BMI The 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?	Good
Are services well-led?	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an announced inspection visit of BMI The Manor Hospital on 6 and 7 October and an unannounced inspection on 14 October 2015.

Our key findings were as follows:

Are services safe at this hospital?

By safe, we mean that people are assured that they are protected from abuse and avoidable harm.

- Staff were encouraged to report incidents and there was an incident reporting system in place that staff were aware of.
- Feedback from incidents was varied and we were not reassured that staff learnt from all reported incidents.
- The hospital reported no never events and no serious incidents. However, when we looked at a small sample of incidents, we found two that had been incorrectly categorised and should have been graded as serious.
- Incidents were not always investigated thoroughly before being closed.
- No one in the hospital, including the senior team, had undergone root cause analysis training.
- Theatre staff did not follow best practice national guidelines according to the Association for Perioperative Practice, or the BMI policy for peri-operative swab, instruments and needle counts. Swabs, instrument and needle counts were not displayed on a white board in the operating theatre, whilst the operation was taking place, although this had been rectified at our unannounced visit on 14 October 2015.
- Potential risks to patients due to the environment and equipment were not adequately identified, including throughout planned refurbishment of the outpatient department which did not meet relevant Health Building Notes (HBN).
- In outpatients, taps did not comply with HBN 00 -10 Part C: Sanitary Assemblies.
- Sharps were not always treated in line with best practice.
- Services were generally clean and equipment was cleaned between patients; however we noted that in outpatients some areas did not appear to have been cleaned thoroughly.
- In the operating theatre, we found a piece of clean equipment stored in the dirty utility room, which did not comply with the recommendations of HBN 00 – 09.
- We observed the cleaning and decontamination of dirty endoscopes in the same room where clean endoscopes were stored. This posed a risk of cross contamination between dirty and clean endoscopes. There was no risk assessment in place to mitigate this.
- We were told that major operations were not commenced after 7pm and minor after 7.30pm. The staff were not aware of any formal policy to support this. However, we found this was not the case and patients were returning to the ward during the night shift when fewer staff were available.
- Staffing levels, skill mix and caseloads were not always planned and reviewed by the senior ward staff, so that people received safe care and treatment at all times.
- An early warning score system was used to alert staff, should a patient's condition start to deteriorate.

Summary of findings

- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists registered with the General Medical Council (GMC). The consultants were mainly employed by other organisations (usually in the NHS) in substantive posts and had practising privileges (the right to practice in a hospital) with BMI The Manor Hospital.
- Staff were aware of their role and responsibilities with regards to safeguarding and 100% of staff were up to date with adult's safeguarding and level one safeguarding children's training.
- Patient records were up to date; risk assessments had been completed and documented for patients undergoing surgery, including the 5 Steps to Safer Surgery safety checklists. However, we found that records were not stored securely throughout the hospital.

Are services effective at this hospital?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Some staff were accessing out of date policies. For example, The
- The endoscopy department did not have Joint Accreditation Group (JAG) or a Global rating score (GRS) or a similar system for collecting data for endoscopy patients.
- All patients were given standard fasting instructions aligned with the recommendations of the Royal College of Anaesthetists. However, despite this, due to admission times and eventual theatre attendance, patients were often fasting longer than required.
- We saw assessments of people's needs were comprehensive and included the assessment of pain.
- There was recording and reporting of some patient outcomes, including pain. However, there was no audit plan for the outpatients department.
- The role of the Medical Advisory Committee (MAC) included ensuring that consultants were skilled, competent and experienced to perform the treatments undertaken. These were reviewed annually.
- There was a process in place for checking General Medical Council and Nursing and Midwifery Council registration, as well as other professional registrations.
- There was a lack of formal supervision for nursing staff.
- Competencies for nursing staff in various areas such as bladder scanning and medicine competencies were not up to date.
- Staff were confident about seeking consent from patients and staff had received training on the Mental Capacity Act 2005.

Are services caring at this hospital?

By caring we mean that staff involve and treat patients with compassion, dignity and respect.

- Patients were treated with dignity and respect.
- We observed good interaction between patients and staff. Staff explained procedures and gave appropriate information to patients to help them to understand and be involved in decisions concerning their treatment. Initial consultations and pre-admissions assessments were thorough and included consideration of patients' emotional well-being.
- Most patients spoke positively about the care provided by staff. Patients we spoke with commended staff saying they were friendly and very attentive.

Summary of findings

- The hospital sought feedback from patients about the service using a BMI questionnaire and the Friends and Family Test. The results were positive as 84% of patients said they would recommend the hospital as a good place to go for treatment.

Are services responsive at this hospital?

By responsive we mean that services are organised so they meet people's needs.

- Information about services provided at the hospital was provided in a way patients understood and appreciated. Staff told us that should a patient have communication problems they were able to address their individual needs. However, not all staff were aware that the hospital had access to an interpreting service.
- The patients we spoke with told us that access to the hospital was good and did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- Staff said they were able to accommodate people's religious needs both pre and post operatively. They said they could contact the local community that offered support for example, church, mosque, temple or synagogue.
- National waiting time targets for referral to treatment (RTT) times in surgery were within 18 weeks (admitted pathway). The hospital met the target of 90% of admitted patients beginning treatment within 18 weeks of referral, for each month in the reporting period, July 2014 to June 2015.
- There was information on the process for making complaints for patients. There were few complaints; all were responded to within industry standard timeframes.

Are services well led at this hospital?

By well-led, we mean that the leadership, management and governance of the organisation, assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- There was a governance structure in place, with committees such as the governance and risk team feeding into the medical advisory committee (MAC) and hospital senior management team. The governance and risk committee was also responsible for clinical governance in the hospital.
- The clinical governance committee, discussed incidents in general. Some had been categorised incorrectly. Appropriate action following incidents was not always taken in both the CG and MAC.
- We were not assured that the senior management team had sufficient control of or oversight of risk within the hospital. The hospital had a risk register in place; however, it was limited and key risks were not assessed and registered.
- We saw evidence of anaesthetists and consultant surgeons being reviewed and discussed at the MAC. Consultants had their practising privileges suspended by the Executive Director if they did not provide the relevant information in a timely manner.
- Appraisal rates were at 100%.
- Staff spoke positively about the high quality care and services they provided for patients and were proud to work for the hospital.
- Staff reported that all their managers, including the Executive Director were visible. Staff told us that senior management were supportive and staff felt able to raise concerns.

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

Summary of findings

Importantly, the provider **must**:

- Ensure enough staff with the appropriate skills are available to care for patients.
- Ensure that all equipment used by the service is clean and stored correctly.
- Ensure sharps are disposed of correctly.
- Ensure clean and dirty equipment is not stored in the same area.
- Ensure the new outpatient room conforms to building regulations.
- Ensure hand wash sinks conform to building regulations.
- Ensure that there is a sufficient supply of personal protective equipment in all consultation rooms.
- Ensure that equipment checks in place are carried out efficiently in accordance with the hospitals policy or to identify all concerns.
- Ensure that incidents are categorised correctly and fully investigated before being closed.
- The provider must ensure effective systems are in place to assess, monitor and improve the quality and safety of the services provided; including undertaking relevant audits to monitor and improve patient outcomes.
- Ensure effective systems are in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users, including ensuring that the risk register is reflective of service risks.

In addition the provider **should**:

- Ensure records are always stored securely.
- Ensure root cause analysis training is undertaken for at least senior staff.
- Ensure all incidents are recorded and staff receive feedback and learn from incidents.
- Ensure that staff receive formal supervision and appropriate competencies
- Ensure staff receive training to care for patients with dementia.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Requires improvement** 	Surgical services were found to be inadequate with regards to being well led. Improvement was required with regards to both safety and effectiveness. Caring and responsiveness were good. Theatre staff did not follow best practice national guidelines according to the Association for Perioperative Practice, or the BMI policy for peri-operative swab, instruments and needle counts. Swabs, instrument and needle counts were not displayed on a white board in the operating theatre, whilst the operation was taking place. In-patient areas were visibly clean, tidy and appropriately equipped. Infection control policies were followed, although we found a clean piece of equipment stored in the dirty utility room. The hospital reported they had no serious incidents, although we found two that should have been categorised as serious and been incorrectly rated. Incidents were not always investigated completely before being closed. The hospital did not have Joint Accreditation Group (JAG) accreditation or a Global rating score (GRS) or a similar system for collecting data and outcomes for endoscopy patients, which is recognised as best practice. Several key BMI policies were out of date including The Deprivation of Liberty Safeguards (DoLS) which had been out of date since 2012. In addition the BMI Pre-operative assessment policy required review in February 2015. Patient surgical outcomes were monitored through formal national and local audit, but the outcomes were not shared with staff. Patients were treated kindly and with compassion. Patients felt involved in decisions about their care and treatment. There were effective arrangements in place to monitor and manage pain.

Summary of findings

Services were responsive to patients' needs. The admission, treatment and discharge pathways were well organised and flexible so that they were responsive to patients' changing needs.
Nursing, medical and other healthcare professionals were caring and patients were extremely positive about their care and experiences. Patients were treated with dignity and respect.
Staff had limited awareness of the hospital's new vision. The ward manager and theatre manager were available to support for staff. There was an open culture where staff felt valued.

Outpatients and diagnostic imaging

Requires improvement

Cleanliness, hygiene and infection prevention and control risks were not adequately assessed and managed. Potential risks to patients due to the environment and equipment were not adequately identified, including a planned refurbishment of the outpatient department which did not meet relevant Health Building Notes. Checks on emergency equipment, for instance the resuscitation trolley, were inconsistent and not always carried out. Records containing patient identifiable data were not always stored securely.
Safety concerns were identified and addressed. Staff were clear with regards to the process to report incidents. Staff were fully aware of the new Duty of Candour regulation (to be honest and open) ensuring patients always received a timely apology when there had been a notifiable safety incident.
There was limited monitoring of patient outcomes of care and treatment. Participation in external audits and benchmarking was limited. Some staff had received Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training.
The annual plan did not demonstrate completion dates or contain detailed objectives. The arrangements for governance did not always operate effectively. Risks and issues were not always dealt with appropriately or in a timely way.
There was a limited approach to obtaining the views of patients. Feedback was not always reported or acted upon in a timely way.

Summary of findings

Records were accessible and completed accurately. Safeguarding systems were in place and staff knew how to respond to safeguarding concerns. Staffing levels were adequate for the service provision.
The imaging department planned and delivered care and treatment in line with current evidence-based guidance, standards and best practice. Staff had the right qualifications, skills, knowledge and experience to do their job.
Multi-disciplinary teams worked well together to provide effective care. Consent to care and treatment was obtained in line with legislation and guidance.
Patients were positive about the way staff treated them. They were involved in decisions around their care and treatment and found leaflets informative regarding any potential surgery.
Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services. Complaints and concerns were always taken seriously, responded to in a timely way and listened to.
Staff had little knowledge regarding the vision for the hospital. There was good staff satisfaction. Staff felt supported and valued.

Summary of findings

Contents

Requires improvement

BMI The Manor Hospital

Services we looked at

Surgery; Outpatients and diagnostic imaging.

Summary of this inspection

Background to BMI The Manor Hospital

BMI The Manor Hospital is a private hospital in Biddenham, a village near Bedford. It has 23 registered beds. The hospital was opened in 1983 and, following three ownerships, is now part of BMI Healthcare.

The original manor house is a grade two listed building; the additional ward and theatre extensions and the administration building were added in1982. There have been several changes to use of the facilities within the buildings to meet the ever evolving needs of the patient pathway. BMI The Manor Hospital also owns the neighbouring house which is used as accommodation for the Resident Medical Officer (RMO). The hospital is registered for 23 beds, for adults only, all with private en-suite facilities, Wi-Fi, TV and telephone.

The hospital undertakes a range of surgical procedures, to patients aged sixteen years and over. They also provide outpatient consultations.

The hospital has one main theatre with laminar flow plus an endoscopy room and minor operations theatre in the outpatient department. The ground floor of the main building consists of theatre, ward, endoscopy, pre-assessment, imaging and pharmacy departments. Upstairs in the main house is the outpatient department with five consulting rooms and a waiting area. The 'Barns' part of the site, houses the physiotherapy department and health screening. Administration staff are housed in a separate building. The hospital is managed by BMI Healthcare and is part of a network of 61 hospitals and treatment centres across England, Scotland and Wales.

The hospital provides NHS funded care, mostly through the NHS referral system.

Our inspection team

Our inspection team was led by:

Inspection Lead: Kim Handel, Inspection Manager, Care Quality Commission

The team of 9 included CQC inspectors and a variety of specialists: theatre nurse, consultant surgeon, governance specialist and an infection prevention and control nurse.

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the hospital and each core service.

