Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

BMI Sarum Road Hospital

Sarum Road, Winchester, SO22 5HA

Tel: 01962844555

Date of Inspection: 07 November 2012

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We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Cleanliness and infection control	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	BMI Healthcare Limited
Registered Manager	Mr. Justin Hely
Overview of the service	BMI Sarum Road Hospital is a purpose built private hospital situated in Winchester, Hampshire. The hospital can accommodate up to 48 in patients and provides a range of out patient services.
Type of service	Acute services with overnight beds
Regulated activities	Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 7 November 2012, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service and talked with staff.

What people told us and what we found

During our visit we spoke with seven people who use the service, they all understood the care and treatment choices available to them. People told us that they were able to discuss any aspects of their care or treatment with the nursing staff or consultants. One person told us "all questions were answered in a way I could understand."

The service carried out an assessment of each person's needs before they started their treatment. Pre admission assessments took place for all people and risk assessments were completed. One of the people we spoke with said, "Nothing is too much trouble, I feel safe."

All staff showed awareness of good hand hygiene. We saw that antibacterial gel dispensers were available in prominent places around the hospital for the use of staff, patients and visitors. Laminated posters demonstrating good hand hygiene techniques were displayed above hand wash sinks.

All the staff we spoke with said that they felt well trained to do their job. We saw the records which were kept by the service to record details of consultants' professional development. These included details of their last appraisal and details of their medical protection insurance.

BMI Healthcare Limited,carried out audits of the service to monitor clinical performance, infection control, patient satisfaction and other aspects of patient care.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

During our visit we spoke with seven people who use the service, they all understood the care and treatment choices available to them.

People who use the service were given appropriate information and support regarding their care or treatment. People told us that they were able to discuss any aspects of their care or treatment with the nursing staff or consultants. One person told us "All questions were answered in a way I could understand." Everybody we spoke with told us that the service had provided them with clear information about their hospital admission and treatment. One person said "I was provided with an information pack with leaflets about the hospital." Another person told us, "I had information about my procedure and a physiotherapy plan."

We saw that information leaflets about specific procedures and general information were available throughout the hospital. Reception staff told us that if patient information was required in a particular language, or for a person with a sensory impairment, they would approach the provider's marketing department. They felt confident that that they would be able to provide appropriate information for people. The service also produced information for children, which prepared them for their stay in the hospital. A paediatric nurse was responsible for preparing individual information for children and their families. This meant that information relevant to the child, and their family, was given in a way that was appropriate to their age and understanding.

People expressed their views and were involved in making decisions about their care and treatment. The provider gave all outpatients, at their first appointment, and all inpatients, the opportunity to complete a patient satisfaction survey. We saw the last analysis of survey results dated October 2012. Feedback from outpatients showed 100% satisfaction with privacy, explanation of treatment and sufficient time for consultation and discussion. In-patient survey results contained comments about the rooms and facilities. Negative comments such as the age of the television sets had been addressed and new televisions had been installed in all rooms. Approximately 8% of respondents were dissatisfied with the after care they had received. The director of nursing told us that as a result of the

comments they had introduced a named nurse system for the immediate post operative period and post operative physiotherapy support. This was done so that people felt more supported and were able to get the information they required, even outside normal working hours. Six of the people we spoke with told us that they were introduced to an allocated nurse for each shift.

People we spoke with all said they were happy with the admission or appointment times. "Times are very flexible to accommodate my husband taking time out of work."

All the people we spoke with commented positively about how the service maintained their dignity and privacy. One person told us about the staff, "They always knock on the door and come and introduce themselves." A chaperone service was available for everyone and this information was on display throughout the hospital. One person told us that they had been offered a choice of gender of consultant. We observed a person walking to theatre with their own dressing gown over the theatre gown. Privacy and dignity was maintained throughout their procedure.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. The service carried out an assessment of each person's needs before they started their treatment. Pre admission assessments took place for all people and risk assessments were completed for relevant aspects of people's care. Risk assessments had been carried out to assess, for example, patient movement and handling, deep vein thrombosis (DVT) and the risk of falling. Staff told us that if pre admission nurses were concerned about any aspect of a person's pre admission assessment they would discuss those concerns with the anaesthetist or consultant. This meant that any tests or checks that may be needed could be arranged in advance. This avoided any delay or change to treatment times. Catering staff told us that they were alerted by the pre admission team of any special dietary requirements people may have. This meant they could ensure that suitable food was available for them during their stay. We also observed the chef visiting one person to discuss their meal requirements.

