO 'Five Steps to Safer Surgery' checks in accordance with the BMI Healthcare Limited policies and national guidance. The Director of Clinical Services (DoCs) was not confident that failure to follow the WHO 'Five Steps to Safer Surgery' checks would be reported as an incident, although this was their expectation. The Quality and Risk Lead was unsure whether they should expect staff to report this as an incident. Neither could recall any time when a breach of the hospital policy on surgical safety checks was reported as an incident. This meant that the frequency of breaches was not recorded, that it was not possible to identify the trend and that the seriousness of the problem was missed. It also prevented the provider understanding the cause of the failings. There was no organisational learning as no root cause was identified. The belief had been, that it was an issue with theatre staff training and that additional learning opportunities for theatre staff was the solution rather than considering why there was a barrier to successful implementation of the checklist.
- Incidents were reviewed and investigated by the manager of the area in which it took place. The designated investigator would also look for improvements to the service. Managers investigated incidents through a process of root cause analysis (RCA), with outcomes and lessons learned shared with staff.
- The hospital reported no expected or unexpected deaths within the last 12 months.
- Between September 2016 and February 2017, the hospital reported 179 clinical incidents. Of these 125 (70%) related to surgery. Of the total incidents 166 (93%) resulted in no harm to the patient, 12 (7%) resulted in low harm and one resulted in moderate harm.
- The hospital followed their corporate Incident Reporting Policy, dated February 2016, which staff could access via the hospital intranet.

- All staff we spoke with said they would have no hesitation in reporting incidents and were clear on how they would report them. All incidents, accidents, and near misses were reported. Staff were able to give us examples of the type of incidents they reported.

Clinical Quality Dashboard

- The NHS safety thermometer is a local improvement tool for measuring, monitoring, and analysing patient harms and harm-free care. The NHS safety thermometer allowed the proportion of patients who were kept 'harm-free' from venous thromboembolisms (VTE's), pressure ulcers, falls and catheter associated urine infections to be measured on a monthly basis.
- Patients identified as being at risk were placed on an appropriate care plan and were monitored more closely by staff. For example, if a patient was at risk of developing pressure ulcers the hospital would provide a special mattress for them, which would help stop pressure ulcers occurring.

Cleanliness, infection control and hygiene

- On our previous visit, we found the theatres were not in a fit state of repair, with skirting coming away from the wall and peeling paint on the ceiling. On this return visit, theatres had undergone a programme of refurbishment. Floors, ceilings, and walls were all clean and intact and met Department of Health guidance.
- We found the theatre environment to be visibly clean and tidy. All computers, keyboards, furniture (such as stools and operating tables), were dust free.
- The hospital had two operating theatres one of which had ultra-clean (laminar flow) theatre ventilation (a system that circulates filtered air to reduce the risk of airborne contamination), which was best practice for ventilation within operating theatres, and particularly important for joint surgery to reduce the risk of infection. However, only theatre one, with ultra-clean ventilation was currently in use, due to staffing difficulties. We saw evidence the theatre filtration systems had three and six monthly and annual checks to ensure compliance.
- On our previous visit, we saw staff setting up their instruments within theatre, but without markings on the floor staff could not ensure they were under the ultra-clean ventilation. It is recommended, that instruments be set up within the ultra-clean air zone, to reduce the risk of infection. However, as part of the refurbishment, theatre one now had demarcation on the floor and saw staff correctly setting up their instruments under the ultra-clean ventilation. This complies with HBN 26: Facilities for surgical procedures in acute general hospital, which says, "In theatres with ultra-clean ventilation the floor area enclosed by the hood should be marked with lines or a contrasting coloured area of flooring."
- We saw that waste was separated and in different coloured bags to signify the different categories of waste. This was in accordance with the Health Technical Memorandum (HTM) 07-01: Safe Management of health care waste and control of substance hazardous to health (COSHH), health, and safety at work regulations. However, not all waste bins were labelled to indicate the type of waste to be disposed, in accordance with HTM 07-01, which says 'labelled colour coded waste receptacles should be supplied for each waste stream'.
- All waste was kept appropriately in bulk storage bins on the hospital premises until collected. However, we found that the one of the bulk storage bins located in theatres was not locked, and contained clinical waste bags. In addition, we saw the outside bulk storage area, which was located beside the public carpark. The hospital told us, they were aware the storage facility was not fully enclosed and on an impervious, hardstanding well drained area, but the bins were locked and chained. When we checked the area all the bulk storage bins were locked, however, they were not enclosed with the chain provided. This was not in line with HTM 07-01, which says bulk storage areas should be away from routes used by the public, be totally enclosed and secure, and kept locked when not in use. We checked the risk register and saw that inappropriate clinical waste hold was included.
- Single use sterile instruments were stored appropriately and were within their expiry dates. The theatres' equipment store had sufficient storage space and items such as surgical procedure packs, implants and consumable items were appropriately stored in a tidy and organised manner.
- Theatre Sterile Supply Unit (TSSU) services had been taken off-site to a corporate hub to ensure compliance with regulatory requirements for decontamination,

Requires improvement

Surgery

- We looked at two dirty utilities in theatres; both had separate dedicated hand hygiene sinks, and a slop hopper for disposal of body fluids and a separate deep sink for cleaning of equipment. However, both dirty utilities were also used for storage for multiple items including sharp boxes. We also saw clean suction equipment stored in the sluice on the floor in a wire basket. Clean items should not be stored in dirty utilities, as it poses a risk to cross infection.
- We also saw there were no domestic waste bins in the dirty utility for items such as paper towels used following hand hygiene; this meant there was the potential for waste not to be segregated correctly.
- We looked at the dirty utility on the ward, which had separate dedicated hand hygiene sinks, and a slop hopper for disposal of body fluids and a separate deep sink for cleaning of equipment. However, the dirty utility was small and cluttered; items such as used linen skips and commodes could not be stored in the room. Linen skips were stored outside of the dirty utility. We saw the lack of space in the dirty utility, and inappropriate storage of the linen skips was included on the risk register.
- The commode was stored in a cupboard along with other items, such as drip stands. During our visit, we checked the commode and found it to be clean and labelled. HBN 00-09, recommends, 'a dirty utility room should include facilities for the decontamination of commode', it goes on to say 'where commodes are to be used, there should be sufficient space allowed for their decontamination and storage'.
- We inspected the linen room on the ward and it was fully stocked and correctly stored. However, items such as pillows and surgical gowns stored in boxes were on the floor. Items on the floor impede adequate cleaning; we found the floor to be dusty.
- We found equipment was visibly clean on the ward and in theatre, and staff had a good understanding of responsibilities in relation to cleaning and infection control.
- Disinfectant/detergent wipes were available on the wards to clean equipment between patient contacts. Good supplies were seen across both the ward and theatre we visited. All equipment we saw had 'I am clean' labels on them, which indicated the date the equipment had been clean and was safe to use.
- We saw on the hospitals action plan had developed following our previous inspection, that all non-intact and rusty equipment had been removed. During this inspection, we saw this was the case. We checked operating table supports, arm supports, and gel pads (used for pressure relief). We found all items to clean, intact and rust free.
- Personal protective equipment (PPE), such as gloves and aprons were generally used appropriately and were available in sufficient quantities, both on the ward and in theatres. However, during our inspection we saw mixed compliance to the practice with some staff using PPE appropriately, only wearing gloves and aprons during patient contact. However, we saw other staff wearing PPE inappropriately for example, we saw a member of the theatre team wearing gloves to collect clean items, and a scrub practitioner who did not wear eye protection while assisting with an operation, despite other members of the team wearing eye protection. Personal protective equipment is protective clothing such as aprons, gloves, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection.
- We looked at three double rooms and six of the single patient rooms on the ward. All rooms were clean and tidy. Beds and furniture were clean and intact. We saw PPE, was available in all patient bedrooms.
- Posters were displayed which explained the 'five moments for hand hygiene'. We saw staff in clean uniforms and all staff that interacted with patients were 'bare below the elbow'. Alcohol-based hand sanitising gel was available in all patients' bedrooms, on the ends of beds and at the entrance to wards. In addition, we saw nurses carried small personal bottles of alcohol-based hand sanitising gel attached to their uniforms. We saw staff using the hand sanitising gel correctly, in line with the 'five moments of hand hygiene' and National Institute for Health and Social Care Excellent (NICE) quality standard (QS) 61, statement

three. This standard states people should receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care.

- However, there were no dedicated hand washbasins in patient bedrooms, staff and visitors used the basin in the bedrooms en suite bathroom, the handwashing facilities in the sluice, or a central sink by the single rooms. The corporate 'Infection Prevention and Control, Hand Hygiene Policy (including training)' (dated May 2016), states 'Basins in patients' bathrooms/en suites must never be used for hand washing by clinical staff ', and goes on to say one sink per room in addition and separate to patient's washbasin. This was highlighted in our previous inspection.
- This does not comply with NICE QS61. The standard recommends hands can be cleaned using the alcohol-based hand sanitising gel except in the following situations, when soap and water must be used. When hands are visibly soiled or potentially contaminated with body fluids, or when caring for patients with vomiting or diarrhoeal illness, regardless if gloves have been worn. We saw the lack of handwashing facilities on the ward was not included on the risk register. This meant the hospital, did not recognise this non-compliance, as a risk, and potentially placed patients are risk of cross infection.
- Hospital data showed that the ward and theatres hand hygiene compliance rate was 100% for February and March 2017, and 96% in January 2017. Where there were episodes of non-compliance we saw that members of staff were spoken to immediately. This meant the hospital could be confident theatre staff were cleaning their hands in line with policy, and that staff were willing to challenge non-compliant behaviour.
- There were 'sharps' bins available in theatres and the ward. We noted the bins were correctly assembled, labelled, and dated. None of these bins was more than half-full, which reduced the risk of needle-stick injury. We saw posters displayed which outlined what action must be taken if a member of staff sustained a sharps injury; this information was also in departmental resource folders.
- The mattresses used by the hospital were fit for purpose and provided protection from infection and pressure damage. We saw the hospital undertook yearly mattress audits, with the most recent completed in March 2017. Where mattresses were deemed to have lost their impermeable protection, they were escalated to the IPC lead for action. Action taken included destruction and replacement.
- However, other zip foam items were not routinely checked for integrity and cleanliness. We found a two zip foam block cushions on the ward, which were not intact and visibly dirty when opened; we were told these items are not routinely checked. These items are a potential risk for cross infection. We informed the lead for infection prevention and control, who removed them immediately.
- The hospital had a designated director of infection prevention and control (DIPC), in line with the recommendations of the Code of Practice on the prevention and control of infections and related guidance ('the code'), Criterion 1 that describes the systems to manage and monitor the prevention and control of infection.
- The 'Director of Infection Prevention & Control Annual Report' for 2015 to 2016, detailed activities to ensure the hospital met the requirements of 'the code'. This report was mapped to the compliance criteria within the code of practice and included systems to manage and monitor the prevention and control of infection, maintain a clean and appropriate environment, ensure appropriate use of antimicrobials and ensure all staff were fully involved in the process of preventing and controlling infection.
- The hospital had a designated IPC lead, in line with the recommendations of 'the code'. They were responsible for checking patient screening and swab pathology results, and supervision of IPC link staff. Audit was undertaken by the lead IPC, and they were responsible for undertaking monthly surveillance of surgical site infection (SSI). The lead IPC also led on infection control training and assessed nurse competency in hand hygiene technique and aseptic non-touch technique.
- We saw an audit schedule for monitoring infections on the ward and in theatre. For example ward and theatres areas complete blood culture, peripheral intravenous lines, and urinary catheters on-going high impact intervention care bundle audits monthly.