We carried out an announced inspection visit on 6 and 7 October 2015 and an unannounced inspection on 14 October 2015. We spoke with a range of staff in the hospital, including nurses, consultants, administrative, ancillary and clerical staff. During our inspection we reviewed services provided by BMI The Manor Hospital in the ward, operating theatre, outpatients and imaging departments.

During our inspection we spoke with 5 patients, 29 staff, including consultants, who are not directly employed by the hospital and 5 family members/carers from all areas of the hospital, including the wards, operating theatre and the outpatient department. We observed how people were being cared for and talked with patients and reviewed personal care or treatment records of patients.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Summary of this inspection

Information about BMI The Manor Hospital

The hospital has 23 inpatient rooms on the ground floor, with en-suite facilities. They have one operating theatre with laminar flow, five consultation rooms, an endoscopy room and minor operation room, the latter is situated in the outpatient department on the 1st floor.

BMI The Manor Hospital provides an outpatient service for various specialties to both private and NHS patients. This includes, but is not limited to, orthopaedics, gynaecology, general surgery and urology. There were 2,593 surgical procedures carried out between July 2014 and June 2015. 654 of these were patients who stayed one or more nights, the rest were day cases.

Between July 2014 and June 2015, 14,288 people were seen in outpatients. The outpatient department provides a local anaesthetic minor operation service.

The hospital is accredited by all the major private medical insurers. Between July 2014 and June 2015 around half of the patients having day or in patient treatment were funded by the NHS, the remaining patients were self-funding or paid for by their insurance companies. In outpatients there was a similar proportion of NHS and patients funded by other means.

85 doctors have practicing privileges and their individual activity is monitored.

BMI The Manor Hospital has no external accreditations.

All patients are admitted and treated under the direct care of a consultant and medical care is supported 24/7 by an onsite resident medical officer (RMO.) Patients are cared for and supported by registered nurses, care assistants, allied health professionals such as physiotherapists and pharmacists who are employed by the hospital.

The hospital Accountable Officer for Controlled Drugs (CDs) is the Executive Director.

The hospital has a contract with Bedford Hospital, which is nearby, to provide imaging, (CT and MRI) and pathology, histology, microbiology and decontamination services in relation to theatre instrumentation. In addition further MRI services, histopathology and pathology services are provided from a number of independent sources.

BMI The Manor Hospital has been inspected three times by the Care Quality Commission, between 2011 and 2013, with 12 of the core standards being assessed during these inspections. All standards assessed were found to be compliant, except one, infection prevention and control, in November 2013.

Detailed findings from this inspection

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	Good	Inadequate	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Overall trust	Requires improvement	Requires improvement	Good	Good	Inadequate	Requires improvement

Notes

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients and Diagnostic Imaging.

Requires improvement

Surgery

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

Information about the service

The hospital has 23 beds, all with private en-suite facilities.

The hospital has one main theatre with laminar flow and a separate endoscopy room. There is a minor operations theatre in the outpatient department. Core services provided include diagnostic imaging, endoscopy, gynaecology, medical care, and surgery.

The hospital does not provide services for children between the ages of 0-16. Any 16-18 year old are seen by the pre-assessment team, prior to any inpatient or day case procedures being agreed. There is a Registered Nurse (child branch) employed on the nurse bank, who will assess any young people if concerns are raised by the preadmission staff.

Between July 2014 and June 2015 there were 2,504 visits to theatre. Of these, the most common surgical procedures were:

- Excision of lesion of skin or subcutaneous tissue- 226
- Multiple arthroscopic operations on knee-144
- Total prosthetic replacement of knee joint - 87
- Arthroscopic meniscectomy - 85
- Primary total hip replacement - 84
- Endoscopic resection of lesion of bladder- 64
- Primary repair of inguinal hernia- 52
- Carpel tunnel release - 49
- Arthroscopic sub-acromial decompression- 43
- Therapeutic endoscopic operations - 41

All patients are admitted and treated under the direct care of a consultant and medical care is supported 24/7 by an onsite resident medical officer (RMO). Patients are screened pre operatively to ensure their suitability for their surgery to be undertaken in a hospital with no critical care facilities. Patients are cared for and supported by trained nurses, allied health professionals such as physiotherapists and pharmacist, all employed by the hospital.

We carried out an on-site inspection of BMI The Manor Hospital between 6 and 7 October 2015 and visited the inpatient, pre admission clinic, theatres and recovery. We carried out an unannounced inspection on14 October 2015. We talked with five patients. We interviewed 20 staff including nurses, allied healthcare professionals, RMO, consultants, support staff and managers. We observed care and treatment and reviewed clinical records. Prior to the inspection, we reviewed performance information about the hospital.

Requires improvement

Surgery

Summary of findings

We found that:

There was an inappropriate skill mix in the ward. The ward was understaffed. Both the ward and the operating theatre used a high proportion of staff from an agency.

Theatre staff did not follow best practice national guidelines according to the Association for Perioperative Practice, or the BMI policy for peri-operative swab, instruments and needle counts.

Swabs, instrument and needle counts were not displayed on a white board in the operating theatre, whilst the operation was taking place, although this had been rectified by the time our unannounced inspection took place on 14 October 2015.

There was a lack of learning and effective review of procedures following an incident where a critically unwell patient was transferred urgently out of the hospital.

In-patient areas were visibly clean, tidy and appropriately equipped. Infection control policies were followed, although theatres had a clean piece of equipment stored together with dirty equipment in the dirty utility room.

The hospital did not have a system in place for collecting data and outcomes for endoscopy patients, which is recognised as best practice.

Staff were accessing key BMI policies which were out of date including The Deprivation of Liberty Safeguards (DoLS) which had been out of date since 2012, although this had been updated in May 2015. In addition the BMI Pre-operative assessment policy needed review in February 2015.

Patient surgical outcomes were monitored through formal national and local audit, but the outcomes were not shared with staff.

Surgery services were found to be caring and responsive. Patients were treated kindly and with compassion. Patients felt involved in decisions about their care and treatment. There were effective arrangements in place to monitor and manage pain.

Services were responsive to patients' needs. The admission, treatment and discharge pathways were well organised and flexible so that they were responsive to patients' changing needs.

Nursing, medical and other healthcare professionals were caring and patients were extremely positive about their care and experiences. Patients were treated with dignity and respect.

Staff had limited awareness of the hospital's new vision. The ward manager and theatre manager were available to support for staff. There was an open culture where staff felt valued.

Requires improvement

Surgery

Are surgery services safe?

Requires improvement

We have rated safe as requires improvement because:

There was a high number of nursing staff vacancies in the ward. The skill mix of nursing was not always appropriate for patients. Frequently only one trained nurse was present on the ward supported by healthcare assistants, to care for post-operative patients and new admissions. When we returned to carry out an unannounced visit, this situation was repeated. We saw from the ward duty rota and staff confirmed this was a frequent occurrence. It was common practice to use a high proportion of bank and agency staff in both the ward and the operating theatre.

Theatre staff did not follow best practice national guidelines according to Association for Perioperative Practice or BMI policy for peri-operative swab, instruments and needle count, although this had been rectified by the time of our unannounced visit on 14 October 2016.

The dirty utility room in the operating theatre had dirty and a piece of clean equipment stored in the same area. The endoscopy room had clean scopes stored in the same room as where dirty scopes were decontaminated, although these areas were separated as far as possible.

There were two serious incidents that had been categorised incorrectly. Not all incident investigations were completed before being closed. There was a lack of learning from a serious incident. There was no one in the hospital who had received training on root cause analysis. There was a culture of incident reporting, but staff said they did not receive feedback on incidents

Despite there being an informal arrangement that advocated that major surgery should not commence after 7pm, in practice it happened regularly.

The medical records storage cupboards behind the work station on the ward, was not locked. There was no separate specimen fridge available in theatres.

There was no system in place to ensure nurse's clinical competencies were up to date.

The hospital's pre admission policy was out of date from February 2015.

We saw that there were effective handovers between shift changes.

Risks to patients, were assessed, monitored and managed on a day-to-day basis. These included signs of deterioration and medical emergencies.

Medicines were appropriately managed and stored.

The environment in theatre and on the ward was visibly clean and staff followed the hospital policies on infection control. The five steps to safer surgery surgical checklists were completed.

Incidents

- There was an incident reporting policy in place.
- Staff understood their responsibilities to raise concerns, record and report safety incidents, concerns and near misses; although they told us they did not receive regular feedback or lessons learnt from incident reporting. Staff completed a paper incident form, which was then entered onto the electronic system by a member of the administration staff. The paper copies were kept by the director of clinical services.
- There had been 208 clinical incidents reported between July 2014 to June 2015. An overall increasing rate of clinical incidents had been reported from the previous year. Staff told us that they were encouraged to report incidents and a better reporting system was in place, which had increased the amount of incidents reported from the previous years.
- The hospital reported that there had been no incidences of a never event, in the reporting period July 2014 to June 2015. A never event is a serious incident that is wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- The hospital reported that were no serious incidents in the reporting period July 2014 to June 2015. However, when we reviewed a sample of them, we found two incidents that the director of clinical services agreed had been incorrectly categorised and should have been reported as serious incidents.
- One of the incidents, surrounded transfer of a deteriorating and unwell patient to the local NHS trust. Although the particular incident had happened some months previously, we noted that the process for

dealing with such incidents had undergone a review, but the fundamental process had not changed to ensure there was adequate support, out of hours, when critically ill patients required urgent transfer. There had been four subsequent transfers to the NHS.

- We reviewed four incident investigations at random, three of which had been closed, but we found to be were incomplete. One said; 'Discussed with nurses.' There was no evidence that this had been done in the CG or ward meeting minutes. Another where a spinal anaesthetic had been converted to a general anaesthetic (GA). The patient's notes stated; spinal→GA. There was no evidence of discussion with the patient, no evidence that consent had been sought for a change in anaesthetic, with the associated risks. The third involved a medication drug error, where the nurse's medicine competency, following the error, had been undertaken by another registered nurse whose drug administration competency had not been assessed for at least two years. This meant they may not have been competent to carry out this assessment. The fourth incident we reviewed had the incorrect statements attached to it. Apart from sifting through the whole system for the correct statements, there was no way of finding the correct statements relating to that incident.
- There was no one in the hospital who had received training on root cause analysis. Analysis is used to identify areas for change and to develop recommendationswhich deliversafer carefor patients.
- Staff told us that incidents were discussed at team meetings and lessons had been learnt from some previous incidents. For example anaesthetic staff were unable to find a specific medicine in Pharmacy when the Pharmacist was not available, therefore the Pharmacist produced a 'map' of each cupboard and drawer highlighting where each medicine was kept. This was displayed in the anaesthetic room and pharmacy to enable staff to locate medicines quickly. However, more junior staff were not aware of lessons learnt from incidents.
- One case of venous thromboembolic event (VTE) had been reported.
- One death was reported in the reporting period July 2014 to June 2015 which was described as expected.

Duty of Candour

- The Duty of Candour regulation requires an organisation to disclose and investigate defined notifiable safety incidents and offer an apology. The ward manager described a working environment in which any mistakes in patient's care or treatment would be disclosed to the patient and their representatives, investigated and an apology given, whether there was any harm or not. However, some ward staff were not able to describe the process to follow, for example, having a conversation with a patient, or carer by explaining what had happened and how the hospital would provide assurance this would not occur again.

Safety thermometer or equivalent (how does the service monitor safety and use results)

- The hospital gathered patient information such as hospital acquired infections and reviewed these through its clinical governance processes. We did not see this displayed in the hospital. However the hospital website for patients provided clear information about overall incidence of MRSA, C. Difficile and MSSA.
- Patients were risk assessed for venous thromboembolism (VTE). The VTE screening rate had been consistently 100% compliant.

Cleanliness, infection control and hygiene

- The hospital had policies and procedures in place to manage infection prevention and control. Staff were able to access the policies on the hospital's intranet and were able to demonstrate how to access policies easily. We saw there were also policies for the management of waste and management of patients with MRSA.
- There were no incidents of Methicillin Resistant Staphylococcus Aureus (MRSA), Methicillin Sensitive Staphylococcus Aureus (MSSA) or Clostridium Difficile (C. Difficile) in the reporting period July 2014 to June 2015.
- We observed staff compliance with infection prevention and control policies, for example correct use of personal protective equipment such as visors in the operating theatre and gloves and aprons on the ward.
- There was a lead nurse for infection control, employed by BMI, who attended the hospital once a week. There was a link nurse assigned to the ward but not for theatres due to staff vacancies. We saw from the infection control committee minutes that the theatre manager had attended this meeting to ensure theatre staff were kept up to date with infection control issues.

