Medical Services International Limited

# Cromwell Hospital

**Inspection report**

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

## Ratings

| | |
|---|---|
| Overall rating for this location | Good |
| Are services safe? | Requires Improvement |
| Are services effective? | Good |
| Are services well-led? | Good |

# Summary of findings

## Overall summary

Our rating of this service stayed the same. We rated it as good because:

- The service documented incidents well and practiced shared learning.
- Staff provided care and treatment based on national guidance and evidence-based practice.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported, and valued.
- The service showed a positive response to the last CQC inspection report and had made all the recommended improvements.

However:

- Staff were unclear with the correct procedures on how to handle an immediate threat to life.
- Managers did not document or formally monitor staff competence after the initial induction period.
- Staff were clear about their own roles; however, they were unclear of who fulfilled local senior roles such as the radiation protection advisor.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Diagnostic and screening services** | Good  | Our rating of this service stayed the same. We rated it as good because:<br>• The service documented incidents well and practiced shared learning.<br>• Staff provided care and treatment based on national guidance and evidence-based practice.<br>• Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported, and valued.<br>• The service showed a positive response to the last CQC inspection report and had made all the recommended improvements.<br>However:<br>• Staff were unclear with the correct procedures on how to handle an immediate threat to life.<br>• Managers did not document or formally monitor staff competence after the initial induction period.<br>• Staff were clear about their own roles; however, they were unclear of who fulfilled local senior roles such as the radiation protection advisor. |

# Summary of findings

## Contents

# Summary of this inspection

## Background to Cromwell Hospital

Cromwell Hospital is operated by Medical Services Internal Limited. The hospital opened in 1981. It is a private hospital located in London. The hospital serves the local community as well as having a wide national and international patient portfolio. The hospital recently appointed a new registered manager, registered in September 2022. Although the appointee had been in post as the chief medical officer since January 2022.

This was a focused inspection that was triggered by information of concern that we received through our enquires. During the last CQC inspection carried out in 2018, we found areas of concern in the documentation of cleaning, the MRI safety barrier, the vetting of MRI scans and child appropriate waiting areas. We looked at all of these areas of concern during this focused inspection and found that the service was now compliant.

## How we carried out this inspection

We carried out this short notice inspection using our focused inspection methodology on 20 February 2022.

During the inspection process we:

- Reviewed areas of concern highlighted through enquires directly to the CQC.
- We also looked at areas of concern highlighted in the previous inspection report in 2018.

The inspection was carried out by a CQC Hospital Inspector and a Specialist Advisor. The main area we looked at was the diagnostic department. We also followed up areas of concern in the surgical department which had been identified from the same enquires. During the inspection we spoke with approximately 14 staff members including the registered manager.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

## Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

**Action the service MUST take to improve**:

- The service must ensure that staff are aware of the correct procedures to follow in case of a deteriorating patient; including, ensuring appropriate staff attendance to crash simulations. (Regulation 12: Safe care and treatment)

**Action the service SHOULD take to improve:**

- The service should ensure that resuscitation crash trolleys are sealed at all times.
- The service should ensure robust, documented competency checks are in place. For example, immediately after an incident, change to procedure or when introducing new machines, protocols, or techniques.

# Summary of this inspection

- The service should consider displaying local rules so that staff have unhindered access to it.
- The service should ensure that items were not stored in boxes on the floor in theatres.
- The service should ensure that actions to make improvements are included in all audit results.

# Our findings

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| **Diagnostic and screening services** | Requires Improvement | Good | Not inspected | Not inspected | Good | Good |
| **Overall** | Requires Improvement | Good | Not inspected | Not inspected | Good | Good |

Good

# Diagnostic and screening services

| | |
|---|---|
| Safe | Requires Improvement |
| Effective | Good |
| Well-led | Good |

## Is the service safe?

Requires Improvement

Our rating of safe went down. We rated Safe as Requires Improvement.

### Environment and equipment

**The design, maintenance and use of facilities and premises mostly kept people safe.**

Prior to the inspection CQC received comments about the location of emergency equipment in the diagnostic department. On inspection we saw the crash trolley housed in a suitable space and was accessible.