Requires improvement

Surgery

- We reviewed two sets of medical records of patients who had a peripheral intravenous line in place. A peripheral intravenous line is a tube that is inserted into a vein and used to administer fluids and medication. Visual infusion phlebitis scores were completed correctly. The documentation contained information about the site of the peripheral intravenous line, skin cleaning product, hand hygiene and how often to review the device, in line with NICE QS61 statement five, vascular access devices. However, the documentation did not show how many attempts were made to insert the device.
- We reviewed catheter care records for patients who had a urinary catheter in place. A urinary catheter is a thin flexible tube used to drain urine from the bladder. We saw the patient was placed on an integrated care pathway, which included information about hand hygiene, catheter insertion, and maintenance in line with NICE QS61 statement four, urinary catheters.
- In addition, we saw as part of the assessment for need of the catheter the hospital had introduced the HOUDINI nurse-led protocol. Urinary tract infections (UTI) are the most common healthcare associated infection in acute hospitals. The risk of developing a catheter associated urinary tract infection (CAUTI) increases the longer a urinary catheter remains in place. HOUDINI is an acronym each letter represents a different reason why a urinary catheter should be inserted or removed. For example immobility or urology surgery. HOUDINI nurse led protocol urinary catheter insertion/removal protocol is a useful tool in reducing the number of days of urinary catheter usage, thus potentially reducing the associated risk of a CAUTI.
- Water supplies were maintained at safe temperatures and there was regular testing and operation of systems to minimise the risk of pseudomonas and Legionella bacteria. During our inspection, we saw copies of the records for flushing of water outlets.
- The hospital had access to microbiologist on call, under a service level agreement (SLA), with a London NHS Trust who gave advice to staff. The lead IPC told us she found the service to be very good. The microbiologist attended the quarterly hospital infection prevention and control committee and the water safety group meetings.
- There was a dedicated infection control link nurse for the department. Link nurses are members of the department, with an expressed interest in a specialty; they act as link between their own clinical area and the infection control team. Their role is to increase awareness of infection control issues in their department and to motivate staff to improve practice.
- Infection control training was mandatory for all staff groups and was undertaken on induction and then yearly. Data supplied to us by the hospital showed that 98% of required staff had completed infection control awareness training level one, and 100% of required staff had completed level two. This was better than the BMI Healthcare target of 90%. However, we saw 93% of required staff had completed infection prevention and control in healthcare. In addition, we saw that 95% of required staff had completed infection control and high impact intervention/care bundle training and aseptic non-touch technique. This meant the hospital did have assurance the majority of staff had the necessary up-to-date training to understand the principles of infection control.
- The hospital followed NICE guidance for preventing and treating surgical site infections (SSI) NICE guidelines CG74. Following discharge, the hospital had implemented a follow up call for all hip and knee patients as part of their 30-day Surgical Site Infection (SSI) audit
- The hospital reported no infections of Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive Staphylococcus aureus (MSSA) in September 2016 – February 2017. There were no reported cases of Escherichia coli (E. coli) or Clostridium difficile (C. diff) in the same period. MRSA and MSSA are infections that have the capability of causing harm to patients. MRSA is a type of bacterial infection and is resistant to many antibiotics. MSSA is a type of bacteria in the same family as MRSA but is more easily treated. C.diff is a type of bacteria, which can infect the bowel and cause diarrhoea.
- At the pre-operative assessment stage, staff screened high-risk patients for Meticillin-resistant Staphylococcus aureus (MRSA), such as orthopaedic surgery, those who had been in hospital previously and patients who had

previously tested positive for the bacteria. This was in line with Department of Health: Implementation of modified admission MRSA screening guidance for the NHS (2014).

- There were clear guidelines for staff to follow to screen patients for the presence of infections. For example, carbapenemase-producing enterobacteriaceae (CPE), on admission and we saw that these had been followed in the records we reviewed. CPE are bacteria that are resistant to the carbapenem class of antibiotics, considered the drugs of last resort for such infections.
- Spillage kits were readily available and within date, which meant they were ready for use.
- We saw disposable curtains were in place and had been changed within the last six months.

Environment and equipment

- The ward comprised of single or twin bedrooms with en-suite bathroom facilities, suction and piped oxygen, and emergency call facilities. Each room had an en-suite bathroom, television and Wi-Fi services.
- At the time of inspection, only one theatre was in use, which had two adjoining rooms. One where patients were prepared for their operations, and a second where patients were recovered following the operations. There was also a separate set-up room and sluice. However, the layout of theatres did present some infection control risks, the layout room and sluice were along the same corridor, and accessed via the same door into the theatre. Therefore, there was no separate flow of clean and dirty instruments. The instruments had to enter the theatre along the same corridor and via the same door. There was no risk entered on to the risk register that related to the lack of space in theatre, but we were told of plans to change theatre lay out, which would result in a separate clean and dirty flow through theatres.
- On our previous inspection, we found the logbooks for anaesthetic machines with evidence of daily checks had not been completed. On this inspection, we also found there were gaps in the completion of the logbooks, particularly in December and January. However, we did see that from 13 February 2017, the anaesthetic machine logbooks were completed in full. This gave assurances that safety checks had been undertaken and equipment was safe to use in line with The Association of Anaesthetists of Great Britain and Ireland (AAGBI) safety guidelines Safe Management of Anaesthetic Related Equipment (2009)
- Access to both theatres and the ward was via a swipe card access. This meant the area was secure and minimised the risk of unauthorised access. However, during our inspection we were able to walk from outpatients, past the entrance to theatres, down the fire escape (where clinical waste was kept), and onto the ward. This meant that anybody in the hospital could access the ward.
- None of the staff we spoke with had concerns about equipment availability. If any equipment required repair, they reported it and it told us it was fixed quickly. Staff were aware of the process for reporting faulty equipment.
- On our previous inspection, we found the cupboard doors containing the electrical circuit board for theatres were not locked. This meant there was a risk of someone being able to turn the electrical supply off to theatres, resulting in a power cut to life saving equipment. On both our announced and unannounced inspections, we found the doors to be locked.
- Theatres had a backup generator, to make sure there was an uninterrupted power supply. This meant lifesaving equipment would continue to work in the event of a power cut.
- Single use items such as syringes, needles, and oxygen masks were readily available on the ward and in theatres. Storage facilities within the hospital for supplies and equipment were well organised and tidy, this meant equipment was easy to locate. This meant storage facilities were easy to keep clean, and items were easy to locate in an emergency.
- On our previous inspection, we found the Control of Substances Hazardous to Health (COSHH) cupboards, which contained hazardous chemicals were unlocked. On this inspection we found them to be locked.
- There was a difficult intubation tray, which contained equipment to be used when a patient's airway was difficult to manage. There was a tidy and completed daily checklist to provide assurance of regular safety checks. We saw where there were no checks made, the

reason for this was indicated, such as 'theatre closed'. This was in line with the AAGBI standards. This also meant staff could be confident the correct equipment was available, if they had to use the difficult intubation trolley. We randomly checked 10 items on the trolley and found them all to within date.

- We saw three resuscitation trolleys in the theatre and on the wards. All trolleys were secure and tamper evident. Records showed the trolleys were checked daily, and a comprehensive check performed weekly, with the seal on the trolley being broken and replaced to check the contents. All drawers had the correct consumables and medicines in accordance with the checklist. We saw consumables were in date and the trolleys were clean and dust free. The automatic defibrillator worked and suction equipment was in order. This meant staff had access to equipment in the event of a medical emergency.
- We saw stickers on equipment, which indicated it had been serviced regularly, portable appliance testing (PAT) stickers on electrical equipment, or some with asset numbers and bar codes.
- These labels showed electrical equipment, had been tested and were safe to use. We spoke with the operations manager who explained that equipment with asset bar codes was not subjected to PAT testing as it underwent electrical safety testing from electronics and medical engineering department (EBME), which was a test carried out at a higher standard. This meant the hospital had assurance that all pieces of medical equipment were tested for electrical safety.
- On our previous inspection, we found there was a lack of overall responsibility for the maintenance of equipment within surgical services. In addition, there was not a robust system in place to ensure regular maintenance and servicing of medical equipment; the service was reliant on the manufacturers contacting the hospital when servicing was due. On this inspection, all equipment was recorded and tracked and an asset list was held corporately and locally by the operations manager. We saw the list was regularly updated with alerts in place to notify staff when equipment is due for servicing. The hospital had a contract with an external provider that completed most of the equipment maintenance in the hospital.
- We looked at 31 pieces of medical equipment on both the ward and in theatres including, a bladder scanner, infusion pumps, cardiac monitors, thermometer, and anaesthetic machine. We found all apart from three mechanical boots that are used in the prevention of a deep vein thrombosis, were all within date. We spoke with the operations manager, who told us they were aware these three pieces of equipment and another three in theatres were out of date, on their servicing. We saw evidence where the operations manager had contacted the company to service them, but had not received a reply.
- Point of care testing (PoCT) machines were available on the ward and in theatres. For example, a blood glucose machine to test blood sugars and a blood gas machine to test the levels of oxygen and other gases present in the blood. We saw staff had competency documents to show they were trained in the use of medical equipment, this meant the hospital ensured staff were safe and competent to use medical equipment on patients.
- The warming cabinet was monitored and records showed that both sections were within the required limits. The cabinet warmed to a maximum 37C (used for irrigation fluids only and max is 65C).

Medicines

- The hospital had a separate policy for the management for controlled drugs (CD's) and intravenous (IV) administration. IV therapy is the infusion of liquid substances directly into a vein and CD's are medicines that are liable for misuse and have additional legal requirements regarding their storage, prescription, and administration.
- We saw medicines were stored securely and handled safely. On the ward, we saw that medicines were stored in a locked room. Only nursing staff had access to the room using a keypad entry system. In the room, medicines were stored in the locked cupboards, which were accessed via key, which only trained nurses held. We saw medicine cupboards, fridges, and trolleys were locked.
- CD's were kept securely and stored in suitable cupboards with records maintained. The CD cupboards were locked, with restricted access and were bolted to the wall.

Requires improvement

Surgery

- On our previous inspection, we found incomplete records for controlled drugs (CD) in the register; this was due to staff 'block signing' for drugs rather than signing them individually at each stage of the dispensary process. On this inspection, we reviewed the CD register, which showed that all medicines had the correct balance recorded and dated with two staff signatures. We saw records of daily checks carried out to ensure this was correct.
- However, on the ward we saw that there was no date when CD's had been received from pharmacy in the CD register. The Nursing and Midwifery Council (NMC) Standards for medicine management, says 'for CDs received, the following details should be recorded, date on which received, name of pharmacist making supply/ serial number of requisition, amount received, form in which received, balance in stock'.
- We also saw when an error had occurred this had been crossed out with multiple lines. The NMC standards for medicine management, recommends 'If a mistake is made, it should be crossed out with a single line or bracketed in such a way that the original entry is still clearly legible. This should be signed and dated, and witnessed by a second registered nurse or midwife who should also sign the change'.
- Staff on the ward told us every week a member of staff checked the medicines to ensure they were all in date, during our inspection we randomly checked medicines and found all of them to be in date.
- Emergency drug packs for cardiac arrest, anaphylaxis (allergic reaction), and deteriorating patients were available and standardised across the service. This meant staff were familiar with them as they were the same throughout the hospital.
- Appropriate medicines were stored in dedicated medicines fridges. We saw records on the ward, which showed daily temperature checks were undertaken. This provided assurance the hospital stored refrigerated medicines within the recommended temperature range to maintain their function and safety. We also saw recommended actions to be taken if the fridge temperatures were not in the correct range. We also checked the records for the ambient temperatures of the drug room, which showed these had been completed correctly.
- We checked the fridge temperatures in theatres and found although daily records had been recorded, in March we saw five occasions where the fridge had dropped below the minimum range. The recommendation form advised to reset the temperature (which had been done on three out of five occasions), but there no was no evidence of an addition recheck as per the recommendations. We raised this with the theatre deputy, who advised that this was because it had not been done; in addition, the variance in the temperatures had not been raised to either him or the theatre manager as issue. This meant, in theatres the hospital did not have assurance that refrigerated medicines were stored within the recommended temperature range to maintain their function and safety.
- A copy of the current British National Formulary (BNF) was available in clinical areas. The BNF is the national authority on the selection and use of medicines. Doctors used the BNF to ensure they were prescribing medicines safely and appropriately.
- We reviewed four prescription charts for patients currently on the ward or recent discharges, all prescriptions were signed and dated, allergies were documented, and medicines omitted had a reason for omission documented. We saw evidence of pharmacy endorsements on the prescription charts.
- There was a programme of medicine related audits in place, for example, missed dose audit and medicines management audit (safe storage and processes). Results showed for the medicines management audit in February 2017 that theatres scored 97%, and in June 2016, the ward scored 100%. A missed dose audit was undertaken in July 2016, which showed a snap shot of a 24 hour period. The results showed there were no medication omissions in the 24-hour audit period.
- Medicines management was part of mandatory training for all clinical staff. This was part of induction and then updated every three years by e-learning. Training records showed us by March 2017, 100% of required staff had completed medicines calculations, including more complex questions. This was better than the BMI Healthcare target of 90%. However, we saw 73% of required staff had completed the safe management of

hypoglycaemia, and 68% had completed the safe use of intravenous insulin infusions in adults and the safe use of insulin, which was worse than the BMI Healthcare target.