Requires improvement

Surgery

- Incidents of surgical site infections were monitored and reported to the clinical governance committee and there had been no incidents reported in 2015.
- Cleaning and decontamination of dirty endoscopes was carried out in the same room where clean endoscopes were stored. This posed a risk of cross contamination between dirty and clean endoscopes. There was no risk assessment in place to mitigate this.
- We found a piece of clean equipment (a tourniquet) stored in the dirty utility room. This does not comply with the recommendations of the HBN 00 -09 'Infection Control in the Built Environment.' March 2013. However, once we indicated this to a member of staff it was immediately removed.
- There was a cleaning schedule for ward equipment cleaning. This had been recently implemented, so there were no audits available to ascertain if cleaning was effective.
- There were adequate hand washing facilities and hand sanitising gel in each patient's room and throughout the ward and theatre environment. We observed good compliance with hand hygiene audits, between 80%-100% compliance from January to June 2015. In addition we saw from meeting minutes that discussions had been held at the infection control committee to raise awareness and compliance.
- We found an alcohol gel and soap dispenser that was not working in the operating theatre. We reported these to the infection control nurse and theatre staff. During the unannounced inspection, we saw that the soap dispenser had been repaired and was in working order.
- Disposable curtains were used in recovery and dates displayed when these had been changed.
- Housekeeping staff worked in their own particular areas within the hospital. Weekly cleaning audits had commenced to ensure that cleaning was effective and to provide feedback. This was a new initiative therefore information was not available at the time of the inspection.

Environment and equipment

- The ward and theatre areas appeared clean and well maintained. Resuscitation equipment, both the operating theatres and the ward area, records showed, were checked daily, and documented as complete and ready for use.
- There was sufficient equipment.
- Only three patient rooms on the wards had piped oxygen. To address this there were supplies of portable oxygen cylinders in a store room on the ward. These were found to have been checked and in good working order. However, the store room used to store the oxygen cylinders was not locked, was on the main ward corridor and accessible to visitors to the ward.
- The patient-led assessment of the environment (PLACE) survey score for the hospital was 98% for cleanliness, 95% for food and 98% for privacy and dignity in 2015. We saw a specific action plan following the PLACE audit to ensure improvements were made.
- Portable appliances that we checked were found to have been tested and labelled as safe for use.

Medicines

- There were effective arrangements for the receipt, storage, dispensing and disposal of unwanted medicines, which was managed by the pharmacist. The pharmacist ensured any drug alerts received were responded to and reported outcomes at the clinical governance meetings.
- The pharmacy staff checked and maintained agreed stock levels in the departments and ensured there was appropriate stock rotation.
- Allergies were recorded clearly on the medicines record.
- Nursing staff were aware of and able to easily access guidance, such as the hospital's medicines policy and up to date British National Formularies.
- We did not observe the administration of medicines during the inspection but the medicine charts were found to have been completed correctly. Entries were signed and dated. Any medicine omissions had the reasons recorded.
- Controlled Drugs (CDs) were stored and reconciled correctly. However, if there was only one Registered Nurse on duty on the ward, a member of staff from theatre checked CDs. This meant that there was a risk the theatre was left short of staff. In addition, at night, if there were two agency nurses on duty, they checked CDs.
- Room and fridge temperatures were checked and recorded daily to ensure stored medicines were kept at a safe level and were safe for use.

Records

- Although records were clear, they were not always stored confidentially.

- The hospital used a paper based record system for recording patients care and treatment.
- Patient's records whilst in use on the wards were stored in a lockable cupboard behind the ward work station, which was open and not locked, putting patients' confidentiality at risk.
- We observed a request form with patient details clearly on display on the nurses' station that was visible to visitors to the ward. Therefore patients' confidentiality was not always maintained.
- The records contained information of the patient's journey through the hospital including pre assessment, investigations, results and treatment provided. There were different pathways for each speciality or procedure.
- We examined seven sets of in patient records. Information was easy to access with each episode of care divided into separate sections to allow staff to access the most recent and relevant information about the patient.

Safeguarding

- The hospital had safeguarding policies and procedures available to staff on the intranet.
- Staff received training through electronic learning, 98% of staff had received training, and had a good understanding of their responsibilities in relation to safeguarding of vulnerable adults and children. They were able to explain how to respond to and escalate a concern.
- There had been one safeguarding concern reported to CQC in the reporting period July 2014 to June 2015, which was still under investigation at the time of the inspection.
- BMI The Manor Hospital's Safeguarding Lead was the Director of Clinical Services who was trained to Level 3. They were also a member of BMI's Group Safeguarding Committee and attended quarterly meetings.

Mandatory training

- Staff explained they received mandatory training to provide safe care. Some of this was completed through e-learning and some through on-site training, for example, manual handling. Staff described a range of topics included in their training such as information security and infection prevention and control.
- Nursing staff on the ward had an overall compliance rate of 100% and staff in theatre, compliance rate of 100%. The hospital target was 85%. Heads of departments were encouraged to support staff to attend sessions to ensure compliance.
- There was an induction programme for all new staff, and staff who had attended this programme felt it met their needs.
- There was a brief induction for agency staff which covered the layout of the department, emergency procedures and where to find essential information.
- Registered practitioners had completed Intermediate Life Support (ILS) training and Basic Life support (BLS) training was provided for other staff including porters to ensure staff were able to effectively respond to the needs of a deteriorating patient. We saw evidence of effective 'scenarios' to support the training.

Assessing and responding to patient risk

- All patients having a general anaesthetic were assessed in a nurse led pre assessment clinic prior to their surgery. Patients for endoscopy or local anaesthetic had a telephone pre assessment carried out. However, the hospital's pre admission policy was out of date from February 2015.
- Patients were swabbed to assess if they had any colonisation of MRSA at the pre-assessment clinic. When results were found to be positive the admission date, if necessary, was deferred and the patient provided with a treatment protocol to use at home, according to the hospital's MRSA policy.
- Risk assessments were completed using nationally recognised tools, such as the Waterlow score to assess patients risk related to pressure ulcers. Other risks assessed were those of mobility and moving and handling and venous thromboembolism (VTE). We saw that these were documented in the patient's records and included actions to mitigate any risks identified.
- The theatre team used the five steps to safer surgery checklist, which was designed to prevent avoidable mistakes; this was an established process within the teams. We looked at the checklists which had been completed. However, we did not see any audits of compliance with the five steps to safer surgery at the time of the inspection.
- Theatre staff did not follow best practice national guidelines, according to Association for Perioperative Practice, or BMI policy for peri-operative swab,

instruments and needle count. This was because swabs, instrument and needle counts were not displayed on a white board. This was discussed with the theatre manager during the inspection. Subsequently, during our unannounced inspection on 14 October 2015 we observed that the national guidance had been implemented and the swabs, instrument and needle counts were recorded on a white board. This meant that it was clear to both the surgeon and scrub nurse that instruments/swabs that could be retained were clearly tracked to ensure patient safety during an operation.

- Senior managers told us that major surgery was not commenced after 7pm in the evening and minor surgery after 7.30pm. There was no policy with regards to late operating to support this. However, we saw from the records in the operating theatre that routine late operating was happening, regularly , in that minor surgery was commencing after 7.30pm and major surgery after 7.00pm. Patients were recovered and returned to the ward during the night shift, when staffing numbers were reduced to two trained nurses. In addition other services were available only on an on call basis, for example, pharmacy and x-ray.
- There was a formal arrangement for patients to be transferred to the local NHS hospital if the patient required critical care to level two or level three. These are critically ill patients, who require either organ support or closer monitoring. However, if the patient required a nurse escort this could not be supplied at night, as there were routinely two nurses only on the night shift. There was an on call system, but this may have defaulted to a non-clinical manager, who would have been unable to assist. The director of clinical services told us that they would come in in these circumstances to offer support; however, it would be unreasonable for them to be on call all the time. There had been an incident whereby a critically ill patient was transferred at night to the local trust with no nurse, doctor or paramedic escort. Although this had happened several months earlier, the system for providing support in these, albeit rare instances, had not been changed. There had been four transfers to the local trust from January to October 2015.
- Resuscitation scenarios were undertaken by an external provider on a regular basis. We saw the evidence of this during our inspection and that following the scenario taking place there was a debriefing and action plan to address any lessons learned. We saw that on one occasion an RMO's clinical skills were not up to the standard required and the director of clinical services had them removed from the hospital.
- There was access to the minimum requirement of two units of O Rhesus negative emergency blood. The blood fridge temperature and stock was checked and recorded daily. Blood transfusion training for all staff who dealt with transfusions had been completed by staff from the local NHS trust.
- The practising privileges agreement required the designated consultant to be contactable at all times when they had inpatients within the hospital. Furthermore, they needed to be available to attend within an appropriate timescale according to the risk of medical or 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.
- Each patient room and bathroom had emergency call bells to be used to alert staff when urgent assistance was required, these were routinely tested to ensure they were fit for purpose.
- The National Early Warning system (NEWS) tool was used to identify the deteriorating condition of patients. This system alerted nursing staff to escalate, according to a written protocol, any patient whose routine vital signs fell out of safe parameters. Monthly audits were carried out to ensure compliance with the policy. The last three audits showed 100% compliance.

Nursing staffing

- Staffing levels, skill mix and caseloads were not always planned and reviewed so that people receive safe care and treatment at all times. There were insufficient numbers of staff with the right skills on duty in the ward. Both the ward and theatre used about 20% agency staff.
- The BMI Healthcare nursing dependency and skill mix tool was a guide to assist trained professionals to exercise their judgement to ensure the right members of staff are on duty at the right time and with the right skills, to ensure safe patient care. This tool was used to plan skill mix five days in advance, with continuous review on a daily basis. The actual hours worked were also entered retrospectively to understand variances

from the planned hours and the reasons for these. Senior staff on the ward were unaware of any dependency tools available, although we did see this used after the inspection.

- Contracted staff worked flexible hours to try and ensure there were adequate numbers of staff. Any gaps were mostly met by overtime or bank staff and agency staff. Night shifts on the ward were mainly covered by agency staff. We observed and staff told us that staffing levels were of a concern and that agency staff had been used on a regular basis to cover shifts. The hospital reported a 20% usage of agency staff in both theatre and wards. There had been three staff leave the operating theatre in the recent weeks prior to the inspection.
- When two agency staff were used to cover the night shift the ward manager would sleep in the hospital to ensure a permanent member of staff was available if required. This was a regular occurrence.
- Staff were recruited from specific agencies with which the hospital had a preferred provider arrangement. This ensured staff provided met key requirements such as having completed manual handling training and competencies to safely administer medicines.
- Agency staff, when used, were provided with an orientation when new to the hospital, which included access to and the location of emergency equipment and fire exits.
- Skill mix of nursing was not always appropriate to meet patient's needs. On the ward we observed only one registered nurse on a shift, supported with three healthcare assistants for post-operative patients and new admissions, with a total of 13 inpatients. Frequently only one registered nurse would be on duty; this was confirmed during the unannounced inspection. The senior managers were aware that this was a recurrent happening, but because the correct numbers of staff were on duty and it was usual practice, it appeared to be accepted.
- There was always a senior nurse available at the hospital as a contact point for both staff and patients, to help resolve patient questions and to accept out of hours admissions. Out of hours the senior nurse or manager on call was available by bleep or telephone.
- Handovers between staff took place between each shift in the ward office to maintain confidentiality. We observed one handover where each patient's condition was discussed, including their care, pain and discharge planning. Patients were referred to by their names and no unnecessary information was discussed.

Surgical staffing

- Patient care was consultant led. The hospital practising privilege agreement required that the consultant visit inpatients admitted under their care at least daily or more frequently according to clinical need, or at request of the executive director, director of clinical services, or RMO.
- The hospital employed two RMOs who worked two weeks on duty and two weeks off duty, 24 hours a day seven days a week, then handed over to the other RMO. The RMO told us they had sufficient time to handover to the new RMO coming on duty.
- Nursing staff and the RMO had found the consultants to be supportive and responsive when they were contacted for advice.
- The hospital maintained a Medical Advisory Committee (MAC) whose responsibilities included ensuring any new consultant was only granted practising privileges if deemed competent and safe to practice.
- It is a requirement of BMI Healthcare's practising privileges policy, that consultants remain available (both by phone and, if required, in person) or arrange appropriate alternative named cover if they were unavailable. This was to ensure that a consultant was available to provide advice or review patients at all times when there were inpatients in the hospital. The staff confirmed that this happened.

Major incident awareness and training

- There was a business continuity plan in place. This had been implemented recently when the water supply to the hospital had been interrupted and bottled water had been purchased and provided for staff and patients. During this time, operating lists had been suspended to ensure patient safety.

Are surgery services effective?

Requires improvement

Surgery services required improvement to be effective.

Requires improvement

Surgery

Some BMI policies were out of date, such as the Pre-operative assessment policy in February 2015. Staff were accessing some out of date policies, including The Deprivation of Liberty Safeguards (DoLS) policy out of date in 2012, which had been updated in May 2015. This meant that staff may not have been following the latest best practice.