People's care and treatment reflected relevant research and guidance. We were accompanied on our visit by a clinical specialist. This person's experience was in theatre management and surgical care. They obtained information on the organisation and running of the theatre suite and observed one person's care throughout their theatre journey. The service had procedures in place to ensure that all patient safety checks took place. This reflected relevant guidance from the Association for Perioperative Practice (AfPP). We saw that all records were completed in a timely manner, both in theatre and pre and post operatively.

During our visit we looked at the medical records for four people. We saw that these were signed and also updated as a person's needs or situation changed. All records contained details of assessments and discussions that had taken place. Three of the people we spoke with said that after their operation staff made regular checks. One person said, "Nothing is too much trouble, I feel safe."

Staff told us that they were kept informed about inpatients' progress and needs during shift handovers. Some handovers were done face to face and others were done with the use of a dictaphone. This meant that staff starting their shift were kept informed and updated about each person without the need to take staff away from providing care. One person told us "Staff are always well versed; they are very well briefed and know all about you."

We spoke to ten staff from various departments and with a variety of job roles. During our conversations with them it was clear that they were all focused on delivering the best care they were able to. All the staff we spoke with appreciated having the time to talk to people about their care and treatment. They were able to answer people's questions and provide reassurance and support. During our visit we spoke with seven people who were all complimentary regarding the care they had received. One person said "Excellent pain management. They ask if I need anything and if I am comfortable."

There were arrangements in place to deal with foreseeable emergencies. All staff told us they received training in life support and had regular updates.The service had a high dependency unit (HDU) available for people. This unit was used for pre planned admissions but was also available for specialist care, for example, following an untoward surgical incident. The service also had protocols in place for admission to and discharge from the unit, which included to National Health Service (NHS) intensive care units.

Cleanliness and infection control ✓ Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

People were cared for in a clean, hygienic environment.

Reasons for our judgement

There were effective systems in place to reduce the risk and spread of infection. All personal protective equipment was available for staff. During our visit we observed this being used appropriately.

All staff showed awareness for good hand hygiene. We saw that antibacterial gel dispensers were available in prominent places around the hospital for the use of staff, patients and visitors. Laminated posters demonstrating good hand hygiene techniques were displayed above hand wash sinks. A member of staff described to us the hand hygiene teaching session they had organised and delivered. All staff we spoke with told us they had taken part in infection prevention and control training.

There was a dedicated Central Sterile Supply Department (CSSD) which ensured that sterile equipment was available for procedures carried out at the hospital. All instruments were decontaminated off site with collections and deliveries twice a day. Staff we spoke with felt that this routine was acceptable. In an emergency, they told us, a four hour turn around time was possible. The CSSD had a fulltime member of staff who ensured that the appropriate equipment was decontaminated and available when required. This person had undergone specific training for their role. The service, as far as it was able, used single use instruments, especially for endoscopic (keyhole) surgery. This meant the medical device was used for an individual patient during a single procedure and then discarded.

We saw that in theatre there were procedures in place to keep clean and dirty instruments separate. This was made easier by the design of the building. We were told by staff that the segregation of instruments was strictly maintained. We also observed this in practice.

The service had systems in place to monitor the prevention and control of infection. The service had an infection control policy which named the person who was head of infection prevention and control. Staff we spoke with knew who was responsible for infection prevention and control and were aware of how to contact them for help and advice. Each hospital department had a link nurse for infection prevention and control. We saw a recent infection control audit which had been completed. No areas for improvement had been identified in the audit report. Infection control link meetings took place every two months.