- There was an up to date localised antibiotic protocol, which included first and second choice medicines to use, the dosage, and duration of treatment. This protocol was developed between pharmacy, IPC and the microbiologist. We were told that pharmacy undertake an audit of antibiotic usage twice a year, with a minimum of 10 patient prescriptions reviewed, which included duration and indication for antibiotic and allergies status. This was in line with 'the code'.
- We also saw that antibiotic flow chart guidelines for first and second line choice medicines were prominently displayed in the clean utility on the ward and recovery in theatres. We saw antibiotic stewardship was included within the hospital infection prevention and control committee (HIPCC) meetings.

Records

- We reviewed seven patient records during our inspection. The records we viewed were generally found to be accurate, fit for purpose, and in line with the Royal College of Physicians Standards for the clinical structure and content of patient records, 2013. However, it was noted that three of the handwritten surgical operation notes were difficult to read and contained abbreviations, which was not in line with the guidance.
- In four out of the seven patient records we viewed were generally found to be signed, dated, legible, complete, and contemporaneous. However, in three of the records we reviewed did not always show evidence of consultant or medical review when this was required. For example, we did not find evidence of a pre or post operation review by a consultant. This is not in line with the Royal College of Surgeons (RCS) (2014); good surgical practice, which recommends that 'surgeons must ensure that accurate, comprehensive, legible and contemporaneous records are maintained of all interactions with patients'.
- Patient medical records were paper based. At the time of inspection, we saw patient personal information and medical records were managed safely and securely, in line with the Data Protection Act, 1998. When not in use, patient's notes were kept securely in the nurse's office. The door to the office was lockable. However, we observed it to be left open during our inspection. There was a ward clerk at the nursing station directly in front of the nursing office. Staff confirmed that the door would be locked when the ward clerk was not on duty or had cause to leave the desk area.
- Patient medical records showed where staff had completed patient risk assessments. These included risk assessments for falls, malnutrition, and pressure ulcers. All risk assessments completed followed national guidance. For example, all patients were risk assessed on admission for their risk of venous thromboembolism (VTE), and this was in line with the National Institute for Health and Care Excellence (NICE) QS3 – statement one.
- Data received from the hospital indicated that 99% of the required staff had completed their mandatory training in information governance training, which was better than the BMI Healthcare target of 90%. This meant the hospital could be confident that staff were aware of their roles and responsibilities to keep patients information safe.
- The hospital's patient health records audit showed scores between 92% and 95% January to March 2017. The audit looked at various aspects of record keeping including secure storage, referral information, nutritional assessment, pre-assessment; risk assessment, discharge summary and evidence of completed 48 hours post discharge follow up telephone call.

Safeguarding

- There was an up to date corporate 'Safeguarding Adults Policy, which incorporated the Mental Capacity, 2005, Deprivation of Liberties Safeguards and PREVENT For England and Wales' (dated May 2015). There was also a 'Safeguarding Children Policy' (dated March 2016) with defined responsibilities at national, regional and hospital level. Staff told us they could access all policies on the intranet.
- Safeguarding vulnerable adults training was undertaken every two years for levels one and two. Data indicated, by March 2017, 100% of required staff had completed level one, and 99% of required staff had completed level

two. This was better than the BMI Healthcare target of 90%. This meant the hospital did have assurance all staff had the necessary up-to-date training to keep patients safe.

- Safeguarding children, training was undertaken every two years for levels one and two. Data supplied to us by the hospital indicated, by March 2017, 100% of required staff had completed level one and two training, which was better than the BMI Healthcare target of 90%.
- On our previous inspection, we found staff were not adequately trained to the correct level for safeguarding of children in line with the intercollegiate document Safeguarding Children and Young People: Roles and responsibilities (2014). Since that inspection, 59 staff had been identified as requiring safeguarding children level three training, as of March 2017, data showed 57 (97%) have undertaken this training. The hospital did not treat children or young people under the age of 18 at the time of the current inspection.
- In addition, since the last inspection safeguarding training had been changed from online training to face-to-face training.
- The DoCs was also the named professional safeguarding lead for the hospital. They now attend the healthcare subcommittee of the Local Safeguarding Children Board and had, "touched base" with the Safeguarding Adults Board. Named professionals have a pivotal role in promoting good professional practice in an organisation, providing advice and expertise for staff to follow and ensure safeguarding training is in place.
- We saw that there were posters displayed on staff notice boards for example, 'Procedure for managing a disclosure of suspected/actual child or vulnerable adult safeguarding incident'. These posters contained flow charts and actions to be taken and who to contact in the event of adult or child safeguarding issues arising.
- The staff we spoke with during our inspection had an understanding of their safeguarding responsibilities and of the safeguarding procedures. They were able to describe how they would act upon and escalate any concerns they had. This had improved since our previous inspection where we found, staff could not all demonstrate knowledge and understanding of how safeguarding issues applied to their work.
- At the time of inspection, staff we spoke with were not aware of any supervision for safeguarding. However, when we spoke with the director of clinical services, they confirmed, safeguarding was incorporated into the clinical supervision programme that was being developed. A cohort of facilitators were receiving supervision training through the University of Greenwich at the time of the inspection.
- Safeguarding was a standing item on the Clinical Governance Committee agenda. All alerts were itemised and discussed in this forum. We confirmed that we saw this in the CGC meeting minutes from December 2016 and January to March 2017.
- All clinical incidents were minuted and reviewed from a safeguarding perspective. Whilst attending the 'Comms Cell' meeting we also saw that safeguarding incidents were discussed.
- There had been three safeguarding concerns recognised during the period January 2017 to March 2017.
- There was a lack of clarity about the provider response to the Lampard Enquiry (following the allegations made against Jimmy Savile) but the hospital did not have any volunteers and there had been no recent celebrity visitors.

Mandatory training

- Mandatory training for all staff groups was comprehensive with many modules accessed through an on line learning system. Mandatory training modules included fire safety in a hospital environment, information governance, protecting people at risk of radicalisation (PREVENT) and safety, health and the environment. Other training was role specific for example patient moving and handling, medical gas training, and acute illness management.
- Staff completed the appropriate courses from this list relevant to their role. This was monitored through the staff member's appraisals. Staff told us the hospital had an electronic system, which recorded the training that was required, its completion dates, and would send a reminder to staff when the training was due for completion. In addition, managers received notification when a staff member's mandatory training had lapsed. The overall mandatory training rates for staff, supplied to us by the hospital prior to the inspection were 94%,

which was better than the BMI target of 90%. This meant the hospital could be confident the majority of staff were aware of their roles and responsibilities to keep patients safe.

- The resident medical officers (RMO) were required to undertake their mandatory training with the agency that supplied them as part of their contract.
- Consultants had to complete mandatory training with the trust they worked for as part of their appraisal process and practising privilege. Records of this training were seen as part of the review of practicing privileges agreement.

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- A theatre communications meeting (huddle) took place each morning at 7.45am where any issues were discussed which might affect the proposed procedures that day. We also saw discussion around incidents such as the previous day's late start due to a problem on the ward, which delayed the theatre team collecting a patient.
- On our previous inspection, we found staff were not carrying out the World Health Organisation "Five Steps to Safer Surgery" (WHO) checklist correctly. All patients undergoing invasive procedures under general, regional, or local anaesthesia, or under sedation, must undergo safety checks immediately before the start of the procedure. The "Five Steps to Safer Surgery" checklist is a national core set of safety checks for use in any operating theatre environment. The checklist consists of five steps to safer surgery. These are team-briefing, sign in (before anaesthesia), time out (before surgery starts) and sign out (before any member of staff left the theatre) and debriefing. This meant that patients were being placed at unnecessary harm.
- Following this inspection, data supplied to us by the hospital indicated all theatre staff had undergone additional training on the WHO checklist in March 2017.
- On our unannounced inspection on 5 April 2017, we observed three patients undergoing surgery and we found staff engagement, with the WHO checklist, remained inconsistent. We observed the surgical team completing the checklist and saw that this was not embedded as a tool to support patient safety.
- A 'team brief' involving all members of the theatre team was carried out before each theatre list. We observed the 'team briefings' (step one). All the team members were present, this meant vital safety information was shared with the whole team.
- As previously found, we saw that staff asked some of the questions at the various stages of the "Five Steps to Safer Surgery" but not all. We observed staff completing the WHO checklist, 'ticked' to indicate all elements had been covered, even though they had not been read aloud and confirmed with the team. This meant important safety checks could be missed and could result in harm to patients.
- Staff involvement remained poor when the safety checks were undertaken, for example, staff were still moving objects around and did not stop, listen, and pay attention, in one instance the radio remained turned on. This made it difficult for staff to concentrate and pay attention to the safety checks. We observed that in two of the three cases, staff did not perform the "time out" stage of the WHO checklist correctly. We witnessed staff continue to complete their own tasks during this stage instead of stopping to engage with the process. The "time out" is the final stage of checks to prevent severe harm being done to the patient. At the "time out" stage, all staff need to stop and listen whilst the relevant checks are undertaken before starting the operation, noise and interruptions should be minimised during the 'time out'.
- We saw it was not routine practice to undertake a 'debrief' following the operation, which forms part of the WHO checklist. Procedural team debriefing is a key element of practice in the delivery of safe patient care during invasive procedures, and forms part of both the WHO Checklist. The debriefing should be seen as being as important a part of the safe performance of an invasive procedure. The surgeon had left the theatre and was changing, when he was requested to attend, he informed the staff member he was "pushed for time". The 'debrief' was led by one of the operating department practitioners. However, during the 'debrief' staff members were generally chatting. Noise and interruptions should be minimised during the 'debrief'.
- On our return visit on 11 April 2017, we observed two patients undergoing surgery. The hospital told us, following feedback from our unannounced they now

had an additional member of staff from another BMI Healthcare Limited hospital, as a WHO checklist 'champion' who would help embed the checklist with staff.

- We observed a good 'team brief' (step one) in the anaesthetic room for theatre one. This included a full introduction of the team and requirements. We saw the process was fully interactive and all team members participated. We saw all elements of the BMI brief checklist were read aloud, including the procedure, equipment, position of the patient, allergies, and any anaesthetic requirements.
- We observed preparation for the surgical procedures, with an appropriate handover from a ward nurse to the anaesthetic practitioner (AP). A full check of the patient's details and consent was carried out, prior to leaving the ward. We saw the pre-operative checklist was completed in full between the AP and the patient, including the patient confirming what procedure was to be performed.
- In the anaesthetic room, we saw staff were introduced to the patient and the anaesthetist was present during the patient's details check and the pre-op checklist for both patients. This included checking the patient identification, consent, allergies, check of the site marking and the last time the patient had anything to eat or drink. This complied with best practice, which says where possible for the patients to be involved in the "Five Steps to Safer Surgery" checklist, as they can confirm their details. We saw all elements of the 'sign in' stage were read aloud and confirmed before marking on the checklist as completed.
- We saw the 'time out' for both operations, was a fully interactive process, one member of the team was absent when 'time out' first called, but a member of staff went to get them. 'Silent focus' was observed in line with guidance. We saw all elements of the 'time out' stage were read aloud and confirmed before marking on the checklist as completed.
- We were told an adapted WHO Checklist was in use for invasive radiology but the senior managers of the hospital did not have oversight of this and were unsure how well it was implemented. There was a view from the DoCs that the radiology manager was, "strong on process" and would insist on proper adherence to policy.
- The service audited staff compliance with the WHO checklist and calculated the percentage compliance each month. We saw the results for January to March 2017. Theatres scored 100% compliance with all areas assessed. However, we observed that compliance with this checklist was variable and not fully embedded with staff. We spoke with one staff member who had been asked to complete the WHO checklist audit, they told us they had received no training on how to undertake the audit, and had looked up a video on 'YouTube' on how the WHO checklist should be completed correctly. We asked three staff on their understanding of the 'Five Steps to Safer Surgery', two members of staff told us "safe, effective, caring, responsive, and well-led", which are the CQC's five domains (safe, effective, caring, responsive, and well-led). This meant, staff understanding about the WHO checklist and the need for the surgical team completing the checklist was not embedded as a tool to support patient safety.
- The quality and risk lead told us, the WHO checklist audits that showed 100% compliance were a retrospective review of 10 patient records selected at random and assessed by the theatre manager. The audit showed whether the form had been completed but not whether the WHO 'Five Steps to Safer Surgery' guidance was being followed in full. This had resulted in a discrepancy between CQC observed practice and the performance measured through audit. In essence, the audit was measuring the incorrect metrics to be able to identify patient safety risks. It was a false assurance.
- In addition, the DoCS confirmed that the audits had been a retrospective review of the paper records rather than observations of how the process was carried out. The Patient Safety Observations the DoCS had instigated had identified shortcomings, which included forms being ticked retrospectively, after the operation was completed.
- The hospital provided subsequent assurances that improvements with the WHO checklist were being maintained. We saw an observational audit carried out by an external theatre manager following our inspection. This showed 100% compliance with all areas

of the WHO checklist. The auditor commented that the WHO checklist flowed much more routinely and that it was "well ingrained". The executive team encouraged staff to report any non-compliance with the WHO checklist on the hospital's incident reporting system. The interim director of clinical services told us staff had reported two incidents of consultant non-compliance.