Most staff on the ward and in theatre were unaware that PROMs and NJR data was collected. Feedback and patient outcomes were not discussed at local staff meetings. This information was discussed at the hospitals Clinical Governance and Medical Advisory Committees on a monthly basis as well as at a regional and corporate level.

The hospital did not have a system for collecting data and outcomes for endoscopy patients, to provide assurance of the effectiveness of the service.

Pre-operative fasting guidelines for adults were aligned with the recommendations of the Royal College of Anaesthetists. However, despite this, some patients were found to have been fasting longer than recommended.

Competency assessments were not always carried out or up to date. In addition, competencies were undertaken by staff whose own competency assessments may not have been up to date.

Patient's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. Patients had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing.

Patients' discharge plans took account of their individual needs, circumstances, ongoing care arrangements and expected outcomes. Patients were discharged at an appropriate time and when all necessary care arrangements were in place. Consent to care and treatment was obtained in line with legislation and guidance.

Evidence-based care and treatment

- Policies were accessible on the hospital intranet and based on professional guidance such as National Institute of Health and Care Excellence (NICE) and Royal College guidelines.
- Not all policies were up to date. Some BMI policies were out of date, such as the Pre-operative assessment policy in February 2015. Staff were accessing some out of date policies, including The Deprivation of Liberty Safeguards (DoLS) policy out of date in 2012, which had been updated in May 2015. This meant that staff may not have been following the latest best practice. This was raised with both the local management team and some of the BMI management team at the time of inspection. They were aware that some of the BMI policies were due for renewal and that the BMI governance team were addressing this.
- We saw that the hospital had systems in place to provide care and treatment in line with best practice guidelines NICE CG50: Acutely ill patients: Recognition of and response to acute illness in adults in hospital. For example an early warning score system was used to alert staff should a patient's condition start to deteriorate.
- The staffs' awareness of data collection such as Patients Reported Outcome Measure (PROMS) and National Joint Registry (NJR) was variable. Staff told us that senior managers collected the data, but were unsure what this was. They did not receive feedback of outcomes or actions required.

Pain relief

- The surgical pathway prompted staff to assess and record if pain was being managed effectively. This commenced in the pre-assessment clinic where actions to deal with pain management were discussed.
- Patient Controlled Analgesia (PCA) pumps were available and staff felt they had sufficient quantities to meet the needs of the patients at any one time.
- Effectiveness of pain relief was measured through the use of a patient questionnaire. Questions such as 'Was the likelihood of pain explained to you?' 'Did staff do everything they could to help control your pain?' Patient told us their pain was well controlled and they were provided with pain relief both regularly and on an as required basis during their inpatient stay. However, there were no formal audits of pain control.
- An anaesthetist we spoke with explained they would discuss and review a colleague's patient's pain control if requested, for example if the patient's consultant was not available. There was an anaesthetist on call 24 hours a day for advice.
- Patient pain was discussed at handovers when appropriate.

Nutrition and hydration

Requires improvement

Surgery

- Staff completed an assessment of patient's nutritional status and their needs when they were first admitted and updated this during their stay.
- Nausea and vomiting were formally assessed and recorded.
- Pre-operative fasting guidelines for adults were aligned with the recommendations of the Royal College of Anaesthetists, (RCA) which states that food can be eaten up to six hours and clear fluids can be consumed up to two hours before surgery. Information regarding fasting was provided to patients during pre-operative assessment stating that they needed to fast for 6 hours prior to surgery. However all patients were given these standard instructions and therefore patients could be admitted at 7am, but not attend theatre until later in the morning. This meant that RCA guidelines were not complied with and patients were often fasting longer than required.
- Intravenous fluids were prescribed as appropriate and recorded according to hospital policy. We observed that fluid balance charts were used to monitor patients' hydration status.
- The Malnutrition Universal Screening Tool (MUST) was used to assess and record patient's nutrition and hydration, when applicable.
- Patients had access to drinks by their bedside. Staff checked that regular drinks were taken where required. Snacks were available.
- The catering arrangements had recently been out sourced to an external provider. Since then most food was cooked off site, chilled and reheated in the hospital. Patients we spoke with told us the quality of the food was good and they mostly received the food they had selected from the menu provided.

Patient outcomes

- There had been four cases of unplanned readmission within 29 days of discharge in the reporting period July 2014 to June 2015. There had been four cases of unplanned transfer of an inpatient to another hospital in the reporting period July 2014 to June 2015. Both were in line with a hospital of this size and the complexity of surgery that was undertaken.
- The hospital participation in the national audit programmes particularly Patients Reported Outcome Measure (PROMS) and National Joint Registry (NJR). Results were monitored and discussed at the hospitals Clinical Governance and Medical Advisory Committees on a monthly basis as well as at a regional and corporate level. However the results were not discussed with staff on the wards or in theatres.
- PROMS for hip replacements: 19 patients were eligible, of which 19 reported an improvement in health. With regards to knee procedures: 20 were patients eligible, of which 20 reported an improvement in health. These results showed that the hospital performed satisfactorily when compared with other hospitals.
- Reports showed that there were 24 patients eligible with regards to groin hernia repair, of which 10 reported an improvement in health, seven reported no change and seven reported worsening health.
- The hospital did not have a quality assurance system such as JAG accreditation or a Global rating score (GRS) for collecting data for endoscopy patients. The GRS is a tool that enables hospitals to assess how well they provide a patient-centred service. The system automatically calculates the GRS scores, which provides a summary view of the endoscopy service. The outcomes for endoscopy patients were not measured therefore we could not be reassured of the effectiveness of the service.
- Patients considered their outcomes as being good. One patient said, "Everything was good, you couldn't fault them." Another said, "I would not have gone anywhere else."

Competent staff

- Registered practitioners had completed Intermediate Life Support (ILS) training and Basic Life support (BLS) training was provided for other staff including porters to ensure staff were able to effectively respond to the needs of a patients who required resuscitation. We saw evidence of effective 'scenarios' to support the training.
- At the time of the inspection only the RMO had received Advanced Life Support (ALS) training. One nurse had an expired ALS certificate and further training had been arranged for January 2016.
- The hospital provided induction, learning development and appraisals for staff.
- Agency staff had a separate induction when they arrived for a shift.
- Two staff had recently completed their induction and thought it was comprehensive and prepared them to work safely and effectively in their roles.

- Appraisal rates for staff were good, theatre and the ward had 100% completion rate, compared to a 77% compliance rate in 2014.
- Staff told us they found the appraisal process helpful and were able to discuss and identify learning needs beyond that of their mandatory training.
- Ward staff received regular one to one meetings with the ward manager to review learning needs and discuss any issues.
- The hospital used electronic learning to provide much of the training although some was provided on site, such as manual handling.
- Competencies for nursing staff in various areas such as bladder scanning were not up to date.
- We reviewed an incident where a medication error had been made. The hospital policy stated that if a member of staff made such an error, their competency for administering medicines was re-done. In this instance we found that the competency had been redone by a registered nurse whose own competency assessment had not been done for more than two years. The policy stated that competencies should be reviewed annually. This meant that competencies were undertaken by staff that may not have had an up to date competency assessment.
- There was a human resource (HR) process for checking General Medical Council and Nursing and Midwifery registration, as well as other professional registrations.
- The role of the MAC included ensuring that consultants were skilled, competent and experienced to perform the treatments undertaken. Practising privileges were granted for consultants to carry out specified procedures using a scope of practice document.
- There were arrangements which required the consultant to apply to undertake a new technique or procedure not undertaken previously by the practitioner at the hospital. The introduction of the new technique or procedure had to have the support of the MAC, which may have taken specialist advice such as that of the National Institute for Health and Care Excellence or the relevant Royal College. The practitioner was also required to produce documentary evidence that they were properly trained and accredited in the undertaking of that procedure.
- Practising privileges for consultants were reviewed annually. The review included all aspects of a consultant's performance, including an assessment of their annual appraisal, volume and scope of activity plus any related incidents and complaints. In addition, the MAC advised the hospital about continuation of practising privileges. The hospital used an electronic system to check when privileges were due to expire.

Multidisciplinary working

- Medical and nursing staff reported good working arrangements and relationships with the local NHS hospital.
- There were formal arrangements within gynaecology and breast surgery for multidisciplinary team working with colleagues from the NHS. For example, women who attended the breast clinic had their case presented at the NHS MDT meeting.
- We observed effective team working among managers, administrative, clinical, nursing and ancillary staff during our inspection.
- Staff described the multidisciplinary team as being very supportive of each other. Staff told us they felt supported, and that their contribution to overall patient care was valued. Staff told us they worked hard as a team to ensure patient care was safe and effective.
- Discharge letters were sent to the patient's GP on the day of discharge, with details of the treatment provided, follow up arrangements and medicines provided.

Seven-day services

- The hospital undertook elective surgery only, with lists planned in advance.
- Consultants were on call 24 hours a day for patients in their care.
- There was 24 hour RMO cover in the hospital to provide clinical support to consultants, staff and patients.
- The hospital had on-call arrangements for theatres, radiology and physiotherapy services.
- During out of hours, if a prescribed medicine was not available on the ward, the RMO could access the pharmacy with a nurse present.
- In addition, there was always a senior nurse available at the hospital during working hours and the on call manager as a contact point for both staff and patients, to help resolve patient queries and to accept out of hours admissions. They were available by bleep or telephone.
- The hospital employed one pharmacist who, nominally was on call for emergencies, although in practice, they

were rarely called out of hours. However, there was an arrangement with the local trust to provide cover both in urgent circumstances and if the pharmacist was not available.
- The hospital had planned closure every seven weeks for two days over a weekend. During this time if a patient needed medical assistance they contacted their own GP or local accident and emergency services. All patients were informed of the hospital closure at discharge and written information was provided to support this.

Access to information

- Results of blood tests and x-rays were readily available.
- Discharge letters were sent to the patient's GP with details of the treatment provided, on the day of discharge detailing follow up arrangements and medicines provided.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a consent policy that staff were familiar with.
- Staff we spoke with were clear about their responsibilities in relation to gaining consent from people, including those who lacked capacity to consent to their care and treatment.
- The theatre manager explained patients were not allowed to be taken to theatre without having a completed and signed consent form.
- We looked at seven sets of notes and saw consent forms were fully completed, signed and dated by the consultant and patient. The forms identified the procedure planned and the associated risks and benefits. The hospital consent forms complied with Department of Health guidance.
- Staff had received training about the Mental Capacity Act (MCA) 2005 to ensure they were competent to meet patients' needs and protect their rights where required. This also included training regarding The Deprivation of Liberty Safeguards (DoLS). The BMI DoLS policy required review in 2012 and had been updated in May 2015. However, staff were accessing the old policy which meant that may not have been using the most up to ate guidance.
- Staff were able to briefly describe how DoLS might be required. They explained they would contact the director of clinical services and involve the consultant and relatives as appropriate.

Are surgery services caring?

Good

We found that surgical services were good for caring because:

Patients were supported, treated with dignity and respect, and were involved in planning their treatment and care. Patients were informed of any associated costs where applicable prior to treatment. Feedback from patients and those who were close to them was positive about the way staff treated and cared for them.

There were appropriate arrangements to support and meet patient and staffs' emotional needs.

Staff were caring and compassionate to patient's needs, and treated patients with dignity and respect. Patients told us that staff treated them in a caring way, and were flexible in their support, to enable patients to access services.

Compassionate care

- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect.
- Patients told us staff were kind and attentive. They felt they were kept well informed about their care and were involved in making decisions about their treatment at each stage. The costs were explained to them before admission. One patient told us, "The consultant's secretary made sure we had all the information to decide if we could afford it."
- Patients told us they would be happy for their family to come to the hospital for an operation.
- Patient feedback included comments such as, "They (the staff) treat people well, with respect and confidentiality is not broken". Another patient said "They (the staff) were fabulous, everyone was so nice, I felt relaxed and they told me everything they were doing."
- We observed good interaction between nurses, allied professionals and patients.
- Patients were spoken to in a courteous manner and their permission was sought before providing treatment, for example assistance with washing and dressing.
- Staff told us they felt they had sufficient time to spend with patients and their relatives. The patients we spoke with and the satisfaction survey results we saw supported this.

Requires improvement

Surgery

- Patients told us they had been given detailed explanations about planned treatment in addition to written information.
- The Patient Led Assessment of the Environment (PLACE) score for ensuring patients were treated with privacy and dignity at the hospital was 98% for cleanliness, 95% for food, 98% for privacy and dignity and 79% for dementia in 2015.
- The Friends and Family survey results for 2015, for both private and NHS patients, showed the response rate varied between 31%-60% during January 2015 to June 2015. 98% of patients would recommend the hospital to family and friends. In addition, the BMI patient satisfaction showed that patients were satisfied with their care. Overall, patients rated their quality of care as 98%.