We looked at the crash trolley for CT and saw that it had not been resealed after it had had its daily check. This meant that medication in the crash trolley could be removed, we informed staff about this, and this was rectified immediately. We looked at the medical consumables on the crash trolley which were all found to be in date. We looked at the logbook for the crash trolley which was well completed with staff signatures.

Local rules in a diagnostic department refers to a document for safe working arrangements and administrative controls intended to restrict doses to individuals working in a radiation-controlled area, and other persons who may be affected. A copy of the local rules must be displayed in all designated areas and those staff working with radiation must have unhindered access to the relevant local rules. Essential contents of local rules include, dose investigation levels, contingency arrangements, name of radiation protection supervisor and advisor, identification of area covered and working instructions. We did not see a copy of the local rules displayed within CT however, staff knew how to access this on the intranet. We were not assured that staff could access the local rules if IT systems or the internet went down and were unassured that staff had unhindered access to it. It is best practice for local rules to be obvious and on display.

Prior to the inspection CQC received an allegation informing us of non-compliance within theatres. In particular staff refusal to wear lead aprons during a mobile scan, emitting radiation in theatre. Staff we spoke with provided reassurance that lead aprons were worn at appropriate times in theatre by the appropriate staff members. We saw lead aprons neatly stored and easily accessible to all staff in the theatre corridor.

The environment in theatres was unorganised. We looked at the storeroom and saw boxes directly on the floor which was a hazard and not suitable for infection prevention control. This was discussed with the registered manager post inspection, the service was already aware of this hazard and had ordered new shelving units to organise equipment more efficiently.

Good

# Diagnostic and screening services

In the X-ray area we saw that the service had made improvements recommended from the last inspection including a separate waiting area for children waiting for a diagnostic image. Children waited for a CT scan in a newly decorated paediatrics wing and was walked into the CT department by staff when it was their appointment time.

In MRI we saw that the service had amended the safety barrier to the MRI unit that was found to be broken during the last inspection.

## Cleanliness, infection control and hygiene

**The service kept equipment and the premises visibly clean.**

Equipment and premises within diagnostics were visibly clean. During the last inspection it was noted that there was a lack of documented evidence to record effective cleaning. During this inspection we saw a detailed documented cleaning check list, including flushing of the taps and the cleaning of the toilet, floors, and the hand wash basin. The list was signed and completed daily, and information was inputted into an electrical spreadsheet. This spreadsheet was used to perform cleaning audits and measure compliance. Staff meeting minutes we looked at reflected the change to the cleaning schedules and minutes were shared with all staff.

### Staffing

**The service had enough staff with the right qualifications, skills and experience to keep patients safe and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.**

Prior to the inspection CQC received an allegation alleging poor recruitment processes. We spoke with a superintendent radiographer and found that they had been promoted after a robust recruitment methodology, which included two interview processes. We also spoke with staff in MRI who said that all staff were encouraged with job promotions and there was an equal opportunity to progress.

68% of posts were filled by permanent staff including 9% in interim positions that included one superintendent position. 23% of these posts were filled by bank and agency staff; including the lead CT radiographer. The MRI and plain film imaging department were fully staffed and there was one vacancy in CT. All agency staff were long term staff and were given full inductions at the hospital and were familiar with working at the hospital.

A 13-page induction booklet which included, but was not limited to; mandatory training, polices, IT systems and protocols were available for staff.

All agency shifts were block-booked in advance.

## Assessing and responding to patient risk

**Staff could not identify the correct procedure for how to quickly respond to patients at risk of deterioration.**

Prior to the inspection CQC received an allegation regarding patients in theatre often getting anesthetised prior to all radiographer staff and equipment being present and available. Staff we spoke with provided mixed feedback on this. When we spoke to senior staff, they confirmed that this had happened once within the last 12 months. An incident form was completed, and it was found that a patient had been anaesthetised and waited on an operating table for 30 minutes pending the arrival of a radiographer. The incident was still under investigation at the time of the inspection this was within the timescales of the incident management policy.