- We also saw a letter drafted by the medical advisory committee (MAC) chair to the consultant body on 4 May 2017. This made explicit the requirement for staff to report breaches of the WHO checklist process as incidents on the electronic reporting system. We also saw an addendum to the hospital's action plan, which provided details of the action being taken in respect of consultants who failed to engage with the WHO checklist process and best theatre practice. This included a meeting with the executive director and the MAC chair that would be recorded in consultant files. Further or persistent failure to follow policy might result in loss of practicing privileges. This demonstrated the hospital was taking action to ensure continuing compliance with the WHO checklist and the requirements of Regulation 12 (1) (2) (b), Safe care and treatment, of the Health and Social Care Act (Regulated Activities) Regulations 2014.
- In four out of the five surgical cases, we observed that the theatre check of instruments between the scrub practitioner and the theatre circulator was both visually and verbally confirmed what was present, against a checklist. This occurred prior to and following the procedure. This was in accordance with best practice guidelines by the association for perioperative practice (AfPP), which says both practitioners must visually check and count aloud in unison. However, during our observation we noted that they were interrupted on occasion, when this occurred they would start from the beginning, this is in accordance with the AfPP guidelines.
- NICE clinical guidance (CG) 65 for hypothermia: prevention and management in adults having surgery was followed, the patients temperature was monitored within an hour of going to theatre, in the anaesthetic room and then every 30 mins if the operation takes longer than 30 mins. This is important as keeping patients warm lowers the risk of complications following surgery.
- Equipment, including consumables such as swabs, used during surgical procedures were recorded on a visible count board to ensure the same number were present at the start and end of each procedure. We saw these whiteboards in use during our inspection. The countable items must be recorded on the dry wipe board, which is pre-printed and states all relevant items used. This board should be permanently fixed to the operating theatre wall and be positioned at a height that facilitates access and visibility during the procedure.
- As part of the preoperative assessment process, patients completed a pre-assessment medical questionnaire (PAMQ). These were reviewed at pre-assessment appointments to assess suitability of patients for surgery and carry out health assessments such as electrocardiogram (ECG). Dependent upon a patient's history, patients either could receive a nurse-led clinical assessment via the telephone, or could be invited to attend a face-to-face assessment where a number of investigations may take place, or be referred for an anaesthetic review.
- The hospital did not have any level two or three critical care beds. To mitigate this risk, the unit only operated on patients pre-assessed as grade one or two under The American Society of Anaesthesiologists (ASA) grading system. Grade one patients were normal healthy patients, and grade two patients had mild disease, for example well controlled mild asthma.
- As part of the PAMQ all female patients of childbearing age were asked the date of their last menstrual period (LMP), to check their pregnancy status. On admission to the ward, female patients had an additional pregnancy test performed. This was in line with the National Patient Safety Agency (NPSA) 2010 'Rapid Response Report', which highlights the 'unreliability of LMP as a sole indicator of pregnancy'. We saw theatre staff checked that a pregnancy test had been performed and the result was available prior to the induction of anaesthesia.
- Patient's allergies had been clearly noted on their paper notes, medication chart and by the colour of their identity band, which alerted staff to their allergy. For example, we saw a patient wearing a red wristband due

to having a medication allergy. The allergy was confirmed at all checks, however, it was not recorded on the visible count board, despite there being a section for staff.

- Medicines were readily available for the emergency treatment of malignant hyperthermia (MH). MH is a rare disease that causes a fast rise in the body temperature and severe muscle contractions when someone with the disease has a general anaesthesia.
- Nurses were updated with the sepsis protocol during their Acute Illness Management (AIMs) training. We saw the training included some scenario based training which reflected national guidance on quality standards for sepsis, such as National Institute for Health and Care Excellence (NICE) NG 51: Sepsis: recognition, diagnosis and early management. Sepsis is a potentially life threatening complication of an infection.
- We saw flow chart pathway for the management of sepsis was prominently displayed on the ward. We also saw there was a 'sepsis box', which contained blood culture bottles and sepsis flow chart. A blood culture is a test that looks for infections in the blood stream. On our unannounced visit we found multiple blood culture bottles were out of date, this meant if a patient required a blood culture test might not be reliable. However, on our return visit, we found all the blood culture bottles had been replaced and were in date.
- There was access to a minimum of two units of O Rhesus negative blood stored in a designated fridge within the hospital for use in an emergency. O negative blood can safely be given to most people. It is often used in medical emergencies when a patient's blood type is not immediately known. The hospital had a major haemorrhage protocol and staff were aware of where the emergency blood was stored and how to obtain it. Further blood for transfusion was obtained through another BMI Healthcare hospital blood bank and the details of how they were contacted were included within the flow chart attached to the blood loss protocol.
- If it were expected for a patient to require a blood transfusion following surgery, they would have a blood group and save prior to surgery. Group and save is a process for determining a patient's blood group and identifying suitable blood in the event of severe bleeding. All patients who receive a blood transfusion will be placed on an integrated pathway, which includes actions to take prior to collection and during transfusion, along with suspected transfusion reactions, and escalation protocol.
- The hospital had a standard operating procedure (SOP) regarding the emergency transfer of deteriorating patients. The SOP was in date and set out actions and responsibilities, should a patient become unwell and required transfer to an acute NHS hospital. This meant there was a process in place to ensure patients who became unwell were transferred to an acute hospital for assessment and treatment. Staff we spoke with were familiar with the escalation process and where necessary, patients were transferred by ambulance.
- Data indicated that by March 2017, 99% (64 out of 65) of required staff had completed adult basic life support (BLS) non-clinical and 97% (35 out of 36) of required staff had completed adult BLS clinical. This was better than the BMI Healthcare target of 90%. In addition, we saw 100% (three out of three) of required staff had completed advanced life support. However, we saw 88% (22 out of 25) of required staff had completed adult immediate life support, which was worse than the BMI Healthcare target.
- In line with NICE NG 51, the hospital used the National Early Warning Score (NEWS), and escalation flow charts. NEWS is a simple scoring system for physiological measurements, such as blood pressure and pulse, for patient monitoring. If a patient's score increased, staff were alerted to the fact and a response would be prompted. The response varied from increasing the frequency of the patient's observations, to urgent review by the patient's consultant. Audits of NEWS assessments for patients at risk of unexpected deterioration had been undertaken which identified a problem with the way staff were scoring and failure to record overall scores. Observation of the three sets of medical records showed these assessments were undertaken and had been scored correctly.
- The hospital used 'intentional rounding' by nursing staff, which was completed throughout the patients stay. This meant patients' were visited in their rooms hourly to

check, for example if call bells and drinks were in reach, if the patient had any pain or any other requests. We saw three intentional rounding charts, which showed these had been completed correctly.

- There were alarm systems to alert medical and nursing staff when immediate assistance was required in the case of an emergency.
- The practising privileges agreement required the designated consultant to be contactable at all times when they had inpatients within the hospital. They needed to be available to attend within an appropriate timescale according to the level of risk of surgical emergency. This included making suitable arrangements with another approved practitioner to provide cover in the event they were not available, for example whilst on holiday.

Nursing and support staffing

- The surgical services department (both ward and theatres) had 26 whole time equivalent (WTE) staff. At the time of inspection, they were established for 37.7WTE, with the majority of the vacancies being in theatres staff told us that they were actively trying to recruit into these roles
- During our inspection, we found the hospital complied with recommendations of the Association for Perioperative Practice (AfPP) for the numbers of staff on duty during a standard operating list. This consisted of two registered nurses, an operating department practitioner, a healthcare assistant, a consultant, and an anaesthetist
- There were a total number of 311 shifts covered by bank or agency staff between October 2016 and December 2016.The highest bank or agency was for theatre operating department practitioners (ODP) and healthcare assistants (150), followed by nursing staff on the ward (82) and the lowest rate was for ward health care assistants (8).
- The hospital told us, they recognised the high use of agency staff due to difficulty in recruitment. To mitigate against this, agency staff had now been given three month fixed contracts. This meant agency staff used, worked at the hospital regularly, and were familiar with policies and procedures. This provided continuity of care for patients and ensured these staff could work safely as they were familiar with the systems and processes of the hospital.
- There was an unfilled agency or bank shift rate 0% for October to December 2016.
- The hospital used the BMI staff planning tool. The planning tool calculated the nursing hours and skill mix needed for the planned patient numbers and acuity levels. The hospital told us they used the tool to plan the appropriate number of hours and skill mix needed to meet demand five days in advance, with continuous review on a daily basis. The hospital told us they also entered the actual hours staff worked retrospectively to understand any variances from the planned hours and the reasons for these.
- We saw that the daily actual versus planned staffing levels were displayed on the 'ward boards.' Actual staffing levels met the expected numbers on all shifts.
- We saw there were arrangements for handovers and shift changes that ensured people were safe. For example, we saw the nursing handover in the morning; this included all information relating to the patient including procedure, patient allergy, pain level, and discharge information.

Medical staffing

- All patients were admitted under the care of a named consultant. There were 154 consultants who had been granted practising privileges at the hospital. A practising privilege is, "Permission to act as a medical practitioner in that hospital" (Health and Social Care Act, 2008). The majority of these also worked at other NHS trusts in the area.
- The Executive Director (ED) and the Medical Advisory Committee (MAC) had over sight of the practising privileges arrangements for consultants. We saw evidence in the MAC minutes of decision-making for renewing or granting privileges.
- Out of the 154 consultants, we saw that 35 had not undertaken work at the hospital within the last 12 months. The ED informed us he had recently written to these consultants, inviting them to reapply for practising privileges if they wanted to.

Requires improvement

Surgery

- Operating theatres were generally in use between 7am and 8pm Monday to Friday, and 7am to 6pm on Saturdays. If a patient was required to return to theatre out of hours due to complications of surgery, there was an on call system in place to notify staff. The resident medical officer (RMO) knew how to contact a patient's consultant.
- The hospital used an agency to provide 24-hour, seven days a week RMO cover on a rotational basis. The RMO worked on a two days on, followed by two days off. This ensured a doctor was on-site at all times of the day and night should an emergency arise. The RMO conducted regular ward rounds to ensure patients were safe. The RMO reported any changes in a patient's condition to their consultant and followed the consultant's advice regarding further treatment.
- All staff and the RMO told us there were no concerns about the support they received from consultants and their availability.
- The RMO had a formal handover when they changed shifts. The RMO told us there was good communication around the patients with specific needs, however we were unable to observe a handover as there was no change over during our visit. The RMO also informed us they attended a morning and evening nursing handover, in order to ensure they were aware of any potential patients who may require further input overnight.
- We saw that surgical first assistants had completed classroom and on the job training before being deemed competent. There were systems and processes in place to ensure competency and security checks were performed. We reviewed two first assistant forms; all were fully completed with information including hepatitis B status, indemnity insurance and registration details and renewal dates. Surgical first assistants work closely with the surgeon to facilitate the procedure and process of surgery.