Understanding and involvement of patients and those close to them

- Patients said the doctors had explained their diagnosis and that they were fully aware of what was happening. In addition the costs for treatment were fully explained.
- None of the patients had any concerns regarding the way they had been spoken to. All were very complimentary about the way they had been treated.
- We observed nurses, doctors and allied professionals introducing themselves to patients at all times.
- The records had individualised care plans, which involved the patient in their planning.

Emotional support

- Staff told us they had time to spend with patients and their families to provide whatever emotional support they needed. However when only one registered nurse was on duty staff told us they found it difficult to provide emotional support and care to all patients on the ward.
- Pre admission assessments included consideration of patient's emotional well-being.
- There was a chaplaincy service available to patients if required.

Are surgery services responsive?

Good

We found that surgery services were good with regards to responsiveness because :

Patients were informed of any associated costs where applicable prior to treatment. Patients were communicated with and received information in a way that they could understand.

There were systems in place that made it easy for patients to complain or raise a concern and they were treated sympathetically when they did. Complaints and concerns were taken seriously, responded to in a timely way and listened to. Staff were unaware of any feedback from complaints, actions taken or lessons learnt.

Services were planned and delivered in a way that met the needs of the local population. Flexibility, choice and continuity of care were reflected in the services. Access to care was managed to take account of patient needs, including those with urgent needs. The appointments system was easy to use and supported patients to make appointments. Care and treatment was coordinated with other services and other providers.

Waiting times, delays and cancellations were monitored and were managed appropriately. There were no breaches of referral to treatment waiting times.

There was no system of screening patients who may have had dementia.

Service planning and delivery to meet the needs of local people

- BMI The Manor Hospital planned and developed services to meet the needs of the local population for both private and NHS patients.
- The booking system was conducive to patient needs in that where possible, patients could select times and dates for appointments to suit their family and work commitments.
- Theatre lists for elective surgery were planned with the theatre manager and bookings team. This ensured all aspects of patients requirements were checked and considered before booking a patient on to the list and ensured that operating lists were utilised effectively.

Requires improvement

Surgery

- National waiting time targets for referral to treatment (RTT) times in surgery were within 18 weeks (admitted pathway). The hospital met the target of 90% of admitted patients beginning treatment within 18 weeks of referral, for each month in the reporting period, July 2014 to June 2015.
- Delays and cancellations were minimal and usually only happened if the patient was unwell on the day of the planned admission. Patients were always rebooked as promptly as possible. There were no breaches of the RTT.

Access and flow

- All patients having a general anaesthetic were assessed in a nurse led pre assessment clinic prior to their surgery. NICE guidelines were used to assess patient's anaesthetic risk in the clinic.
- Patients undergoing endoscopy or local anaesthetic had a telephone pre assessment carried out. This meant patients were identified as being safe for surgery and unnecessary cancellations were avoided.
- When procedures had to be cancelled or were delayed this was recorded as a clinical incident and appropriate actions taken. During the inspection one patient's operation was cancelled due to the theatre list overrunning and the consultant having a commitment elsewhere. We saw that an incident form was completed and the patient was re booked for the following week. Cancellations were rescheduled within 28 days and there was no distinction made between NHS and private patients.
- The number of admissions and planned treatments reduced at weekends with the provision of only one operating list on Saturdays.

Meeting people's individual needs

- Patients' discharge planning began during the pre-admission process where staff gained an understanding of the patient's home circumstances and likely care needs. Staff could refer patients directly to a community service for home visits and for additional support following discharge.
- All clinical areas were accessible to patients and relatives who had reduced mobility.
- If a patient became unwell after treatment, there were arrangements for the patient to be seen promptly by a doctor, the RMO and if necessary reassessed by the admitting consultant or anaesthetist where required.
- Throughout the hospital we saw information for patients about the services offered and how to access them.
- Patients' special needs such as specific dietary requirements were identified at pre admission.
- There were no tools to screen patients who were living with dementia and no admission criteria in place.
- There were no specific systems in place to support patients who had dementia or who had a learning disability.

Learning from complaints and concerns

- The hospital used the BMI Complaints policy.
- There was information on the process for making complaints for patients. Sixteen complaints were received by the hospital in 2014 and 24 in 2015 from January – September. Staff told us they were encouraged to report verbal complaints as well as written complaints. The complaints included issues with appointments, obtaining results, catering and some aspects of care. There were no obvious trends.
- All complaints were reviewed by the director of clinical services, then the clinical governance committee to identify trends and ensure complaints were managed in accordance with the hospitals complaints policy.
- Staff we spoke with were familiar with the complaints policy and their responsibilities if a patient or relative raised a concern.
- Staff were unaware of any feedback from complaints, actions taken, or lessons learnt.
- A regular patient satisfaction survey was carried out, where patients had an opportunity to comment on aspects of their care. However results of patient satisfaction these did not appear to cascade to the ward or theatre levels as staff were unable to identify outcomes of their key performance indicators.

Are surgery services well-led?

Inadequate

We found that surgery services were inadequate with regards to being well led because:

The arrangements for governance and performance did not always operate effectively.

Requires improvement

Surgery

Key risks to patient safety were not recognised by the senior team and tools and relevant legislation to effectively evidence this were not used. The risk register did not identify known risks.

Serious incidents were not always correctly categorised. There were no root cause analysis undertaken. Infection prevention and control measures were not utilised, including compliance and monitoring of the antibiotic prescribing policy, to minimise risk to patients. There was no evidence of learning from incidents.

Staff were accessing out of date policies. Several BMI policies had been identified as out of date.

Information used to monitor performance or to make decisions about the service did not monitor patient outcomes sufficiently to provide assurance of the effectiveness of the service.

Feedback, outcomes or actions were not discussed with staff.

The hospital management team were visible. There was a statement of the hospitals values, based on quality and safety. There was limited awareness amongst staff of the hospital's values.

People's views and concerns were encouraged; patients were engaged through feedback from the NHS Friends and Family Test. In addition, BMI surveyed their patients. Information on patient experience was reported and reviewed alongside other performance data. However these did not appear to cascade to the ward or theatre levels as staff were unable to identify outcomes of their key performance indicators.

Vision and strategy for this this core service

- BMI had launched a new version of their values and vison some two months prior to our inspection. The executive director told us that they wanted the best outcome for patients but no evidence was given to support this statement.
- Most staff we spoke with said they were unaware of the hospitals values.

Governance, risk management and quality measurement for this core service

- Several BMI policies had been identified as out of date such as BMI practicing privileges policy, for review in 2014. We found that the hospital's pre assessment policy was out of date in February 2015. This meant the hospital had not reviewed all their own local policies and procedures and had failed to develop a local policy to mitigate BMI's out of date policies. These had been raised with both the local management team and BMI directors during our visit. There was an awareness that these policies were out of date.
- We saw a plan for 2016 which outlined the hospital's business plan including strengths, weaknesses, opportunities and threats, some of which were obvious risks to patients and to the hospital's business. However, they were not included on the hospital's risk register, for example, recruitment and retention of key staff and that the mammogram was not digital.
- Key risks, for example, recruitment difficulties and lack of staff were not included on the hospital's risk register. This demonstrated a lack of understanding of significant risks to patient safety.
- A nurse's drug competency was undertaken by another whose own competency was out of date. There was no appreciation that this was unacceptable.
- There was a BMI nursing acuity tool, there was no knowledge of this by the senior ward staff and was not used by them to assess staffing requirements. It was completed by the Director of Clinical Services. This demonstrated a lack of understanding of the use of this tool by senior ward staff to determine the impact of lack of staff on patient care and safety.
- Two incidents had been incorrectly categorised as moderate, when they were in fact serious incidents. These had not been recognised by the senior team.
- The clinical governance meetings included input from each hospital department and outcomes of the meeting were disseminated back to heads of department to discuss with their staff at departmental meetings. We saw the minutes of meetings displayed within the ward. Some of the ward staff we spoke with said such information had not been shared with them.
- The risk register did not reflect the risks within the hospital. The hospital leaders did not seem to be aware of the key risks.
- Risks were not assessed correctly following incidents, as root cause analysis were not undertaken.
- The hospital followed the local NHS trust's antibiotic policy for consistency in prescribing, however, the policy

was out of date and it was reported to us that the some consultants used the antibiotics they wished to use. There was no evidence of monitoring the use of antibiotics by the senior team.

- The Medical Advisory Committee (MAC) met quarterly. The MAC had terms of reference which outlined their role supporting the hospital. However, this document was not dated.
- The MAC was attended by a group of consultants who held practising privileges and represented their colleagues with BMI The Manor. Its terms specified membership, quorum and responsibilities which included regulatory compliance, practising privileges, quality assurance and proposed new clinical services and techniques.
- The MAC carried out checks, according to BMI's practising privileges policy, before granting new consultants practicing privileges, including checks on their scope of practice to ensure they were undertaking procedures that they were not competent to do. It was noted the policy was due for review in February 2014.
- Consultants were required to produce evidence annually of their professional registration, revalidation, indemnity insurance, appraisal, mandatory training and continuous professional development before their admitting privileges were renewed.
- We saw evidence of anaesthetists and consultant surgeons being reviewed and discussed at the MAC. Consultants had their practising privileges suspended by the Executive Director if they did not provide the relevant information in a timely manner.
- Temporary privileges could be granted, if for example a specialist opinion from a consultant was required, who did not have privileges. Again, an up to date CV, references, professional registration, revalidation, indemnity insurance and appraisal were required before temporary privileges were granted.
- The hospital participated in national audits including the National Joint Registry, Patient Reported Outcome Measures (PROMS), Friends and Family tests and Patient Led Assessment of the Environment (PLACE).

Leadership / culture of service related to this core service

- The ward and theatre staff told us they felt that they found the ward manager and theatre manager approachable. However, the ward manager and theatre manager were both compelled to regularly work clinically due to staff shortages and had very little time to complete their management and planning duties. We saw evidence of this when we considered the staff duty rota.
- Staff told us that the both the hospital director and head of clinical services were visible and approachable. Staff valued this level of support and they could approach them if required, for example to inform them of a patient's complaint.
- Patient's medical care was personally provided by their consultant.

Public and staff engagement

- Patients were encouraged to provide feedback from the Friends and Family Test. We saw that the response rate varied between 31%-60% during January 2015 to June 2015. 98% of patients would recommend the hospital to family and friends
- The hospital encouraged patients to participate in the BMI patient survey. We saw patients being offered a form to complete and there were boxes throughout the hospital to place completed forms.
- The theatre and ward team meetings encouraged staff to raise any concern or share an experience. The ward manager had recently introduced one to one meetings with staff in which they could raise concerns or make suggestions for improvement.

Innovation, improvement and sustainability

- We saw a plan for 2016 which outlined the hospital's business plan, strengths, weaknesses, opportunities and threats. Within this there were requirements for capital expenditure. However, it was noted that these were only proposals and had not been approved by BMI.
- There were plans to add an MRI scanner, which was awaiting planning permission.
- The hospital was in its third year of providing musculoskeletal services, subcontracted from another independent provider.

Requires improvement

Outpatients and diagnostic imaging

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Requires improvement

Information about the service

BMI The Manor Hospital provides an outpatient service for various specialties to both private and NHS patients. This includes, but is not limited to, dermatology, gynaecology, orthopaedic surgery and urology. There were 14,288 outpatient attendances between July 2014 and June 2015. 32% of the first attendances were for NHS patients.

There is a minor operations theatre in the outpatient department, which provides a service for minor dermatological and ophthalmic procedures. The minor operations theatre is also used for phlebotomy and post discharge wound checks and removal of sutures.

There is a small waiting area located on the first floor of the hospital, along with the five consultation rooms. The imaging department is located on the ground floor. A separate building houses the physiotherapy department and health screening.

The hospital does not see patients aged between 0 and 16 years old.

We spoke with three patients and 13 staff members, including care assistants, nursing staff, senior management and support staff.

Summary of findings

We found that:

Cleanliness, hygiene and infection prevention and control risks were not adequately assessed and managed. Potential risks to patients due to the environment and equipment were not adequately identified, including a recent, planned refurbishment of one room in the outpatient department which did not meet relevant Health Building Notes.

Checks on emergency equipment, for instance the resuscitation trolley, were inconsistent and not always carried out.

Records containing patient identifiable data were not always stored securely. This was rectified immediately after it had been raised with the outpatient sister.

There was limited evidence of how practice was audited against current evidence-based guidance, standards and best practice in the outpatient department. There was limited monitoring of patient outcomes of care and treatment. Participation in external audits and benchmarking was limited in the outpatient department. Limited numbers of staff had received MCA and Deprivation of Liberty Safeguards (DoLS) training.

The annual plan did not demonstrate completion dates or contain detailed objectives. The arrangements for governance did not always operate effectively. Risks and issues were not always dealt with appropriately or in a timely way. There was a limited approach to obtaining

Requires improvement

Outpatients and diagnostic imaging

the views of patients. Feedback was not always reported or acted upon in a timely way. Appropriate improvements were not always identified or action not always taken.