Good

# Diagnostic and screening services

During the inspection surgical staff told the CQC that sometimes the wrong patient ended up in the wrong theatre. Staff we spoke with thought that this was because the theatre rooms were not numbered in a sequential order. The error had been resolved and rectified before the operation had begun. There had been one case of this incident recorded over the last 12 months.

Diagnostic staff identified that lone working occurred on weekends however, there was an out of hours Standard Operating Procedure (SOP) to follow. Radiographers identified that lone working was a risk, we raised this with the senior leadership team who stated the CT staff members were not alone as the nurses from the ward would be present with patients from the wards to assist. We looked at the SOP and saw that it was in date and up for review in January 2025. The SOP made a clear reference to CT scans being performed with a physical accompaniment of a registered ward nurse throughout the duration of the scan, which was in line with the clinical lone worker best practice. There was also a lone worker policy in place which stated that staff were able to retrieve a lone working pager from security before their shift, to call for help or assistance if required.

Saturday clinics were held to deal with patient demand, these clinics ran from 8am to 4pm. There were no out of hours MRI services due to low patient demand. If a patient was required to have an MRI scan out of hours, then one MRI radiographer would be called in to perform the scan.

We were not assured that correct procedures would be followed in an emergency as staff stated that they would do multiple things to call for help. This included pressing a button on a handset that staff would carry, calling 2222 and using a wall panel to ask for help. We raised this with the senior leadership team who confirmed that the correct response to ask for assistance was to call 2222. We looked at the SOP for outpatients and diagnostics on the management of clinically unwell patients which was updated in 2021 and up for renewal in 2024. There was no mention of the wall panel but, there was a clear reference made to call 2222 if there was an immediate threat to life. This was outlined clearly via a flow chart.

We asked radiographers when they last tested the control panel, and they did not know. Staff assumed that security staff tested this. We raised this with the senior leadership team, and they were unable to identify when they last tested the control panel. We were sent a report carried out by the control panel manufacturer stating that preventative maintenance had been carried out along with electrical safety tests in July 2022. The control panel was ready for use and subject to appropriate customer acceptance testing. We did not see documented testing from the service for this piece of equipment. Further data provided showed that the Cromwell Estates Team had performed a preventative maintenance task check on 17 January 2023 and had replaced the batteries in the panel.

Staff we spoke with stated that they had not performed any crash simulations within CT to help prepare them for an emergency. We obtained evidence that a recent resuscitation simulation was performed in March 2022 and repeated in August 2022. We looked at the attendance record for the exercise and saw there was a total of three staff members in March and two in August. However, one of these staff members no longer worked for the service.

## Incidents

**The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.**

Good

# Diagnostic and screening services

Prior to the inspection CQC received an allegation informing us that the duty of candour was not exercised when things had gone wrong. Duty of candour training was not a mandatory training module for all staff. Despite this, staff we spoke with were familiar with exercising a duty of candour and were able to provide examples of when to do this. We saw that incident forms had a clear space to document if and when a duty of candour was exercised. Managerial staff informed us that they had not had to exert a duty of candour in the last 12 months.

Prior to the inspection CQC received an allegation regarding the ability to report an incident due to a blame culture at the service. Staff we spoke with unanimously said that they knew how to raise and report an incident and felt comfortable in doing so. Managerial staff informed us of a change in the processes around inputting an incident via the electronical incident system. Using the system previously meant that you could be identified as the person who raised the incident. Avenues became available to staff to allow for anonymity when raising an incident. Also, the incident management policy referred staff to a speak up policy. The service worked to ensure a no blame culture and shifted the focus onto learning and improving.

Prior to the inspection CQC received an allegation regarding outcomes of incidents going unanswered or were replied with 'staff training.' We looked at four closed incidents between March and February and found that all incidents had a different type, category and subcategory. The incidents were also reported by severity. All incidents we looked at were closed off and did not have generic responses. We saw that the provider focused on the incident alone rather than the individuals involved.

## Is the service effective?

Good

Our rating of effective stayed the same.

### Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence-based practice.**

Prior to the inspection CQC received an allegation that alleged that there was poor compliance in completing World Health Organisation (WHO) checklists concerning the use of radiation, including in surgery. We requested WHO audits and found that there was a 97.8% compliance in radiology in February 2023 with clear indications on how to improve. This was an improvement of 2.71% from the previous audit in January 2023. We looked at the WHO checklist for surgery and specifically looked at the data where there was a crossover between radiology and surgery. It was found that in all four cases audited all team members were present during their sign in, time out and sign out periods, including a radiographer.

Prior to the inspection CQC received an allegation regarding non justified portable imaging of patients. However, radiographers we spoke with had a good understanding of Ionising Radiation (Medical Exposure) Regulations. Staff knew their legal obligation as operators to refuse to justify an exposure when insufficient or incorrect clinical information was provided by a referrer.

Good

# Diagnostic and screening services

Prior to the inspection CQC received an allegation about patients in intensive care being scanned more often than required resulting in unnecessary doses of radiation. We spoke to a general superintendent and was told that staff checked the imaging system before scanning ITU patients. The radiographers checked to see if any other scan had been done in the last 24 hours. If a scan was still required a discussion would take place between the radiographer and the referrer and documented.

## Competent staff

**The service did not make sure staff were competent for their roles.**

Prior to the inspection CQC received an allegation regarding poor training or lack of qualifications in CT. During the inspection we found that five patients were scanned in the PET-CT scanner using a CT protocol for hip and knee scans. The protocol was not optimised for PET-CT and therefore these patients received a slightly higher dose. Although the doses received in PET-CT were still justifiable the scans were not in adherence to As Low As Reasonably Achievable (ALARA) principles set out by the National Council of Radiation Protection (NCRP). This was an ongoing risk reviewed in the latest clinical staff meeting and at the radiation protection medical exposures committee.

During the inspection we found that staff were signed off as competent as part of their induction period. Staff obtained competencies by modalities, i.e., CT or MRI. Competencies were supervised by lead radiographers and signed off. However, there were no formal processes in place to reassess competences after the induction period. Senior staff we spoke with said that radiographers were supervised on an ongoing basis, but there was no documented evidence to show staff competence after their induction period. Reassessments of competencies usually occur after a set time, after new clinical updates or after an incident. There was no evidence of competency reassessment after the PET-CT incident where five patients received higher radiation doses.

Three patients had been rescanned in the last 12 months. All three scans were classed as an unintended exposure as per the Significant Accidental and Unintended Exposures August 2020 guidelines. Two were a direct result of an operator error and one was a requestor and communication error. All three over exposures did not fit the criteria for a notification. Again, there was no evidence for a competency reassessment for all staff involved in the three incidents.

Prior to the inspection CQC received an allegation about the competency of staff in the diagnostic department. When questioning staff, they were unfamiliar with the departments Diagnostic Reference Level (DRL). This is a tool for medical imaging procedures using ionising radiation. The tool gives an indication of the expected radiation dose received by an average sized patient undergoing a given imaging procedure. The service was currently using the National DRLs known as NDRL which are set by the government and had not calculated their own Local DRL known as LDRL. LDRLs were finalised and published in March 2023 based on 2022 data. This was disseminated to all superintendents.

Prior to the inspection CQC received an allegation that alleged that image requests were done by inappropriate staff, including nurses. All staff we spoke with informed us that image requests followed protocol and were completed by the correct senior staff members. Radiographers we spoke with had a good understanding of Ionising Radiation (Medical Exposure) Regulations. Staff knew their patients must only be referred for a medical exposure by a registered health care professional referrer. We looked at a documentation audit for PET-CT from July to December 2022 and found 98% of request forms were fully compliant and up by 4% from the previous audit. We did not see an action plan for further improvements. Audit outcomes for request forms for MRI showed a decrease in compliance at 71% in January 2023. Actions had been implemented to improve the level of compliance and a repeat audit was due in July 2023.

We found that radiographers had regular one to ones with their line manager.