Emergency awareness and training

- Members of the senior management team and heads of departments were briefed each morning at the daily 'Comms Cell' hospital meeting to ensure that there were clear lines of accountability and responsibility in managing emergencies. For example, we attended two 'Comms cell' meetings and saw staff were informed who the members of the resuscitation team were for the day, including their roles within the team.
- All staff received fire training as part of their mandatory training programme. Emergency plans and evacuation procedures were in place and arrangements were displayed on noticeboards. Staff were trained in how to respond to fire and evacuation procedures.
- Scenario based training was held regularly this ensured staff responded appropriately to emergencies. For example, staff told us these included major haemorrhage scenarios. More recently, staff told us of an unannounced resuscitation-training scenario that took place in the car park, which took place two weeks ago. The resuscitation lead for the hospital told us, although the scenario went well, and they were able to respond, it highlighted some potential problems. As a result new equipment such as an automated external defibrillator (AED), portable suction and a 'grab bag' containing emergency equipment, and medication, had been purchased and would be kept at reception.
- The hospital had a back-up generator to ensure services could continue in the event of a disruption to the main power supply. Maintenance staff told us the generator was checked on a monthly basis. Generator testing provided the hospital with assurance that the generator would provide back-up power and enable services to continue in the event of a power failure.
- The hospital had a Business Continuity Plan, which set out clear roles and responsibilities to ensure service continuity in the event of a business continuity incident.

Are surgery services effective?

Requires improvement

At our last inspection in 2016, we rated effective as 'requires improvement'. At this inspection, we have maintained this rating. However, we did see improvements in key areas including evidence based care, patient outcomes following surgery and dementia awareness, we have now rated effective as 'requires improvement'.

Evidence-based care and treatment

- Staff could access updated policies and guidance on the hospital's intranet. The hospital informed staff of policy changes through a monthly clinical governance bulletin, which included action plans. The Clinical Governance Committee (CGC) and the MAC discussed changes to policies, for example, the meeting minutes showed both committees discussed the interpreter policy. This meant staff were kept up to date with the latest guidance.
- In the theatre rest room, there was a resource folder, which contained a variety of risk assessments. There was a completed signatory list, which demonstrated staff had read the risk assessments, understood and agreed to follow the control measure put in place to manage the risks.
- As part of the hospital's improvement plan, each department would nominate a policy champion who would be responsible for ensuring any paper copies of policies were up to date in their department. This ensured staff had access to policies that were in date and referred to the latest evidence or legislation.
- During our previous inspection, theatre staff did not measure patient's temperatures consistently. At this inspection, staff monitored patient temperatures before induction of anaesthesia and then every 30 minutes until the end of surgery. This was in line with the National Institute for Health and Care Excellence (NICE) guidelines [CG65] Hypothermia: prevention and management in adults having surgery. The minutes from the MAC dated March 2017, showed the committee discussed the key changes and amendments to this guideline.
- The surgical service audited staff compliance with hospital policies in several areas and reported the results monthly. For example, the monthly World Health Organisation (WHO) surgical safety checklist audit and theatre environment audits. The staff meeting minutes demonstrated staff received feedback on local audit results and areas for improvement. For example, theatre staff received feedback on completion of WHO checklists at their December 2016 theatre department team meeting.
- The hospital also participated in national audits such as patient reportable outcome measures (PROMs), the patient led assessment of the clinical environment (PLACE) and the national confidential enquiry into patient outcomes and deaths (NCEPOD).
- We reviewed seven patient records, which all showed evidence of regular observations, for example, blood pressure, and oxygen saturation, to monitor the patient's health post-surgery. Staff had completed all observations in line with NICE guideline CG50: Acutely ill patients in hospital- recognising and responding to deterioration.
- The hospital followed the Royal College of Surgeons (RCS) professional standards for cosmetic surgery by keeping a breast prosthesis book in theatres. This meant the hospital could identify patients in the event of product safety concerns. It was unclear however, if the hospital submitted data on the breast and cosmetic implant registry (BCIR).

Nutrition and hydration

- Nutrition and hydration was included in the 'patient needs' prompt on the 'nursing intentional rounding' form used by staff, to ensure their patients were safe and comfortable. Staff undertook intentional rounds hourly for all inpatients and day patients. Patients told us nurses routinely offered them drinks as part of these rounds.
- Patient advice followed the Royal College of Anaesthetists guidance on fasting prior to surgery. It recommends patients can eat food up to six hours and drink clear fluids up to two hours before surgery. The patients' admission letters showed clear instructions for fasting prior to surgery.
- Although, the service did not audit adult pre-op fasting times there was an effective process to ensure patients fasted for an appropriate period before undergoing general anaesthetic. Staff asked each patient to confirm when they last ate and drank during the checking process on arrival in theatres. Patients we spoke with confirmed they had fasted for the appropriate period before surgery in line with pre-operative information given to them by staff.

- The patient led assessment of the care environment (PLACE) results in 2016, for organisational food was 89% and ward food 93%. These scores were better than the England average for other acute/specialist hospitals, which was 87% and 88% respectively.
- The PLACE action plan showed the management team discussed the PLACE audit results with the catering team. One completed action was the catering team making and leaving sandwiches in the fridge for patients who are likely to miss mealtimes.
- Patients had a menu on a daily basis that set out the meals available for that day. Catering staff freshly prepared the food onsite. Patients had access to food between meal times as required. This included toast, sandwiches, cereal and fruit. Water was available to all patients throughout the day. A member of catering staff spoke with patients daily to discuss any individual needs.
- The hospital had a five star rating in the local authority "Food Hygiene Certification Scheme". This gave the hospital assurance staff knew best practice in food hygiene standards.
- The hospital used the Malnutrition Universal Screening Tool (MUST) as part of pre-assessment screening. The MUST tool enabled staff to identify patients at risk of malnutrition and make adjustments to mitigate any risk where appropriate. We reviewed seven sets of patients' notes, which provided evidence of MUST assessment.

Pain relief

- There were posters in patient rooms displaying the WHO verbal rating scale which used a 4 point scale with zero representing no pain and three representing severe pain. However, patients we spoke to stated staff asked them to rate their pain on either a scale of zero to three or one to ten. The importance of using the same pain assessment tool is that the number relates to the same pain intensity in each tool. Staff recorded pain scores along with clinical observations following surgery.
- Pain score and assessment prompts were included in the 'nursing intentional rounding' form used by staff, to ensure their patients were safe and comfortable. Staff undertook intentional rounds hourly for all inpatients and day patients. Patients told us nurses routinely asked them about their pain levels as part of these rounds.
- Staff assessed patient's vomiting and nausea after their surgery. There were completed vomiting and nausea assessment forms in patient nursing records.
- All patients we spoke with told us staff had managed their pain well during their inpatient stay.
- The pain management audit for February 2017 showed staff audited 10 sets of medical notes for day patients and inpatients. The audit looked at pain assessment, pain management and documentation. The audit showed an overall compliance rate of 93%. This was better than the overall compliance rate of 61% in the previous audit in August 2016.
- During our previous inspection, pain was the second most common complaint on the ward. Hospital data showed there was only one complaint relating to pain within the past six months.
- The hospital told us the anaesthetist managed patient pain; however, nurses could escalate their concerns to the resident medical officer (RMO) or consultant if required.
- The hospital told us the pharmacy team pro-actively supported pain management at ward level providing advice and support to the patient and clinical teams. The ward nurses told us the pharmacy team were very visible on the ward and visited three to four times a day.

Patient outcomes

- There was one case of unplanned readmission within 28 days of discharge between September 2016 and February 2017.
- There were no reported unplanned returns to theatre between September 2016 and February 2017.
- The hospital reported three unplanned transfers of inpatients to other hospitals between September 2016 and February 2017.
- The hospital provided data to national Patient Reportable Outcomes Measures (PROMs) for NHS and private patients. PROMs used patient questionnaires to assess the quality of care and outcome measures following surgery. The hospital provided PROMs data from three areas: groin hernia repair, primary knee

replacement and primary hip replacement. The hospital used the national EQ-5D and EQ-VAS indices to assess patients' changes in health. EQ-5D and EQ-VAS indices are generic health status measures.

- PROMs data between April 2015 and March 2016 showed 29.4% of patients at the hospital
- PROMs data for the same reporting period showed the hospital did not have enough data available to calculate average health adjusted scores for hip replacements and knee replacements for the period April 2015 and March 2016. However, since August 2016 the hospital included eligible private patients to improve the amount of data collected.
- For the patients treated for primary knee replacement between April 2015 and March 2016, 70% of patients reported their health had improved following surgery under the EQ-5D criteria. Under the EQ-VAS criteria, 38.9% of patients reported their health had improved following surgery. These patient outcomes are worse than the England average of 81.6% and 56.3% respectively.
- For the patients treated for primary hip replacement between April 2015 and March 2016, 91.7% of patients reported their health had improved following surgery under the EQ-5D criteria. Under the EQ-VAS criteria, 90% of patients reported their health had improved following surgery. These patient outcomes are better than the England average of 89.6% and 66.5% respectively.
- During our previous inspection, patient outcomes were not itemised as standard agenda item at meetings. During this inspection, meeting minutes showed patient outcomes including audits were a standard agenda item and regularly discussed at quarterly MAC meetings, monthly CGC meetings, monthly department meetings and monthly management team meetings. This gave assurance the hospital regularly benchmarked, monitored and discussed patient outcomes and areas of improvement. However, the discussion of PROMs data in the MAC meeting (minutes dated March 2017) were minimal and did not focus on using the outcome measurements to improve to patient care.
- The hospital provided data to the National Joint Registry (NJR). The NJR collected information on all hip, knee, ankle, elbow and shoulder replacement operations to monitor the performance of joint replacement implants. At our last inspection, the hospital did not review or benchmark this information in order to improve patient care. We saw no evidence during this inspection how the hospital had improved on this.
- The hospital also participated in the Patient Led Assessment of the Clinical Environment (PLACE) audits.
- BMI Healthcare produced monthly quality dashboards, which enabled each hospital to monitor outcomes such as return to theatres, unplanned readmissions, transfers out and infection rates. The CGC shared and discussed the patient satisfaction dashboard at their March 2017 meeting.
- BMI Healthcare worked with the Private Healthcare Information Network (PHIN), which meant the hospital submitted data in accordance with legal requirements regulated by the Competition Markets Authority (CMA). This enabled effective comparison of patient outcomes by clinician improving transparency and patient choice.
- BMI also had a database, which measured performance for every consultant and made comparisons. This included incidents and complaints.

Competent staff

- Hospital data showed 18% of inpatient nurses, 67% of inpatient healthcare assistants (HCAs) and 25% of operating department practitioner/theatre healthcare assistants had completed their annual appraisal for this year (October 2016 to September 2017). None of the theatre nurses had completed their annual appraisal for this year at the time of our inspection. This meant the hospital might not have had assurances around the competencies of all staff involved in the care of surgical patients.
- The hospital reported 100% registered nurses, theatre operating department practitioners and consultants, who had worked for six months or more at the hospital, had their professional registration validated within the last 12 months.
- Staff completed a revalidation module on the electronic learning system. BMI corporate supported staff during the process of revalidation by running workshops for staff. Staff received an email to remind them when their registration was due to expire.

- We reviewed six competency folders, which showed staff were up to date with training. The competency folders had ten sections and included moving and handling, infection control qualifications and competencies.
- During our previous inspection, we found staff lacked knowledge of the WHO surgical safety checklist. During this inspection, the hospital had appointed a WHO Champion (a consultant at a local NHS Trust) and they had worked with theatre and ward staff providing workshops and learning opportunities.
- Subsequent to our inspection feedback the DoCS has confirmed that further training in the form of a workshop is being offered to theatre staff and consultants. It is timed to follow the next MAC meeting to encourage attendance.
- The hospital implemented a WHO checklist lead and the theatre board showed the responsible lead for each operation. The Director of Clinical Services (DoCS) told us the barrier to a team member effectively leading the WHO checklist process was less about their confidence to challenge consultant behaviour and more about their lack of confidence to speak out loudly in theatres. Management considered these staff might need 'Human Factors' training and this was completed in December 2015.
- All inpatients had a named registered nurse who was responsible for their care whilst admitted. However, HCAs who had completed the necessary competencies undertook the pre theatre checklist and escorted patients to theatre. The DoCS told us the HCAs were carrying out the pre surgery markings and identity checks on patients before they went to theatre but that the registered nurse remained responsible. The ward duty board identified the designated theatre escort HCA each day. The registered nurse did not directly supervise the HCA in this role. For each operation, the hospital held the registered nurse to account for work done by the HCA that the nurse had not had the opportunity to supervise.
- We asked a senior staff nurse how she had assurances about the competencies of bank and agency staff. She told us all bank staff received an induction and agency staff completed an induction checklist, which included fire safety and orientation to the ward. In addition to this, all bank staff had to complete mandatory training, which included acute illness management (AIMs).
- Bank staff had an induction to their area prior to starting work. The interim ward manager told us the ward did not book bank staff that had not completed the mandatory induction. This ensured the bank staff selected to work were familiar with the hospitals policies, procedures and environment.
- The hospital granted practising privileges to consultants, which gave consultants permission to practice as a medical practitioner at the hospital. The hospital's practising privileges policy detailed roles and responsibilities, relevant legislation, eligibility and function of the MAC. It also outlined the need for consultants to provide documentary evidence before being able to practice at the hospital. This evidence included their disclosure and barring service (DBS) enhanced check, self-declaration of registration with the General Medical Council (GMC), medical indemnity/ insurance and evidence of participation in appraisal.
- We checked four consultant files during our inspection and found one consultant had an out of date appraisal. Hospital data showed the hospital temporally suspended two consultants for non-production of essential paperwork. The hospital told us they reviewed consultant files on a regular basis to ensure they were up to date. The senior management team and the MAC chair discussed any areas of concern. The senior management team also conducted a formal audit of the consultant files every two years. This meant the hospital had robust systems in place to ensure their consultants were fit to work at the hospital.
- Hospital data showed there were eight consultants with practising privileges for cosmetic surgery, all of which had specialist registration with the GMC.
- The hospital told us there was ongoing clinical supervision with theatre and ward staff regarding the WHO 'Five Steps to Safer Surgery'. The senior management team carried out daily observation of their practice.