Safety concerns were identified and addressed. Staff were clear with regards to the process to report incidents. Staff were fully aware of the new Duty of Candour regulation (to be honest and open) ensuring patients always received a timely apology when there had been a defined notifiable safety incident. Records were accessible and completed accurately. Safeguarding systems were in place and staff knew how to respond to safeguarding concerns. Staffing levels were adequate for the service provision. The risks associated with anticipated events and emergency situations were recognised and systems were in place to deal with these.

The imaging department planned and delivered care and treatment in line with current evidence-based guidance, standards and best practice. Staff had the right qualifications, skills, knowledge and experience to do their job. The learning needs of staff were understood. Staff were supported to participate in training and development. Multi-disciplinary teams worked well together to provide effective care. Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 (MCA) by the consultants.

Patients were positive about the way staff treated them. They were involved in decisions around their care and treatment and found leaflets informative regarding any potential surgery. Patients were informed about relevant fees for their consultation before they attended for their appointment.

Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services. People could access the right care at the right time. Complaint information or how to raise a concern was available for patients. Complaints and concerns were always taken seriously, responded to in a timely way and listened to.

Staff had knowledge regarding the vision for the hospital. There was good staff satisfaction. Staff felt supported and valued.

Requires improvement

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated safe as requires improvement because:

Cleanliness, hygiene and infection prevention and control risks were not adequately assessed and managed. Potential risks to patients due to the environment and equipment were not adequately identified, including a recent, planned refurbishment of one room in the outpatient department which did not meet relevant Health Building Notes. A naso-endoscope was stored in a plastic container; however, there was no evidence as to when the device was last cleaned.

Checks on emergency equipment, for instance the resuscitation trolley, were inconsistent and not always carried out.

Records were accessible and completed accurately. However, records containing patient identifiable data were not always stored securely. This was rectified immediately after it had been raised with the outpatient sister.

Safety concerns were identified and addressed. Staff were clear with regards to the process to report incidents. Staff were fully aware of the Duty of Candour regulation (to be honest and open) ensuring patients always received a timely apology when there had been a defined notifiable safety incident.

Safeguarding systems were in place and staff knew how to respond to safeguarding concerns.

Staffing levels were adequate for the service provision.

The risks associated with anticipated events and emergency situations were recognised and systems were in place to deal with these.

Incidents

- There had been no serious incidents reported for outpatient and diagnostic imaging services between July 2014 and June 2015.
- Between October 2014 and September 2015, two clinical incidents and four non-clinical incidents had been reported within outpatient and diagnostic imaging services. There were no themes that emerged from the incidents and we noted that immediate action was taken to ensure the patient received appropriate care and treatment.
- Staff were aware of how to report an incident and explained the process that they would follow. The outpatient sister described an incident where specimens had not been received by the local NHS trust. Although BMI The Manor recorded all specimens that left the hospital, there was no record at the NHS trust of receipt on this occasion. In response to this incident, a new system had been implemented.
- Staff confirmed that imaging incidents would be reported to the Care Quality Commission (CQC) under the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and the Radiation Protection Adviser (RPA). The imaging manager confirmed that the RPA carried out a review every three months in relation to radiation doses and any anomalies would be reported back. The imaging manager informed us that the following a review completed by the RPA of radiation doses, it had been identified that there had been some instances of higher doses being given. The staff within the imaging department completed an informal peer review and noted that although there were some anomalies, the radiation dose was still within an acceptable range.
- Staff were knowledgeable regarding the new Duty of Candour regulation and described it as being open and honest with patients at all times when there had been a defined notifiable safety incident.

Cleanliness, infection control and hygiene

- Before our visit, we had been informed that the outpatient department was in need of a total refurbishment. The refurbishment commenced in September 2015.
- We saw that one of the five consultation rooms had been completed. However, the new laminate floor did not comply with Health Building Note (HBN) 00-10 Part A: Flooring, where the floor joined to the wall. The HBN states that, 'In clinical areas and associated corridors, there should be a continuous return between the floor and the wall. For example, coved skirtings with a minimum height of 100 mm allow for easy cleaning.' We also saw that the work surfaces were not sealed against the wall. This meant cleaning between the work surfaces would be difficult and could possibly harbour bacteria posing a risk of cross infection.

Requires improvement

Outpatients and diagnostic imaging

- The infection control lead and director of clinical services confirmed neither of them had 'signed off' the new consultation room to ensure it was safe and fit for purpose, however clinics had been held in the room since the refurbishment.
- The flooring in the treatment / minor operations room was stained and had a number of visible holes. The flooring and carpeting did not comply with HBM 00-99. The coved flooring was seen to be coming away from the wall in places. The coving was not consistent throughout the room. This meant cleaning would have been difficult and may have increased the risk of infection. The four consultation rooms waiting to be refurbished had carpets in the rooms. In two of the consultation rooms, the carpet was in a poor state of repair. The carpet was coming away from the wall exposing laminate coved flooring in one and in the other; the carpet had been taped over to prevent a trip hazard. The outpatient sister confirmed that steroid injections into joints were carried out in the consultation rooms and if the minor operations room was in use, blood tests and removal of sutures were also carried out in the consultation rooms. There was limited evidence to assure us that if a spillage occurred on the carpet that appropriate cleaning could be carried out.
- We inspected all five consultation rooms and noted that there were no aprons in the apron dispensers. A staff member confirmed that the apron dispensers had been erected two days before and that aprons were taken into the consultation rooms before each clinic. Although we did not observe this, we could not be assured that staff were wearing disposable aprons in line with relevant guidance, including the Royal College of Nursing; Essential Practice for Infection Prevention and Control, Guidance for Nursing Staff.
- Other personal protective equipment (PPE), for instance, gloves were available in all of the consultation rooms. A staff member confirmed that goggles were also available as required, however staff did not routinely use them. One pair of goggles which were visibly dirty, were found in a cupboard within the treatment / minor operations room.
- The hand wash sinks in the remaining four consultation rooms did not comply with HBN 00-10 Part C: Sanitary Assemblies. The HBN states that, 'Basin taps used in clinical areas and food-preparation and laboratory areas are required to be operated without the use of hands.' However, this was not possible in the four un-furbished rooms. The hospitals' risk register identified in December 2013 that sinks did not conform to HBN 95 standard. The control measures in place were limited and did not identify the actions in place to mitigate the risk of cross infection. Staff informed us that they used paper towels to turn the taps; however this was not an effective process to prevent cross infection.
- The taps in the newly refurbished room did not comply with the HBN 95 standard as they did not have separate hot and cold taps.
- Sharps bins for the safe disposal of needles were present in the five rooms. However, we noted that the temporary closure was not used on two of the sharps bins and a further two had been assembled incorrectly. This meant that sharps were not disposed of safely and used needles could still be accessed.
- A biohazard spill kit (containing relevant equipment to manage blood and other bodily fluid spillages) was located in a separate room off the treatment / minor operations room in a cupboard. However, various other objects had been stored in front of the biohazard spill kit which prevented quick and easy access in the event of a spillage.
- We found the outpatient department waiting areas to be visibly clean and consultation rooms were tidy. However, we found visible dust, predominately at high levels, in four of the consultation rooms and in the treatment room.
- In one consultation room, we noted that a naso-endoscope was stored in a plastic container with the word 'clean' written on top. However, there was no evidence as to when the device was last cleaned. Within another consultation room, a trolley had a yellow tag which stated that the trolley was last checked and cleaned on 03 October 2015. During the unannounced visit on 14 October 2015, we noted this tag was still in place and a thin layer of dust was visible on the top of the trolley.
- Staff informed us that nurses were responsible for cleaning the examination bed and work surfaces between each patient, using wipes. If a patient with an infection, for example, with infectious diarrhoea, 'flu or MRSA, was seen, staff confirmed that they would still use detergent wipes and were unsure if chlorine was available for use. The Department of Health (DH) recommends use of chlorine-containing cleaning agents to ensure the prevention of spread of infection.

Requires improvement

Outpatients and diagnostic imaging

- With the exception of the public toilet in the outpatient department, there were no cleaning schedules displayed. The outpatient sister informed us that cleaning schedules had been implemented two weeks before our inspection and was aware that the housekeepers kept their own record of cleaning. The senior management team confirmed that there had been a change of contracts with regards to some support staff. Most had been directly employed and had all worked at the hospital for some time, the external contractors had only been in place for around two months. Each completed cleaning schedule was given to the support services manager. The completed schedules for September 2015 had gaps and we were told that they were unsure what the reasons were for these. The support services manager showed us quality assurance internal audits which were undertaken to ensure the cleanliness of the environment had been satisfactory. Any areas that required attention was raised to the housekeeping staff, who were required to sign the schedule to demonstrate completion. New corporate cleaning schedules had been developed and were to be placed in each of the rooms. However, from our findings, we could not be assured that appropriate cleaning was undertaken in the outpatient areas to prevent the spread of infection.
- We found the x-ray room and ultrasound room to be visibly clean and tidy. Within the x-ray room, a diagnostic imaging department environmental checklist had eight daily tasks to check for example, the mobile x-ray unit, image intensifier and lead aprons; however it was noted that these were not consistently checked.
- PPE was available, including gloves and aprons.
- Staff were observed and noted to be 'bare below the elbow' in line with the hospital's infection control policy.
- Staff informed us that infection control audits were completed, including for hand hygiene; however they were unsure of the most recent results. We saw that hand hygiene audit results from January 2015 to August 2015 ranged from 80% to 100% for all staff, and had been 100% from May 2015 to August 2015. However, the audit did not differentiate between departments, therefore we were unable to identify a particular department or any themes relating to hand washing.

Environment and equipment

- We inspected the resuscitation trolleys which were located in the corridor of the outpatient department and in the waiting area in the physiotherapy and health screening department. We noted that all equipment was in place and in date. Records showed that daily checks of the resuscitation trolleys had not always been completed in the outpatient department and checks were not completed at weekends. This was raised with the outpatient sister who informed us a list was produced every Monday to allocate an individual to check the trolley each day, except weekends. However, reception staff confirmed that outpatient clinics occurred at least one Saturday per month. This meant that checks were not consistently carried out to ensure emergency equipment and medication was safe and fit for purpose in the event of a life threatening situation.
- The imaging manager confirmed that the nearest resuscitation trolley for the imaging rooms was the ward.
- The resuscitation trolley in the physiotherapy and health screening department contained a folder with various policies and procedures. One of which contained the instructions on how to check a defibrillator, 'Lifepak 20 defib', which had a review date of February 2011. A defibrillator is a portable electronic device that delivers a dose of electrical energy to the heart during life threatening cardiac arrhythmias and ventricular fibrillation.
- We saw each consultation room had a pocket mask, used for resuscitation, which was placed by the hand wash sink. We saw that one of which had water insider the pocket mask container and another had a gel hand wipe with an expiry date of March 2014.
- During our walk around, we looked at a sample of equipment and noted that where applicable a portable appliance test (PAT) had been carried out to ensure it was safe for use. Fire extinguishers had also been checked recently, in August 2015.
- The outpatient sister confirmed that one consultant who specialised in ear, nose and throat (ENT) surgery had their own equipment which remained onsite. Records had been received to ensure the equipment had been maintained and calibrated, as required. The hospital confirmed that there was no specific policy in place for consultants bringing in their own equipment; however this was encompassed in other BMI policies including the Practising Privileges policy. The Practising Privileges policy was due for review in February 2014 and said to be currently being reviewed, however it did not reference consultants using their own equipment.

Requires improvement

Outpatients and diagnostic imaging

- The hospital risk register highlighted that one consultant brought in their own liquid nitrogen. The outpatient sister confirmed that the consultant remained responsible for this. However, as the consultant was working under the hospital's practising privileges, the hospital was responsible. The outpatient sister understood that the liquid nitrogen was transported in a special flask and appropriate plates and signs were used during transportation. The hospital ensured that appropriate PPE was available and signs were available to use on the consultation room door.
- The imaging manager explained that the hospital had basic x-ray equipment which included an analogue mammography unit that was located in the x-ray room. Meeting minutes we reviewed highlighted that the mammography unit was ageing; however six monthly inspections were undertaken to ensure it remained fit for purpose.
- Space in the imaging department was limited. The imaging office shared its environment with the ultrasound machine and we saw that a privacy curtain was drawn around the bed so that patients did not feel like they were in an office. We noted that the room was very hot and staff confirmed that the temperature in the room was often uncomfortably warm, but were unable to have air conditioning. We were told that a risk assessment would be carried out on the afternoon of 7 October 2015 and then reviewed by the health and safety lead.
- Radioactive isotope was disposed of through the orange hazardous waste stream. The imaging manager confirmed that the radioactive isotope used had a short 'half-life', which meant after six hours it could be disposed of in this way. Once the radioactive isotope had been used, it was locked away for six hours before being disposed of. All clinical and radioactive isotope waste was stored securely.