The service had a contract for the disposal of various types of hazardous and clinical waste. We were able to see consignment notes and quarterly returns which confirmed that

waste was collected regularly. The service also had a waste management policy which was regularly reviewed. The service had appointed a senior member of staff as waste officer to oversee the implementation of the waste management policy.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

Staff received appropriate professional development. During our visit we spoke with 10 staff with various roles within the service. All staff said they felt well supported to carry out their role. They felt able to discuss any issues with their line manager, although one member of staff said that they had found some senior staff difficult to approach. Staff we spoke with were able to tell us of the one to one supervisions they received and appraisals which the service aimed to carry out at least twice a year. We were unable to discuss training and appraisal with the consultants working on the day of our visit. We saw the records which were kept by the service to record details of consultants' professional development. The provider may find it useful to note that there were some records missing for some consultants. These included details of their last appraisal and details of their medical protection insurance.

All the staff we spoke with said that they felt well trained to do their job. Some staff felt their competence was due to their experience rather than recent training provided by the service. A relatively new member of staff told us about the induction they had been required to undertake before starting work. This had included an induction day and relevant training. They told us that they had also been supernumerary for three to four weeks before being included in the staffing rota. This meant they had been able to learn all aspects of their role by shadowing more experienced staff.

Staff training was coordinated by the heads of departments. They told us that they regularly assessed staff training needs and found relevant training courses as and when required. In some cases, staff were able to attend training organised by the local NHS hospital. Staff told us that they had face to face training in certain subjects such as life support and blood transfusion. There was a programme of e-learning subjects that they all had to complete. Catering staff told us that they completed the same training as all other staff with the exception of subjects only relevant to clinical staff. The e-learning was on a yearly cycle and staff were allowed time to complete the modules. Some staff told us that they found e-learning to be a difficult format if they had limited information technology (IT) skills. Some staff also felt that more formal training was sometimes easier to arrange in terms of staff rostering. The provider may find it useful to note that some staff found it difficult to access a computer in a quiet area for uninterrupted learning.

Staff were able, from time to time, to obtain further relevant qualifications. We saw two

members of staff carrying out extended duties. These people had received the necessary additional training to fulfil these roles as part of their professional development. One member of staff we spoke with said they had expressed an interest in a specialist course and that was currently being considered by their manager.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

As provider BMI Healthcare Limited carried out audits of the service to monitor clinical performance, infection control, patient satisfaction and other aspects of patient care.

The service kept a record of all clinical governance issues. There was also a record of any lessons that had been learnt as a result of any of the incidents. For example a root cause analysis meeting had been held to discuss a patient infection. This had included a study of the patient's record and a review of the hospital's processes. A root cause analysis is a process which allows organisations to understand areas requiring improvement in patient care and identifies actions to minimise the chance of recurrence for future patients.

We looked at the minutes for management team meetings and clinical risk manager's meetings. One of the incidents discussed was escalated to the Medical Advisory Committee (MAC). We were able to see that incidents discussed at management meetings were taken, if relevant, to the MAC and possible improvements and changes were discussed and implemented.

The provider took account of complaints and comments to improve the service. We followed a complaint which had been made regarding post operative care. We saw that this had been discussed at the MAC and new procedures had been introduced. All patients now had a named nurse both during their admission and post operatively. This meant that people felt supported and able to discuss their needs or ask questions. Physiotherapy support had also been introduced for certain post operative patients to give them advice and exercise if relevant. We observed a person being escorted into theatre by a nurse who was later the person's recovery nurse, ensuring continuity of care. One person told us, "They were very attentive in anaesthetic and in my aftercare."

People who use the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. We saw results of the latest patient satisfaction survey. There had been a full analysis of the results and comments from the survey had been acted upon. One person had commented that their late admission had been at a time when the chef was not in the building and they had not been able to have a meal. We spoke to the chef who told us that if they know of late admissions they made

sure that a meal was left for nursing staff to serve. There was always a selection of food available in the ward kitchen for unexpected admissions and for people who felt hungry during the night.

Staff told us that they had the opportunity to provide feedback about the service and how it could be improved. One member of staff told us about the oncology care pathway they had on trial. Staff were encouraged to feedback their opinions and to suggest changes or improvements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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