- Since our previous inspection, senior members of staff were given time away from the clinical environment for reflection. The staff member then had clinical supervision and mentorship from senior members of staff from other BMI hospitals.
- We spoke with a student nurse who felt supported by the team and had a designated mentor who signed off her competencies as her placement progressed.
- An agency provided the hospital with two RMOs and supplied evidence of their mandatory training. This included advanced life support training (ALS). We spoke to a new RMO who confirmed they had updated their ALS training in February 2017, had an annual appraisal with the responsible officer at the agency and completed a local induction prior to starting employment at the hospital.
- The RMOs were included in the hospital's resuscitation scenarios and management feedback any areas for improvement directly to the agency.
- Consultants sometimes brought clinical practitioners into the hospital to act as surgical first assistants (SFAs); however, they mostly used hospital theatre staff. SFAs worked closely with the surgeon to facilitate the procedure and process of surgery. Consultants who wished to use external SFAs were required to submit a permission form to the Executive Director for consideration. However, we found this was not always happening which meant the hospital did not have assurances around the competence of external staff.

Multidisciplinary working

- At our previous inspection, the multidisciplinary theatre team had started undertaking meetings. During this inspection, we saw the theatre team held these meetings three monthly and the meeting minutes showed equality and risk, feedback from hospital meetings and policies were a standard agenda item.
- Each morning the hospital held a daily communications cell, to which a representative from each department attended. We observed positive interaction and respectful communication between professionals during the communication cell on the day of our inspection. It enabled the wider hospital population to understand the daily tasks and challenges as well as communicating the presence of contractors or visitors on site. Staff documented the communication cell and archived the summary sheet.
- Throughout our inspection, we saw evidence of good multidisciplinary working in all areas. We observed the planned discharge of a patient, which involved the pharmacist, physiotherapist ward clerk and ward nurses.
- The hospital told us consultants attended a multidisciplinary meeting at the local NHS Trust. As part of the hospital's improvement plan, the DoCS was to attend a meeting and to develop a service level agreement (SLA) with the Trust to formalise this process.
- The hospital had SLAs with other service providers where needed, for example microbiology and infection prevention doctor at an NHS trust.

Seven-day services

- Since our previous inspection, the senior management team took the decision to close one complete theatre list per day until there were sufficient staffing levels within theatres to improve the wellbeing of the staff.
- An RMO provided a 24 hour seven days a week service on a rotational basis.
- The theatre team had an on call rota, which consisted of a scrub practitioner, an anaesthetic practitioner and a circulating practitioner. This ensured staff were available should a patient need to return to theatre out-of-hours.
- It was a requirement of BMI Healthcare's practising privileges policy that named consultants remained available by telephone, and in person if required, 24 hours a day, whenever they had a patient in the hospital. This ensured inpatients recovering from surgery over the weekend had 24-hour access to consultant input if needed. If a consultant was not available, the policy required them to arrange 'fit for purpose' cover.
- Staff told us they did not have trouble in contacting consultants to escalate concerns about patients.
- The hospital had a consultant anaesthetist and a consultant radiologist on call rota which ensured constant availability if required.

- The hospital had on-call rotas for clinical and non-clinical staff for example hospital administration, nursing, pathology and maintenance.
- The pharmacy department was open Monday to Friday 8:30am until 5pm. There was an on call pharmacist outside these hours.
- One member of staff told us rota and subsequent staff contact details of on call services such as pathology and pharmacy were only available online. Bank and agency staff did not have access to this system. The staff member had plans to implement a contact folder on the ward.

Access to information

- There were comprehensive pathway records available to staff that contained all the information staff needed to deliver effective care and treatment. These included risk assessments for venous thromboembolism (VTE), falls and nutrition, and medical notes.
- Staff sent discharge letters electronically to the patient's GP on the day of discharge, with details of the treatment provided, follow up arrangements and medicines provided. This allowed continuity of care in the patient's community.
- Theatres kept a breast prosthesis book with entries for each patient episode using traceability stickers. The hospital told us staff gave patients an implant card with the relevant information. Staff recorded information in the care pathway and operating notes. The hospital retained this information in the patient's medical record.
- For patients under 'SPOT' contract work, the hospital obtained medical notes for NHS patients from the local NHS hospital prior to the patient's pre assessment clinic. The hospital made a copy of the inpatient medical notes and sent this to the local NHS hospital for their records.
- The hospital could send and receive diagnostic images using a secure image exchange portal (IEP). If the other provider does not have IEP, the hospital could burn diagnostic images onto an encrypted CD.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent forms were audited four times a year. We saw the consent audit for March 2017. The audit was not specific to theatres and looked at various aspects of obtaining and documenting consent, including, but not limited to, use of correct form, patient's details completed fully, a record of information provided to the patient and documentation of risks, which may occur. Ten completed consent forms were audited to see if staff documented consent in line with policy. The audit showed an overall compliance rate of 87%. This is worse than the overall compliance rate of 96% in the previous audit in December 2016. This audit failed to identify the timescales for when staff obtained patient consent.
- We looked at six consent forms and found four patients had signed on the day of surgery. This meant staff did not obtain patient consent consistently in advance of the day of the procedure. This was not in line with guidance from the RCS Good Surgical Practice 2014, which states staff should "obtain the patient's consent prior to surgery and ensure that the patient has sufficient time and information to make an informed decision".
- We also found on two occasions, staff did not give a copy of the consent form to the patient for their records. The copies were in the patient's medical records.
- At the previous inspection, consent forms were illegible and some had missing patient information. During this inspection, we found one consent form, which was illegible, and the confirmation of consent was not completed.
- At the previous inspection, the consent forms did not contain any abbreviations that a patient may not have understood. During this inspection, we found three of the six consent forms had a lot of abbreviations for example SNB + OSNA + IBR with Beckel 35. The use of abbreviations can reduce clarity, increase mistakes and cause confusion in management plans.
- Hospital data showed 100% of relevant staff had completed online mandatory training on consent at the time of our inspection. This was better than the BMI corporate target of 90%. This did not include consultants.
- Ward staff told us the pre assessment clinic completed the mental capacity assessment and would notice if a patient had any advocacy needs.
- The hospital reported no Deprivation of Liberty Safeguards applications within the past 12 months.

Requires improvement

Surgery

- We saw corporate BMI policy on “Safeguarding Adults Policy: Incorporating Mental Capacity Act, 2005 and Deprivation of Liberties Safeguards and PREVENT (for review November 2018). During the inspection, staff provided us with their hard copy of the Mental Capacity Policy (for review January 2016). This meant there were out of date policies in circulation within the department.
- All staff received face to face mandatory training from the regional clinical educator on the mental capacity act in January 2017.
- Although staff had better awareness of dementia, all staff we spoke to told us patients living with dementia would lack capacity. This is not in line with the Mental Capacity Act, 2005 which states, a person is presumed to have capacity "unless all practical steps to help him (or her) to make a decision have been taken without success". There was limited understanding that capacity was decision specific.

Are surgery services caring?

Good

At our last inspection in 2016, we rated caring as good. We saw no evidence to suggest a change to the good rating for caring at this inspection.

Are surgery services responsive?

Requires improvement

We rated responsive as requires improvement

At our last inspection in 2016, we rated responsive as ‘requires improvement’. On this inspection, we have maintained the rating of ‘requires improvement’.

Service planning and delivery to meet the needs of local people

- Since our previous inspection, the hospital had suspended the children’s and young person’s surgical service.
- The hospital provided elective surgery Monday to Friday each week from 7am to 8pm and between 7am and 6pm on Saturdays.
- The hospital mainly treated private patients but also treated NHS patients through local contracts with NHS trusts and commissioners in Kent. This allowed local people to receive NHS-funded surgery at the hospital. There were 416 inpatient and 1409 day-case attendances to the hospital between September 2016 and February 2017
- Due to the elective nature of surgery and the reduced operating lists at the hospital, service planning was relatively straightforward because the workload was predictable.
- The theatre scheduler facilitated the booking of operations and co-ordinated with the theatre manager to ensure there were staff and resources available. Since our last inspection, the hospital had implemented weekly multi-disciplinary activity planning meetings to improve the management of theatre lists and resources.
- BMI had introduced a theatre utilisation tool (TUT) which was used to analyse theatre department processes. The hospital told us the tool increased the efficiency of the department by reducing staffing costs and highlighted capacity for additional caseloads.
- The hospital used the BMI Resource Model for theatres, which incorporated the The Association for Perioperative Practice (AfPP) guidelines. AfPP had recommendations for the number of staff on duty during a standard operating list. In addition, the hospital used a four week rostering system across all departments with variable shift patterns in line with the BMI Rostering Policy. This meant the hospital could plan appropriate staffing ratios based on the planned number of patients.
- The hospital offered free of charge parking for its patients. There was disabled parking access and a drop off point near the hospital entrance for patients with limited mobility.
- Patients’ friends and families had access to free tea and coffee on the ward. They also could order and pay to have food from the kitchens. Catering staff delivered the food to the patient’s room so patients and their families could eat together.

- GPs referred patients to the hospital via the “choose and book” system, or the local NHS Trust referred patients directly to the hospital.
- Staff sent patients detailed information about the surgery with the admission letter, which included admission date and time, payment details and pre-operative instructions such as fasting times. We saw examples of this information and it was in clear, simple language.

Access and flow

- There were 1,787 visits to theatre between September 2016 and February 2017.
- Hospital data showed the service cancelled 30 operations on the day of surgery, for a non-clinical reason within the last 12 months. The hospital offered only a third of these patients with another appointment within 28 days of their cancelled appointment. This was in not in line with the NHS Constitution pledge.
- The hospital had become stricter with their five day booking rule, which meant no patient could be booked in in less than five days unless they met strict criteria. This meant staff obtained medical information, carried out investigations, completed the pre-assessment and obtained tests results in time for the date of operation. The Director of Clinical Services or the Executive Director agreed and signed off additions to the operation list. Staff reported better compliance by consultants to this rule and felt empowered to challenge this.
- The reservation staff booked the operation dates on the hospital’s electronic system. The medical secretaries confirmed the list order with the surgeon, theatre teams and ward staff the day before admission.
- On arrival at the hospital, staff collected the patient from reception and showed the patient to the ward.
- Patients changed into theatre gowns and prepared for surgery in their room. A HCA who had undertaken the necessary competencies escorted patients to the theatre suite for their operation.
- Immediately after surgery, theatre staff cared for patients in the recovery room.
- Once patients were stable and pain-free, staff took them back to the ward to continue recovering. HCAs would escort patients who had local anaesthetic to ward. If a patient had sedation or general anaesthetic, a registered nurse would collect the patient. Patients had a responsible adult to collect, escort and stay with them for 24 hours if they were a day case patient. Inpatients stayed on the ward for one or more nights after surgery.
- Throughout our inspection, we observed five theatre cases and all cases ran on time.
- Nurses gave patients a direct telephone number to the ward on discharge. Patients could call this number and speak to a nurse, if they had any concerns, and the service was available 24 hours per day, seven days a week.
- The hospital used the corporate BMI policy ‘Referral to Treatment Access’ to manage their patient waiting times. The national guidance states no patient should wait longer than 18 weeks from referral to the start of their treatment. Patients under 'choose and book', are tracked for 18 week compliance via an internal data base.
- The hospital liaised with the local NHS hospital to monitor 'SPOT' contract patient wait times and help facilitate admissions to ensure no breeches occurred.
- The hospital monitored compliance regarding referrals to treatment timelines and patient listings on BMI's NHS Quality Dashboard and through the 18 week Referral to Treatment tool. Information regarding the hospital’s performance against waiting times was not available prior to the inspection.