Medicines

- A British National Formulary (BNF), which is a pharmaceutical reference book, was found in each of the consultation rooms. All BNFs seen were valid until September 2015; therefore this was only just out of date.
- Temperature checks were completed on a daily basis where medication was stored, including a fridge. Records were also seen in the x-ray room of temperature checks of the medication cupboard and room. This was to ensure the correct temperature was maintained and medication was stored appropriately.
- FP10 prescription pads were stored in a locked cupboard within the outpatient department. We noted that each prescription allowed for a trace and track which could be linked to each patient. This meant prescription pads were stored securely to prevent theft and abuse.
- The outpatient sister confirmed that they worked to two patient group directives (PGDs) and were required to undertake regular annual training to continue this. One of the PGDs was to administer the 'flu vaccine. However, we were informed that if they were unable to attend training, the RMO would write a prescription to allow the outpatient sister to administer the vaccine as needed.

Records

- We reviewed a random sample of six patient records following minor procedures in the outpatient department. We noted that the records were fully completed, recording if the patient had any allergies, on any regular medication and if they had any previous operations. All records were legible and stored securely in a locked drawer with the outpatient sisters' office, which had keypad entry. The outpatient sister confirmed that records were kept at the hospital for three months and then sent off site for storage.
- Copies of the consultants' notes were kept in the hospital.
- During our walk around of the outpatient department we found patient identifiable data in two consultation rooms that were not stored securely. We raised this with the outpatient sister who acknowledged that this information should be locked, archived or destroyed depending on what the information was and how long it should be retained for. During our unannounced visit, we noted that patient information was no longer accessible.
- We also observed that patient identifiable data was locked in a drawer when receptionists left their desk to prevent this from being accessed by other patients or visitors.
- This meant patient records and other documentation containing patient identifiable data was legible, complete and stored securely.

Requires improvement

Outpatients and diagnostic imaging

Safeguarding

- Safeguarding records confirmed that 100% of staff had undergone safeguarding children and vulnerable adults training.
- Staff in the outpatient and diagnostic imaging departments were knowledgeable about safeguarding and the training they had received. All staff could inform us who the local safeguarding guardian for the hospital was. This meant we were assured that staff would know the appropriate steps to take if they had any safeguarding concerns.

Mandatory training

- Staff informed us they had completed all mandatory training and e-learning. Some of the topics covered by mandatory training included fire, infection control and health and safety.
- Training records confirmed that mandatory training had a completion rate of between 88% and 100% for all topics, with the exception of medical gases, which had a completion rate of 84%. However, the data was not provided at departmental level.
- The physiotherapists were not direct employees of the hospital. However, physiotherapy staff undertook BMI training, including e-learning and face to face training. This ensured that all staff on site were familiar with local procedures and received the same training.

Assessing and responding to patient risk

- Clinical and non-clinical staff were knowledgeable about the actions they would take if a patient deteriorated in the outpatient department. This included dialling 2222 and all staff were aware where the nearest resuscitation trolley was located. Staff told us that they had undergone training, which included scenario training or 'mock arrests.'
- The imaging manager was the Radiation Protection Supervisor for the hospital. They informed us that all patients were asked if they had undergone a recent x-ray. If the x-ray was applicable to the appointment, the image would be obtained to prevent the risk of over exposure to radiation.
- All women within child bearing age were asked whether there was a possibility they could be pregnant. This was to ensure appropriate actions were taken to reduce any potential risk to the unborn foetus from radiation.

Nursing staffing

- There were 3.4 full-time equivalent (FTE) nursing staff, including the outpatient sister, and 2.7 FTE care assistants employed within the outpatient department. Staff confirmed there was always one trained nurse and one care assistant working at any point to maintain safe staffing levels.
- Records provided to the CQC before the inspection indicated that the hospital did not use any agency staff in the outpatient department between July 2014 and June 2015. The outpatient sister confirmed bank staff would be used to cover any holiday or sickness. This meant patients could be assured that staff were familiar with the service provided and the needs of the patients.
- All new staff had to complete mandatory e-learning before they could start their role. Bank or permanent staff members were asked to cover any shifts until the new staff member had completed relevant training.
- The imaging department consisted of two full-time radiographers, including the imaging manager, and one part-time radiographer. Staff told us that agency staff had not been used in the imaging department for over six years. If cover was needed, a nearby hospital within the BMI group would be contacted.

Medical staffing

- Consultants attended the outpatient department on set days at set times. This meant that the department knew in advance of which consultant was attending and were able to allocate nursing staff appropriately to the clinics.

Major incident awareness and training

- Staff were aware of actions to take in the event of a major incident, including if there was a fire. One staff member was able to describe in detail the actions they would take and the training they had. This included taking part in role play as a patient and being strapped to a ski slide and taken down the stairs. We were informed that this allowed the staff member to be able to reassure a patient in the event of an emergency and empathise with any anxieties they may feel.

Requires improvement

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

The effective domain for outpatient and diagnostic imaging services was inspected; however, this domain is not currently rated.

There was limited evidence of how practice was audited against current evidence-based guidance, standards and best practice in the outpatient department. However, the imaging department planned and delivered care and treatment in line with current evidence-based guidance, standards and best practice.

There was limited monitoring of patient outcomes of care and treatment. Participation in external audits and benchmarking was limited in the outpatient department.

Staff had the right qualifications, skills, knowledge and experience to do their job. The learning needs of staff were understood. Staff were supported to participate in training and development.

Multi-disciplinary teams worked well together to provide effective care.

Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 (MCA) by the consultants. Limited numbers of staff had received MCA and Deprivation of Liberty Safeguards (DoLS) training.

Evidence-based care and treatment

- The diagnostic imaging audit carried out in May 2015 identified that diagnostic reference levels were last reviewed in 2012. As a result, the Radiation Protection Adviser carried out a review and an internal peer review session was held in August 2015.
- A radiologist told us that breast screening for symptomatic women was carried out for patients aged 47 years upwards. Appointments were made following a referral from the patients' GP. The radiologist confirmed that mammograms were double read, which was in line with best practice guidance within the NHS breast screening programme.
- Triple assessments were also carried out in line with clinical guidelines produced by the NHS breast screening programme (clinical guidelines for breast cancer screening assessment). This included imaging, clinical examination and image guided needle biopsy, if required.
- Staff informed us that an up to date policy manual was in place in each of the departments, however these were rarely used and staff would review the policy or guidance on the hospital intranet site. Staff were able to demonstrate to us how to locate relevant policies.

Nutrition and hydration

- Staff informed us that patients were offered tea and biscuits if a minor procedure had been carried out, or if the patient had undergone a fasting blood test. If a patient needed additional food, staff could request a sandwich or toast from the hospital kitchen. This meant patients nutrition and hydration needs were met as required when attending the outpatient department.

Pain relief

- Pain assessments were documented in patient records when they attended for a minor procedure. We reviewed a random sample of six records which evidenced this.
- Patients informed us that adequate pain relief was provided, if needed, following minor surgery.

Patient outcomes

- We were told that BMI The Manor Hospital followed a corporate plan of audits, which included medical records, consent and infection control. On review of the corporate plan, there were no specific audits for outpatient services. Staff informed us that audits were carried out regarding hand hygiene, fire and the environment. However, we were unable to assess how the hospital monitored and compared patients' care and treatment outcomes with other services, specific to outpatients.
- The imaging manager confirmed that annual imaging audits and radiation protection audits were carried out. We reviewed the results from the most recent audits and noted that action plans had been put in place. Radiation risk assessments, local rules training and quality assurance testing were the main areas for improvement. Head of department meeting minutes evidenced discussions that the hospital had held regarding the audit results and actions needed.

Competent staff

Requires improvement

Outpatients and diagnostic imaging

- The appraisal rate for all staff at BMI The Manor Hospital was 100%. All staff confirmed that appraisals were carried out every six months, which included a mid-year review. One staff member told us they discussed in their appraisal that they wanted to learn phlebotomy. With support from their line manager this had been completed.
- Data provided to us before our visit, confirmed that the 100% of the nurses employed by the hospital had verified registration with the Nursing and Midwifery Council (NMC). The imaging manager confirmed that radiographers' registration was renewed every two years with the Health and Care Professions Council (HCPC).
- Physiotherapy staff confirmed that all professional updates and best practice was checked by the hospital, including training records to ensure patients were treated by competent staff.
- The outpatient sister told us that competencies were maintained by completing e-learning training. All new staff members were inducted corporately and were supernumerary until they had completed their induction.
- Staff confirmed they had protected time to complete competency training. This included IR(ME)R training for radiographers. The imaging manager told us that they were a member of the society of radiographers. Monthly journals were received and contributed towards continuous professional development.
- The outpatient sister confirmed clinical supervision was carried out to reflect on practice and peer support was available at other BMI hospitals nearby. However, we did not see any formal record of clinical supervision.
- We noted two consultants had their own assistant that attended their clinic. The outpatient sister confirmed the assistants' qualifications, training and skills would be checked by the consultant and covered by the consultants' practising privileges rights. Although the hospital policy was under review, we saw that the policy stated that the assistants must be fully registered and that their activities were the sole responsibility of the consultant. This ensured additional staff had the correct competencies to safely carry out care and treatment on patients.
- All doctors who had practising privileges were at consultant level and were registered with the General Medical Council (GMC). This meant patients could be assured that they were treated by registered practitioners.

Multidisciplinary working

- Staff felt that there were good working relationships between colleagues.
- A one stop breast clinic was held on a Friday. The results from the clinic were discussed at multi-disciplinary meetings at the local NHS hospital. A radiologist confirmed that one radiologist and two surgeons were involved in the clinic and the radiologist and breast surgeon attended the multi-disciplinary meeting. Documented actions from the meetings remained with the responsible consultant and if the patient required surgery, the notes would be transferred to BMI The Manor Hospital.

Seven-day services

- The outpatient department was open Monday to Friday and one full Saturday per month. Staff confirmed that additional clinics were held on request from the consultant.
- The imaging department was open Monday to Friday, 8.30am to 8.30pm. The imaging manager confirmed that the service provided was 24 hours, seven days a week and radiographers took it in turns to do out of hours on call. If a radiologist was available and the patient needed an evening appointment, an additional clinic would be held.

Access to information

- The hospital confirmed that NHS records were kept on site and consultants kept their own patient records for private patients. Outpatient staff confirmed NHS records were available for appointments and consultants would be responsible for their own records relating to private patients. This ensured that staff had access to the relevant information.
- BMI The Manor Hospital informed us that hospital patient records were not removed from site by a consultant. As part of consultants' practising privileges, they had to be registered with the Information Commissioner's Office (ICO).

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Requires improvement

Outpatients and diagnostic imaging

- The outpatient sister told us that consent was obtained before a patient had a minor procedure carried out in the outpatients department. This consisted of a written consent and a copy was kept by the patient and consultant.
- We reviewed a random sample of six patient records that had undergone a minor operation and noted that patient consent was obtained as required. The risks and benefits had been noted on the document. One patient had an interpreter attending with them who had also signed the form to evidence they had communicated the risks and benefits to the patient.
- The imaging manager confirmed that implied consent was used before a patient had an x-ray. This meant consent was granted by the patients' actions.
- Training records demonstrated that 88% of staff employed by BMI The Manor Hospital had received training for mental capacity act (MCA) and deprivation of liberty safeguards (DoLS). However, this data was not split down to department level and was applicable to 25 staff members. Therefore, we could not be assured that all relevant staff had received training to provide effective care and treatment if a patient had mental capacity issues.

Are outpatients and diagnostic imaging services caring?

Good

We found outpatient and diagnostic imaging services to be good for caring because:

Patients were positive about the way staff treated them and found staff to be polite and respectful.

Patients were involved in decisions around their care and treatment and found leaflets informative regarding any potential surgery.

Patients were informed about relevant fees for their consultation before they attended for their appointment.

Compassionate care

- Patients told us staff were polite and respectful. One patient said that the staff's consideration towards patient's privacy and dignity was exceptional.
- We observed staff to be personable and professional when they spoke to patients. Outpatient reception staff were polite and respectful of confidentiality. Although the reception area was small, patients were able to have conversations with staff without being overheard and minimal patient identifiable data was discussed.

Understanding and involvement of patients and those close to them

- Patients told us that treatment options were discussed with them before a plan was agreed.

Emotional support

- Durations of appointment varied and were set by the consultants. Staff informed us that a first appointment could range between 15 and 40 minutes, while a follow up appointment ranged between 10 and 15 minutes. This meant patients could be assured they would have enough time to ask any questions, if they needed to.

Are outpatients and diagnostic imaging services responsive?

Good

We found outpatient and diagnostic imaging services to be good for responsive because:

Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services.

Care and treatment was coordinated with other services and other providers.