Good

# Diagnostic and screening services

## Seven-day services

**Key services were available to support timely patient care.**

Prior to the inspection CQC received an allegation regarding non justified imaging of patients due to a lack of cover at the weekend. We were notified that a patient was scanned using a CT scanner instead of an MRI scanner over the weekend as there was no MRI cover. This meant that the patient was exposed to radiation that could have been unnecessary as MRI's do not emit radiation. Staff we spoke with in MRI confirmed that there was now an MRI clinic that runs on a Saturday between 8am and 4pm. Sunday cover met the needs of the service demands which were low. There was currently no on-call MRI service.

## Is the service well-led?

Good

Our rating of well-led stayed the same.

**Leadership**

**Leaders had the skills and abilities to run the service. They supported staff to take on more senior roles. Senior leaders including the chief executive were visible and approachable in the service for patients and staff. However more localised leaders were not so visible to staff.**

Prior to the inspection CQC received an allegation about poor visibility of the Senior Leadership Team (SLT). We asked staff how often they saw the SLT, staff reported seeing them daily on their walk arounds in diagnostics and at the coffee bar in reception. Staff could name members of the SLT and spoke highly of their leadership team this included the chief executive.

However, we found poor local oversight of senior members of staff in diagnostics and medical physics department. Staff could not correctly recall the name of the Radiation Protection Advisor, the Radiation Protection Supervisor, or the Medical Physicists Expert. This information is normally found on the local rules and was not on display in CT.

## Culture

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**

Prior to the inspection CQC received an allegation about bullying in the diagnostic department from referrers and the SLT to operators. Staff we spoke with denied these comments and referred to scenarios where there had been situations of high pressure to scan a patient, but clear communication had provided positive outcomes.

The daily schedule for MRI scans had daily slots booked out specifically for in-patients which meant that urgent requests by senior medical staff to scan a patient could be fulfilled avoiding challenges for urgent requests and improving the culture within MRI.

Staff we spoke with said that most reporting radiologists and consultants were very approachable and that they had a good relationship with them.

Good

# Diagnostic and screening services

Staff we spoke with were happy with changes made in the department and expressed that they were happy that they had a voice that was listened to. They gave us an example of the change in process for the vetting of MRI scans which was also picked up in the last inspection. Radiographers had raised concerns in MRI with non-clinical staff vetting patients for MRI scans. This sometimes led to a miscommunication in what the referring doctor wanted scanned and could end up in repeated scans. Radiographers raised this with senior staff and the responsibility of the vetting process shifted to radiographers. Radiographers we spoke with described how they would look at the patient list for the next day to identify and read clinical notes to ensure scans included the appropriate anatomy. This was a newly implemented task and work had not yet been done to show the effectiveness of this change.

We looked at the last staff survey results for radiology completed in November 2022. There was an 84% response rate which was 16% higher than the previous rate recorded. There were also 68 more comments in the survey compared to the last survey which indicated that staff felt happier to provide feedback and comments. The survey showed an increase in staff being confident to use the speak up service if they were unable to raise concerns with their manager.

The quality and safety boards in the diagnostics department had a space for suggested improvements that staff could write on anonymously. These suggestions were an ongoing item discussed in team meetings and documented in meeting minutes. Suggestions made in January 2023 included increased staff recognition, refreshing certain areas in the department, and encouraging and providing healthy eating for staff and patients. All suggestions had actions to implement a positive change.

Staff had recently improved their communications with theatres and attended regular catch up meetings with theatres on Fridays.

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 | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>**Regulations 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**<br><br>Regulation 12<br><br>The provider did not ensure that robust systems were in place to ensure staff knew the correct procedures to take in case of an emergency. Staff numbers that attended the crash simulation was low, and although the exercise was within the last 12 months some of staff that attended the simulation no longer work at the service.<br><br>Providers must do all that is reasonably practicable to mitigate risks. They should follow good practice guidance and must adopt control measures to make sure the risk is as low as is reasonably possible.<br><br>They should review methods and measures and amend them to address changes in practice and staffing. |