Meeting people’s individual needs

- Staff assessed patients individual needs at the pre-assessment clinic including any cultural, linguistic, mental or physical needs.
- Hospital data showed 100% of managers and 90.1% of relevant staff had completed online mandatory training on equality and diversity at the time of our inspection. This was better than the BMI corporate target of 90%.
- Hospital data showed 96.9% of relevant staff had completed online mandatory training on dementia awareness at the time of our inspection. This was better than the BMI corporate target of 90%. The hospital was implementing online dementia awareness training for non-clinical staff. In addition to this, all senior nursing staff had attended face-to-face dementia training.

Requires improvement

Surgery

- At our previous inspection, staff had a lack of understanding regarding the specific needs of patients living with dementia. At this inspection, staff appeared to have a better awareness of dementia and we found staff could describe how they would meet the needs of a patient living with dementia for example, providing one to one care and use the 'This Is Me' Passport. This is a simple and practical tool, people living with dementia and their carers can use. It told staff about patient's needs, preferences, likes, dislikes and interests.
- We were unable to obtain feedback from patients and their relatives as there were no patients living with dementia in the hospital at the time of our visit.
- The Patient Led Assessment of the Care Environment (PLACE) results in 2016 showed the hospital scored 75% for dementia. This was slightly better than the England average of 74% for other acute/specialist hospitals. The PLACE audit dementia measure focused on key issues proven helpful to patients living with dementia. These included, flooring, decoration (for example contrasting colours on walls), and signage, along with seating and availability of handrails.
- An adult safeguarding lead gave us an example of when staff undertook a best interest assessment for a patient living with dementia. The team decided it was in the patient's best interest to have the surgery at a local NHS hospital due to the high risk of the patient's dementia worsening post operatively. However, this resulted in a patient complaint and we saw actions taken included implementing a dementia friendly room.
- At our previous inspection, we saw patient rooms were not adapted to meet the needs of patients living with dementia. During this inspection, we saw the ward had a dedicated dementia friendly room, which was closest to the ward reception desk. The room featured a clock indicating day and night, contrasting red and white cutlery and bowls, signage on the toilet and a red raised toilet seat. There was a dementia box which contained adhesive sheets. Staff would use the sheets to display messages on the wall such as 'your nurse today is' or the days date.
- Since our previous inspection, the hospital had appointed a dementia lead and had implemented a dementia standard operating procedure (SOP). The SOP outlined actions the staff could do to improve the patient's experience such as encourage the patient to dress in their own clothes, provide entertainment such as pictorial books and inform all housekeeping and portering staff of the patient's needs.
- Ward staff completed intentional rounding throughout the patients stay. This meant staff visited patients in their rooms hourly to check for example, if call bells and a drink were in reach, if the patient had pain or had any other requests.
- The PLACE results in 2016 showed the hospital scored 90% for Privacy, Dignity and Wellbeing. This was slightly better than the England average of 83% for other acute/specialist hospitals.
- The DoCS recognised that the hospital was not particularly good at meeting the needs of people with a physical or learning disability. The DoCS told us it was on the list of things to address but that the overriding safety concerns had been the priority. We saw the reviewing of information and facilities for patients with additional needs was on the hospital's improvement plan.
- Staff could not tell us how they provided extra support to patients with learning disabilities. One member of staff told us they would cater for this group of patients in the same way as they would for patients living with dementia.
- The PLACE results in 2016 showed the hospital scored 78% for disability. This was slightly better than the England average of 77% for other acute/specialist hospitals.
- Patient baths and showers had step access. Therefore, they were not accessible for wheelchair users.
- We saw three wheelchairs were accessible for patient use on the ward.
- A hearing loop recorder was available at the hospital two reception areas to support patients who are hard of hearing. Some staff have attended external deaf awareness training and staff can offer patients the use of an assistive listening device to aid communication.
- Patients had access to a variety of food, which ensured personal choice. The catering department could meet the cultural needs and religious beliefs of patients for

example, providing vegetarian and kosher options. Menus were available in a number of different languages including Polish, Iranian and Lithuanian as well as large print.

- Translation services were available from an external provider to provide face to face and telephone services if required and staff knew how to access this. We saw the hospital had completed a standard operating procedure (SOP) for the translation services, which the Executive Director was signing off.

Learning from complaints and concerns

- BMI Healthcare followed a three stage process in dealing with complaints, with clear timeframes set out in BMI Healthcare's complaints policy. The responsibility for all complaints rested with the Executive Director.
- The hospital received 40 complaints between January 2016 and December 2016 but information regarding how many related specifically to surgical services was not available. No patients escalated their complaints for independent review outside the hospital. The number of complaints for 2016 is similar to the number of complaints received in 2015 and 2014.
- We saw the hospital kept a complaints log, which included the date the complaint was received, the associated consultant, subject of the complaint, status, and action plan and follow up. We saw the hospital had closed and resolved 16 out of the 33 complaints received this year. Of the remaining 17 complaints, we saw all had been acknowledged, and were awaiting either a response from the patient or a meeting between patient and consultant, or were still being investigated. Five of the complaints related to a consultant who no longer worked at BMI Fawkham Manor.
- BMI recorded all complaints about consultants on the central database, which allowed trends to be identified.
- Staff we spoke to were aware of the corporate 'Complaints Policy' (for review April 2018). The provider's website had a section detailing how to make a complaint and how patients could escalate their complaint in the event of an unsatisfactory response from the hospital.
- Staff informed us the nurse in charge would speak to anyone raising a verbal complaint at the time they raised it. The aim was to try to resolve the issue at the earliest opportunity. If the patient was not satisfied, staff provided them with the complaints leaflet.
- We saw a space on the ward noticeboard for 'You said, We did', however this was filled with a poster displaying, 'Hello my name is'.
- Staff discussed all complaints at senior management, clinical governance committee (CGC) and department meetings. The CGC meeting minutes dated January 2017, showed staff discussed every complaint and its associated action plan. At our previous inspection, we saw the complaints action plan did not include any changes to policy or practice because of the complaint. This meant staff missed the opportunity to share learning from complaints. This practice remained unchanged at this inspection, for example, we saw the action plan consisted of actions taken as 'responded to patient'.
- At our previous inspection, we did not see posters informing patients and their relatives of how they could highlight any concerns. During this inspection, we saw posters displayed along the ward corridor informing patients how they can raise concerns.

Are surgery services well-led?

Requires improvement

At our previous inspection in 2016, we rated the service as 'inadequate' for well-led.

On this inspection, we have changed the rating to 'requires improvement' because we have seen improvement in key areas such as the development of a hospital risk register to ensure a comprehensive process in place to identify, understand, monitor, and address current and future risks, a change in leadership, which has had a positive impact on staff morale.

Subsequent to our inspection visits we have been provided with further assurance about the oversight of the way the WHO checklist is monitored and the requirement for consultants to uphold corporate policy.

Requires improvement

Surgery

Leadership / culture of service related to this core service

- The interim Executive Director led the management team and was supported by the interim director of clinical services, the quality and risk manager and operations manager. An additional eight managers who were part of the management team managed individual departments.
- The overall lead for the surgery service was the Director of Nursing, who was also the Director of Clinical Services. An interim clinical nurse manager led the surgery inpatient ward. An additional theatre manager was supporting the current theatre manager and the department at the time of inspection.
- On our previous inspection, we saw from time sheets in the theatre rest room that theatre staff were working long hours and often going without a break. This meant there was a risk that the workforce would become tired and affect staff morale. On this inspection, the hospital had reduced to one theatre; we reviewed the theatre logbook and saw there was a reduction in the operating hours.
- Some staff told us the uncertainty of not having a permanent Executive Director (ED) had affected morale. However, since the temporary ED had been in place, a member of staff told us "things are beginning to feel a bit more stable". Staff said the interim executive director was supportive and approachable. One member of staff said the executive director was "involved" and "approachable". Staff described knowing them on first name terms and were encouraged in conversation and feedback.
- Staff on our previous inspection exhibited a culture of discontent amongst theatre staff they did not have adequate support for their role. However, they said this improved since the new interim management team started.
- The new interim management team encouraged learning and a culture of openness and transparency. They operated an 'open door policy' and encouraged staff to raise concerns directly with them. We saw senior managers visiting the ward and theatres during our inspection, we saw them in the nursing handovers. Staff told us this was a normal daily occurrence.
- Staff told us they did feel they could raise concerns or have confidence that their concerns would be listened to. We were given examples of when this had occurred. There was an open culture in the hospital with non-medical staff feeling able to speak with medical staff on an equal basis.
- We spoke with a student nurses who told us that they felt well supported by their mentors and confirmed that the NMC rule, which stipulated that they must work with their mentor for 40% of the time spent on placement, was fully met.
- There was a staff turnover of 7% for all surgical services staff (both ward and theatre) between January 2016 and December 2016.
- Data sent to us by the hospital before the inspection showed, staff sickness (between January and December 2016) for inpatient nursing staff ranged from 0.5% in February 2016 to 11% in November 2016, and no levels of sickness in April 2016.
- Data sent to us by the hospital before the inspection showed, staff sickness (between January and December 2016) for inpatient healthcare assistants ranged from 2.4% in August 2016 to 16.5% in March 2016, and no levels of sickness in January and September 2016.
- Data sent to us by the hospital before the inspection showed, staff sickness (between January and December 2016) for theatre nursing staff ranged from 1% in June 2016 to 3.3% in December 2016, and no levels of sickness in January, February, August and October 2016.
- Data sent to us by the hospital before the inspection showed, staff sickness (between January and December 2016) for Theatre healthcare assistants and operating department practitioners ranged from 0.3% in June 2016 to 25% in February 2016, and no levels of sickness in January and April 2016.

Vision and strategy for this this core service

- The service shared the BMI Healthcare vision. This was to provide the best outcomes, the best patient experience, and the most cost-effective care.
- Staff we spoke with had some understanding of the goals and values of the hospital and how it had set out to achieve them. They gave us examples such as

keeping a safe and clean environment, and being empowered to make change. Staff were proud of the job they did and now felt they were being supported by interim management team.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- The hospital followed the corporate governance structure. The hospital held meetings through which governance issues were addressed. The meetings included Medical Advisory Committee (MAC), Senior Management Team (SMT), Infection Control and Health Safety and Environment meeting.
- The Clinical Governance Committee (CGC), met monthly. Items discussed, but not limited to, included complaints and incidents, reports from other clinical committees, and an update on the risk register. There was a standing agenda item to review external and national guidance and new legislation, such as Medicines and Healthcare Products Regulatory Agency (MHRA) patient safety alerts. This ensured the hospital implemented and maintained best practice, and any issues affecting safety and quality of patient care were known, disseminated managed and monitored. During our inspection we saw the minutes of the CGC held in December 2016, and January, February and March 2017.
- The MAC met quarterly and the minutes of the meetings held in December 2016 and March 2017, were reviewed. The minutes showed clinical governance areas such as complaint and incidents, review of practising privileges, and the CQC report were discussed. However, there was a lack of clarity about how the consultant body was held to account. The Quality and Risk Manager was unclear about how information from the hospital governance framework fitted and shared information with the MAC. We were told the MAC were held to account by the MAC chair.
- We saw the route cause analysis (RCA) investigation reports but we could not see evidence that the all findings and learning from RCAs following serious incidents was shared and discussed at the MAC. We looked at the MAC minutes and saw the RCA findings of the patient who went to theatre without site being marked, but there were no other clinical incidents or findings discussed.
- We were told there would be support for staff who challenged other staff's failure to comply with checklist. This included supporting staff to challenge consultants who were not complying.
- A letter had been sent from the MAC to all consultants about the last inspection findings but it did not appear to make explicit the requirement for consultants to follow hospital policy in respect of the WHO checklist. The letter appeared to focus on providing reassurance to the consultants that their businesses would not be unduly affected by the inspection findings.
- We could not find in the minutes of the MAC evidence about where the findings or lack of assurance around the WHO checklist had been discussed.
- However, subsequent to the inspection visits, we have been provided with assurance that a letter requiring consultants to comply with the theatre staff requests to undertake a comprehensive WHO checklist has been drafted and is being sent out to all consultants with practicing privileges.
- We have also been provided with training data from the trust in good theatre practice that is being opened to consultants and that is at a time they are likely to be able to attend.
- The DoCS was undertaking regular patient safety observations in theatres and the senior management team were no longer reliant on retrospective audits of paperwork for assurance.
- The MAC was not involved in the creation of the action plan to address the shortcomings identified at the previous inspection. We were told the chair of the MAC was involved in discussion and that 'elements' of the plan were shared at the MAC but there did not appear to be an expectation that the consultant body should accept responsibility and ownership of the problem.
- There was a hospital risk register, which staff reviewed at monthly clinical governance committee meetings as a standard item. However, the MAC Chair was not aware of any items on the risk register. When asked, the MAC chair said they felt there "were risks to the hospital, but none now". This meant the MAC was not aware of key risks to the service.