Reasonable adjustments were made most of the time and action was taken to remove barriers when patients found it hard to use or access services.

Premises were appropriate for the services being delivered. People could access the right care at the right time.

Complaint information or how to raise a concern was available for patients. Complaints and concerns were always taken seriously, responded to in a timely way and listened to.

Service planning and delivery to meet the needs of local people

Requires improvement

Outpatients and diagnostic imaging

- The outpatient department was on the first floor of the main building and could be accessed by lift and stairs. The health screening and physiotherapy were in a separate building, which was accessed by a ramp. This meant that the departments were easily accessible for all patients.
- The waiting areas were comfortable and refreshments were available for patients. The dedicated outpatient waiting area was small. A receptionist informed us that if the outpatient waiting area was full, main reception would be made aware and patients would be able to wait either in the main reception area or the conservatory adjoined to the ward area.
- Information leaflets regarding different surgery and magazines were available in the waiting areas. This meant patients could access additional information according to their needs and other reading material was available while they waited for their appointment.
- Patients told us information leaflets with relevant information about treatment options were provided.
- The hospital had service level agreements (SLAs) in place with a local NHS hospital with regards to some services, for instance magnetic resonance imaging (MRI) and computed tomography (CT) scans. This demonstrated that the hospital worked with local providers to ensure patients received a streamlined service.
- Almost half of patients seen in the outpatient department were funded by the NHS. This included patients who had chosen to attend the hospital through the NHS referral system and also through Circle Health for patients undergoing orthopaedic surgery.
- The local clinical commissioning group (CCG) set criteria within the contract with the hospital for NHS patients. This meant local commissioners and other providers were involved in planning services to deliver the needs of the local population.
- Staff told us when a new consultant started at BMI The Manor Hospital, the consultant would liaise with the support services manager and outpatient sister to ensure a consultation room was available. Some consultation rooms were used for specific specialties, for example ear, nose and throat (ENT). This meant consultants would be able to work in an appropriate room according to their specialty and staff could be arranged to support and deliver the service.

Access and flow

- Data demonstrated for the reporting period provided (July 2014 to June 2015), BMI The Manor Hospital met their contractual target of 95% for non-admitted pathways in 18 weeks each month.
- Staff confirmed that a patient's first appointment was booked through the national enquiry centre (NEC). With the exception of orthopaedic patients, NHS patients were booked through the NHS referral system. Any follow up appointments were booked while the patient was still at the hospital. The patient would be informed what days the consultant had a clinic and the time of the appointment could be flexible to meet the patients' needs. We observed this.
- Reception staff told us a weekly meeting was held between the support services manager and NEC regarding any issues that had been raised around the booking system. Staff were aware that all calls were recorded, therefore a transcript could be requested to ensure there were no discrepancies. Incidents data demonstrated that between November 2014 and September 2015 there had been three incidents where patients had received information from NEC containing other patient information.
- Patients felt that the booking system for appointments was excellent. One told us they were referred by their GP, seen within days at BMI The Manor Hospital and had no wait for their appointment on arrival to the hospital.
- Patients would be contacted if they did not attend (DNA) for their appointment. If the patient no longer needed an appointment, a note was put on the patient's file and the consultant informed. The same process was followed for NHS patients. If the patient still needed an appointment, a further one would be made. However, if the patient did not attend for a second time the hospital discharged the patient and recorded its decision on the patients' file.
- One patient informed us that on two attendances there had been a 20 minute and 30 minute delay in their appointment, however they had not been informed regarding the delays and received no explanation as to why it happened.
- The imaging department saw between 200 and 250 patients per month. The imaging manager confirmed that there was no waiting list and the longest a patient would need to wait for an appointment, if a radiologist was needed, would be up to a week.
- If the patient was referred for an appointment in the imaging department following an outpatient

appointment, or while they were an inpatient, the department made contact themselves with 24 hours to arrange an appointment. When a patient booked an appointment through NEC, the patient was asked if they had a recent x-ray. If the x-ray was relevant to the appointment, a copy of the x-ray was requested to prevent additional radiation exposure.

- MRI and CT scans were carried out at the local NHS hospital or another nearby BMI hospital. A referral from BMI The Manor Hospital would be made by fax and the hospital would contact the patient directly to make an appointment. This meant there was a reduced risk in delays to patient care and treatment and patients were able to access the relevant services.
- Health screening services were provided on a weekly basis and staff confirmed there was no waiting list for physiotherapy appointments.

Meeting people's individual needs

- A patient told us they were informed about the fees for their consultation before their appointment. This meant patients received appropriate information in relation to costs to enable them to make an informed decision about their appointment.
- Another patient told us that they were given good advice and information, including a leaflet, regarding pre-procedure preparations, the procedure and information for when they were discharged from the hospital. This meant patients were fully informed of their care and treatment.
- Staff told us that there was no translation service available and they relied on patients to bring a relative with them. This is not best practice.
- There was no structure in place to support people with a learning disability or those living with dementia.
- A hearing loop was in place in the outpatient department for patients with hearing difficulties. This meant some adjustments had been made to remove barriers and meet individual needs.
- Weight limits on the x-ray and ultrasound equipment meant that heavy patients would need to attend another hospital for an imaging appointment. Staff told us that the patients would be sympathetically informed at the time of their consultation.

Learning from complaints and concerns

- Patients were aware of the complaints process. Patients told us they were happy with the service, however knew how to raise a concern or complaint if they had one.
- Staff were knowledgeable about the process and explained how they would try to resolve a patients' concern or complaint at the time.
- The hospital had set up a weekly call with NEC as a result of three complaints received since the booking process had changed. Staff were aware of this and raised any issues with the support services manager to escalate further.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We found outpatients and diagnostic imaging services required improvement for well-led because:

The arrangements for governance did not always operate effectively. Risks and issues were not always dealt with appropriately or in a timely way, particularly with regards to infection prevention and control. This included the oversight of the refurbishment of the outpatient department in accordance with relevant infection prevention and control legislation.

There was a BMI vision and a hospital annual plan.

Staff satisfaction was good. Staff felt supported and valued.

There was a limited approach to obtaining the views of patients. Feedback was not always reported or acted upon in a timely way.

Appropriate improvements were not always identified or action not always taken.

Vision and strategy for this this core service

- Staff were aware of the overall corporate vision. When asked about the vision for the hospital, they explained part of the vision was to refurbish the outpatient department and gain planning permission for a MRI scanner.
- One staff member told us they were unsure what the future plans were for the hospital, as they had been told in the past, of potential developments, which did not start.

Requires improvement

Outpatients and diagnostic imaging

- The annual plan detailed the objectives around the installation of the MRI scanner and the refurbishment of the outpatient department. However, neither had a due date for completion.

Governance, risk management and quality measurement for this core service

- The membership, as stated within the terms of reference, for the hospital governance committee included the director of nursing. We noted that heads of departments, for instance, the outpatient sister reported directly to the director of nursing. However, within the hospital structure, there was not a director of nursing. This position was entitled Director of Clinical Services, therefore reporting structures were not accurate.
- The terms of reference for the infection prevention and control committee required members to attend at least three meetings annually and to provide a written report for their department in their absence. However, we noted the outpatient sister or a representative had not attended since October 2014 and there was no evidence that a written report had been provided.
- We reviewed the hospital risk register and noted three risks that related to the outpatient department. The risk register did not detail actions needed to mitigate risks. For example, sinks that did not conform to Health Building Notes (HBN), needing to be replaced. These risks had been added in 2013 and included the actions being taken as a control measure, which were limited, one of which was using paper towels to turn the taps on and off. However, this was not checked or audited.
- The outpatient sister and imaging manager were aware of the biggest risks in their departments. This included the building, need for refurbishment in the outpatient setting and ageing equipment in the imaging department. Neither of these risks were on the risk register. This meant we could not be assured there was sufficient governance systems in place to assess, monitor and mitigate risks.
- The four consultation rooms waiting to be refurbished had carpets in the rooms. In two of the consultation rooms, the carpet was in a poor state of repair. The carpet was coming away from the wall exposing laminate coved flooring in one and in the other; the carpet had been taped over to prevent a trip hazard. There were no risk assessments in place to describe how hazards to patients and staff were minimised.
- Neither the senior management team or the infection control lead were aware that that the newly refurbished outpatient room was non-compliant with Hospital Building Notes with regards to infection prevention and control. This demonstrated lack of attention by the senior team with regards to patient safety. The infection control lead nurse and director of clinical services confirmed that they had not signed off the new consultation room as fit to use following the refurbishment, to ensure the room met current infection prevention and control legislation to prevent the risk of spreading infections. This meant current legislation and guidance had not always been taken into consideration when changes were made.
- Staff told us that audits, for example, hand hygiene and the environment, were completed monthly and the results were discussed at relevant meetings, including the hospital governance committee. Meeting minutes we reviewed confirmed this.
- Departmental meeting minutes demonstrated that information from other meetings were cascaded, this included information around the risk register, clinical incidents and infection control.
- The hospital maintained a Medical Advisory Committee (MAC) whose responsibilities included ensuring any new consultant was only granted practising privileges if deemed competent and safe to practice.

Leadership / culture of service

- Departmental leads told us they were proud of their staff. The imaging manager and outpatient sister had worked in the hospital for many years and progressed to their current role.
- The outpatient sister informed us that sickness rates were low; however, data demonstrated the sickness rate was 10% for nursing staff and care assistants from July 2014 to June 2015, with the exception of August 2014 (25% for care assistants).
- The nursing team and reception team communicated well together and supported each other.
- Staff told us they felt valued and connected with their work and colleagues. They said the managers in the hospital were approachable.

Public and staff engagement

Requires improvement

Outpatients and diagnostic imaging

- Patient experience surveys were available in outpatient department. However, we did not see any evidence how this information was used to develop the services.
- Patient focus groups consisted of the executive director, director of clinical services and patients. Staff told us the patient focus groups did not have good attendance; however work was ongoing to improve the attendance and involvement of patients. We were also told heads of departments were not involved in these groups.
- Staff told us they were informed regarding any new developments within the service; however the developments either took a long time to complete or did not happen. Departmental meeting minutes evidenced staff involvement in local matters, specifically training requirements.
- Staff were aware the outpatient department was to undergo a refurbishment. However, were unsure when this would be completed by and had no involvement in refurbishment plans.
- Imaging staff were aware of the plans for the installation of the MRI scanner and that planning permission was awaited.
- Minutes from the medical advisory committee (MAC) evidenced discussions around the outpatient department and MRI scanner. It was noted that the project team would be responsible for the décor and furniture during the refurbishment.
- However, we found that there was a lack of robust governance processes in place to review the quality of the service provision and implement improvements.

Innovation, improvement and sustainability

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the hospital MUST take to improve:

- Ensure enough staff with the appropriate skills are available to care for patients.
- Ensure that all equipment used by the service is clean and stored correctly.
- Ensure sharps are disposed of correctly.
- Ensure clean and dirty equipment is not stored in the same area.
- Ensure the new outpatient room conforms to building regulations.
- Ensure hand wash sinks conform to building regulations.
- Ensure that there is a sufficient supply of personal protective equipment in all consultation rooms.
- Ensure that equipment checks in place are carried out efficiently in accordance with the hospitals policy or to identify all concerns.
- Ensure that incidents are categorised correctly and fully investigated before being closed.
- The provider must ensure effective systems are in place to assess, monitor and improve the quality and safety of the services provided; including undertaking relevant audits to monitor and improve patient outcomes.
- Ensure effective systems are in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users, including ensuring that the risk register is reflective of service risks.

Action the provider SHOULD take to improve

In addition, actions the provider SHOULD take to improve:

- Ensure records are always stored securely.
- Ensure root cause analysis training is undertaken for at least senior staff.
- Ensure all incidents are recorded and staff receive feedback and learn from incidents.
- Ensure that staff receive formal supervision and appropriate competencies
- Ensure staff receive training to care for patients with dementia.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12. (1) (2) (a)(b)(c)(d)(h) Care and treatment must be provided in a safe way for service users.** How the regulation was not being met: The provider did not operate effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. Ensure equipment is clean and stored correctly. The provider did not operate effective systems designed to prevent, detect and control the spread of infection and did not maintain appropriate standards of cleanliness and hygiene in relation to equipment and fixtures and fittings in outpatients and the operating theatre. In outpatients, the resuscitation trolley was not checked regularly.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(1) (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing**

How the regulation was not being met: The provider did not operate effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users including undertaking relevant audits to monitor and improve patient outcomes.

Risks were not always identified, monitored and mitigated.

Incidents were not always categorised accurately and closed before investigations were complete.

Resuscitation equipment was not checked thoroughly in outpatients.

Incidents were not always categorised correctly and were closed before they had been fully investigated.

This meant that the provider did not have appropriated systems and processes in place that enabled them to identify and assess risks.

There were not always sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the ward.