- A Quality and Risk Manager had been appointed but had only been in post three days at the time of our inspection visit. They worked three days each week.
- Their role was to look at the Patients Satisfaction Survey results, to review audit action plans and to monitor the audit programme. They attended but did not chair the Clinical Governance Meeting. There was acknowledgement from the Quality and Risk Manager that the current governance arrangements were not sufficiently robust to provide assurance about patient safety.
- The executive director (ED) or director of clinical services (DoCs) were responsible for submitting statutory notifications to CQC. There was an incident where no notification was received for an event in October 2016 where we would have expected to see a notification but we accept this was before the time the current ED and DoCs were in post. It is an offence not to notify CQC when a relevant incident, event, or change has occurred.
- The SMT met weekly and the minutes of the meetings held in September, October and December 2016 and March 2017, were reviewed. The minutes showed items discussed included complaints, incidents, patient feedback, and key departmental feedback.
- A 'Comms cell' meeting took place every morning, this was a meeting of key members of staff from each department, it allowed for communication of key issues, regarding patients, procedures and operational issues
- At the time of our inspection, the hospital had no reported incidents of sepsis, and did not collect specific audit data on sepsis. The director of clinical services told us, there was currently no lead for sepsis at the hospital, although it had been identified as something that was required.
- In September 2015, the National Safety Standards for Invasive Procedures (NatSSIPS) were published. The evidenced based standards are applicable to invasive procedures carried out within the surgery department at the hospital and aimed to reduce the number of patient safety incidents related to invasive procedures. There was a requirement for all organization's providing NHS funded care to implement local safety standards for invasive procedures. The director of clinical services confirmed that they had received a new NatSSIPS policy and were reviewing procedures locally to standardise practice, referred to as LocSSIPS.
- The Hospital Infection Control Committee (HIPCC) met quarterly, and fed into the clinical governance meetings. We saw the minutes of the HIPCC meetings held in September 2016 and February 2017. Items discussed, but not limited to, included infections and surveillance, outbreaks, infection control training, audits and decontamination.
- In our previous report, the executive director and the head of clinical services were not aware of the infection prevention and control issues that we highlighted in theatres. We spoke with the infection control lead that provided a good overview of systems and process now in place to manage infection control. This included the auditing of saving lives care bundles (sets of interventions that, when used together, improve patient outcomes), links to other organisations such Public Health England (PHE), escalation routes to the hospital management team. This was in line with NICE QS 61, statement 2 which states 'organisations that provide healthcare have a strategy for continuous improvement in infection prevention and control, including accountable leadership, multi-agency working and the use of surveillance systems'.
- The hospital had a designated water safety group (WSG), in line with the recommendations of the Code of Practice on the prevention and control of infections and related guidance ('the code'), Criterion 1 that describes the systems to manage and monitor the prevention and control of infection. This is also in line with requirement of Health and Safety Executive (HSE) L8; and Health Technical memorandum HTM04-01 A and B: guidance on the control of legionella. The WSG met quarterly and fed into the clinical governance meetings. We saw the minutes for February 2017. Items discussed, but not limited to, included legionella management, alerts and updates, and water sampling and results.
- The hospital had a newly designated decontamination lead, in line with the recommendations of the Code of Practice on the prevention and control of infections and

related guidance (the code), Criterion 1 that describes the systems to manage and monitor the prevention and control of infection. We saw decontamination, was included within the HIPCC meetings.

- The hospital had a new designated resuscitation committee, which fed into the clinical governance meetings. We saw the minutes for March 2017. Items discussed, but not limited to, included training compliance, scenario training, and audits to be undertaken. We saw a recent audit had been undertaken of the resuscitation trolleys throughout the hospital. Actions had been identified; however, there were no timescales for completion of actions.
- On our previous inspection, we found, the risk register was generally used for issues where control lay outside the hospital, and was not adequate for assurance of the assessment of risks pertinent to The BMI Fawkham Manor hospital and there were not processes in place to mitigate these risks. However, on this inspection we found the hospital had a risk register, which covered the whole hospital. The ED with regional support maintained the risk register.
- The hospital risk register had clear reference if the risk was a hospital risk or a department risk, with the department clearly identified within each risk description. This meant that staff were able to identify which area a risk is related to. Staff we spoke with were able to tell us what was on the risk register.
- The hospital risk register was divided into categories such as patient safety, facilities and infrastructure, leadership and workforce, governance, information management, financial, reputation, operational, and workforce health and safety. The risk register had an explanation of the risks, allocated key leads (accountable executive and responsible manager) who had responsibility for ensuring existing risk controls and actions were completed for the identified risks.
- The risk register was reviewed monthly at CGC meetings as a standard item to ensure that identified risks were on the register and if any risks had changed, they were re-categorised. We saw this in the CGC meeting minutes from December 2016 and January to March 2017.

Public and staff engagement (local and service level if this is the main core service)

- Patients were regularly asked to complete satisfaction surveys on the quality of care and service provided. We saw their satisfaction surveys were left on patient's bed, a box to place completed form. The hospital also gathered patient opinion from the friends and family test (FFT), and patient led assessment of the care environment (PLACE). Departments used the results of the survey to improve the service.
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction they have received. The test data for all patients between July to December 2016 showed the hospital had consistently high scores (98% and above) and the response rates varied between 26% and 71%.
- To address recruitment challenges, the hospital extended the reach of their advertising outside the local area. They were looking at new ways of attracting staff to the area and the hospital, including recruitment fair.
- In addition to this, the Senior Management Team took the decision to close one complete theatre list per day until there were sufficient staffing levels within theatres to improve the wellbeing of the staff.
- Staff were encouraged to recognise and celebrate success. There was an 'Above and Beyond' award scheme in place, where staff could nominate colleagues or patients could nominate a member of staff member. Successes were awarded in categories such as; outstanding care, innovative thinking, amazing support, true inspiration, brilliant leadership.
- The hospital held a twice-monthly staff forum for staff to come and discuss complaints/incidents that they may have been involved with, this was to share the learning.

Innovation, improvement and sustainability

- During this inspection we saw there were improvement from our last visit, including a refurbishment of theatre. The hospital showed us the further plans for theatres, which included a complete redesign. The executive director told us they had not yet consulted theatre staff, but this was planned as part of the next phase of the design process.
- The hospital were in the process of developing local safety standards for invasive procedures (LocSSIPS) within their theatre.

Requires improvement

Surgery

- The introduction of the HOUDINI nurse-led protocol is an innovative programme to help reduce the length of time a urinary catheter is place. The risk of a catheter-associated urinary tract infection (CAUTI) increases the longer a urinary catheter is in place. HOUDINI is a nurse led protocol urinary catheter insertion/removal protocol. The introduction of this protocol means nurses are empowered to either insert or remove a urinary catheter without having to wait for a consultant, which may delay the insertion or removal. HOUDINI is an acronym each letter represents a different reason a nurse should not remove a catheter, and, is a useful tool in reducing the number of days of urinary catheter usage, thus potentially reducing the associated risk of a CAUTI.
- Staff we spoke to in the departments were unable to give any examples of innovation or service improvements.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure failures to complete the WHO 'Five Steps to Safer Surgery checklist' are reported as clinical incidents.
- The provider must ensure that they comply with their regulatory duty of candour.
- The provider must ensure there is a contemporaneous written record of any pre or post-operative review is documented in patient records, in line with Royal College of Surgeons (2014); good surgical practice.
- The provider must ensure that there is a contemporaneous written record available for all patients, including those not admitted for surgery.
- The provider must ensure all staff receive an annual appraisal.
- The provider must ensure it has robust systems in place to assess the competence of and record the use of external first surgical assistants.
- The provider must ensure compliance with Department of Health's Health Building Note 26, when carrying our refurbishment works in theatres, including ensure infection control risks are minimised by making sure there is a clean and dirty work flow.
- The provider must ensure all items are off the floor in storage rooms to allow for effective cleaning.
- The provider must ensure staff record medicine fridge temperatures daily to ensure medicines remain safe to use.
- The provider must ensure there are appropriate records and storage of all controlled drugs in line with national legislation.
- The provider must ensure staff wear the appropriate personal protective equipment provided to protect themselves and other against the risk of cross infection.
- The provider must ensure waste bins are labelled and bulk storage of waste is secure in accordance with HTM 07-01.
- The provider must ensure they have assurances of DBS checks and evidence of appraisals for all consultants with practicing privileges.

Action the provider SHOULD take to improve

- The provider should take action to ensure there is permanent control of access into the ward.
- The provider should ensure compliant hand hygiene sinks in patient bedrooms are included when carrying out refurbishment.
- The provider should ensure that medical staff documenting in patient notes do not use abbreviations.
- The provider should consider displaying results of safety thermometer audits.
- The provider should ensure all zipped foam items are included in the yearly audit
- The provider should ensure staff have awareness on how to meet the individual needs of patients with learning disabilities.
- The provider should ensure that bathrooms are accessible to people reliant on a wheelchair.
- The provider should ensure it robustly discusses and documents the actions taken in response to complaints within senior meetings.

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
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **(1)**Care and treatment of service users must only be provided with the consent of the relevant person. **(3)** If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act. The provider was not meeting the regulation because patients were being asked to give written consent on the day of surgery. Not all patients were given copies of their consent forms and there were abbreviations used that patients were unlikely to understand. Staff did not demonstrate a good understanding of the Mental Capacity Act 2005 and the impact of this on their work.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment (1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks;

This section is primarily information for the provider

Requirement notices

(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;

(d) ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way;

(e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;

(f) where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs;

(g) the proper and safe management of medicines;

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

Controlled drugs on the ward were not always recorded in line with national legislation and guidance. Fridge temperatures were not always monitored and recorded on a daily basis to provide assurances about the safety of refrigerated medicines. Some equipment was stored on the floor, which created a risk of cross-contamination. Surgical services were not on target to ensure all staff received an annual appraisal to provide ongoing assurances around staff competencies.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment (1) All premises and equipment used by the service provider must be— (b) secure, (c) suitable for the purpose for which they are being used, There were no compliant hand washing sinks in patient bed rooms.

This section is primarily information for the provider

Requirement notices

A lack of storage resulted in potential risk of cross contamination between clean and dirty equipment.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance (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); (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; The medical advisory committee did not have sufficient understanding of risks relating to the hospital. The provider did not have a copy of records of Consultation or care provided by employed staff where the patient was not admitted as an inpatient. The provider did not have up-to-date assurances of DBS checks for all consultants.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

This section is primarily information for the provider

Requirement notices

(1) Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.

(2) As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a registered person must—

(a) notify the relevant person that the incident has occurred in accordance with paragraph (3), and

(b) provide reasonable support to the relevant person in relation to the incident, including when giving such notification.

(3) The notification to be given under paragraph (2)(a) must—

(a) be given in person by one or more representatives of the registered person,

(b) provide an account, which to the best of the registered person's knowledge is true, of all the facts the registered person knows about the incident as at the date of the notification,

(c) advise the relevant person what further enquiries into the incident the registered person believes are appropriate,

(d) include an apology, and

(e) be recorded in a written record which is kept securely by the registered person.

Following a serious incident in February 2017, no written response was provided to the person involved.