Inspection Report

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

BMI The Clementine Churchill Hospital

Sudbury Hill, Harrow, HA1 3RX

Tel: 02088723872

Date of Inspection: 27 January 2014

Date of Publication: April 2014

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

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Safeguarding people who use services from abuse	✗ Action needed
Cleanliness and infection control	✗ Action needed
Management of medicines	✗ Action needed
Safety and suitability of premises	✗ Action needed
Safety, availability and suitability of equipment	✗ Action needed
Staffing	✗ Action needed
Supporting workers	✗ Action needed
Assessing and monitoring the quality of service provision	✗ Action needed
Records	✗ Action needed

Details about this location

Registered Provider	BMI Healthcare Limited
Registered Manager	Mrs Janice Hale
Overview of the service	BMI The Clementine Churchill Hospital provides acute services with overnight beds to both private and NHS patients. The hospital provides a broad range of specialist services and treatments.
Type of service	Acute services with overnight beds
Regulated activities	Diagnostic and screening procedures Surgical procedures Termination of pregnancies 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 27 January 2014, 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, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We were accompanied by a pharmacist and were accompanied by a specialist advisor.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

We spoke with 21 patients, six friends and relatives and 30 members of staff including members of the Executive team, department managers/directors, consultants, surgeons, nurses, health care assistants, porters, administrative, human resource and clinical governance staff.

Although most of the patients we spoke with were happy with their care and treatment and had their consent obtained, there were not adequate arrangements for foreseeable emergencies, and patient safety and welfare were not always ensured.

A few patients were concerned about the way they were treated by staff and we found that the provider had not taken sufficient steps to ensure patients were safeguarded from abuse.

Although most of the patients we spoke with were happy with the environment and found it clean and tidy, the provider had not put in place appropriate measures to ensure patients were protected against the risk of infection and parts of the premises were not fit for purpose.

Patients were not protected against the risks of the unsafe use or management of medicines.

The provider did not always have sufficient or maintained equipment.

Most patients were happy with the numbers and the quality of staff that cared for them, however we found there were not always sufficient, trained or professionally developed

staff.

There were not appropriate arrangements in place to monitor the quality of the service.

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

What we have told the provider to do

We have asked the provider to send us a report by 03 April 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

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

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

Before patients received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. All the patients we spoke with told us that their consent had been requested before any treatment was conducted. Comments included, "I choose not to have a male carer/nurse assist me with my personal care and staff respect my wishes." We were also told and we observed that staff knocked and asked to enter patient bedrooms, before patients agreed they could enter. Patients also told us that their consent was informed. Comments included, "I was given information about the spinal surgery care pathway, which helped me understand the procedure," and "I was allowed time to make my mind up about the treatment and I found this very comforting."

We saw a number of patient records and they all had consent correctly recorded and checked, particularly when a patient was having surgery. We observed that double checks were also undertaken by administrative staff before patients were admitted or had an appointment to ensure patient details were correct. Records showed that the hospital had an up to date chaperone policy in place both for adults and children so those that wanted or required a chaperone were accompanied in appointments by an appropriate member of staff and that this was recorded. However we saw a record of two incidents reported in the past three months where consent had not been completed correctly prior to patients having surgery. In addition, there was an action plan regarding consent for consultation room procedures but this had not yet been completed despite being due for completion by 30 November 2013.

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Most of the patients we spoke with were happy with the care and treatment they received. Most told us that staff treated them with dignity and respect and that treatment was explained to them. One person said, "I am of the belief that staff treat me with dignity and respect, I am called by my christian name, because I have given them permission to do so." Another said "my key nurse spends time with me and can discuss any difficulty I have...my nurse never leaves without asking if I am ok." However there were a minority of comments where people felt they were not treated well.

When we tracked a patient having surgery, the appropriate pre theatre checks were carried out and recorded such as WHO safety check lists, positioning done in line with guidance on pressure care and safety, and instrument and swab checks. Specimens were processed in line with current policies. Nursing for recovery was conducted correctly. When we spoke with staff throughout the hospital, they were aware of the specific needs of the patients they were caring for and were knowledgeable about treating pressure sores.

Care and treatment was not always planned and delivered in a way that was intended to ensure patient's safety and welfare. We saw records of incidents that had been reported within the hospital where the investigation had not been concluded at the time of the inspection. We identified that a number of incidents had occurred. These included two incidents, one where a portion of a pin was retained in a patient, although it was agreed during the operation that leaving this in the patient was the best option for them. Another where a screw had broken in the patient although again it was agreed during the procedure that leaving this in the patient was the best option. Other incidents were reported that involved complications from prolonged positioning during an operation and wound complications following surgery. Although the recording and reporting of these incidents is a suggestion of a good patient safety culture and that the theatres team had discussed incidents in its last team meeting, they only discussed the completion of incident forms and not learning from the incidents themselves. The incidents had been discussed and action plans created in executive team and clinical governance meetings, however we

saw no evidence of trends being identified with theatres apart from the amount of incidents being reported.

The patient records we checked showed that pre assessment checks were carried out such as deep vein thrombosis (VTE), skin integrity, infection, falls and nutrition risks. However there had been a number of incidents in these areas where these checks had not been carried out. When we spoke with staff about learning from incidents, there were a number of staff who told us that they got very little feedback on incidents that had occurred. This meant that there was a risk to patient's health as measures to prevent patient deterioration and to prevent incidents were not always put in place. When incidents occurred, these were not always learned from.

We checked the quality and safety report for December and noted that there was a report on NICE guidance that included updates from as far back as June 2013. We were told these updates were distributed monthly to staff but when we spoke with some staff in ITU about the NICE guidelines, they were unable to find them. This meant that there was a risk some staff may not be aware of current NICE guidelines and so there could be a risk to patient safety.

In some areas in the hospital the arrangements in place to deal with foreseeable emergencies were inadequate. Although the outpatients department reviewed the resuscitation calls it made every six months, its own policy said the meetings should occur quarterly. It was not clear if this was replicated in the rest of the hospital. The records for staff training in various forms of life support showed that only 31% of clinicians required had up to date adult basic life support training. Percentages of staff trained were even lower for other forms of life support training such as paediatric life support (2%), immediate life support (12%), advanced life support (0%). Some of the crash trolleys we checked had a number of gaps on their checks. One had five gaps in a month.

Some of the patients we spoke with in outpatients told us there were times their appointments ran late although they were apologised to when this occurred. The staff we spoke with told us that they informed patients when appointments were running late. They said some consultants often ran late and there was reliance of the staff to inform patients of any delays as there was no display regarding any delays in the waiting area. Staff told us patients were frustrated with the waiting system in the outpatient area as although patients pre-booked their appointments, they had to obtain a ticket before checking in at the department and this caused both confusion and frustration.

Safeguarding people who use services from abuse ✖ Action needed

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was not meeting this standard.

Patients were not always protected from the risk of abuse, because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Patients were not always protected from the risk of abuse, because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. Although most patients we spoke with were not concerned by how they were treated by staff, a few patients had concerns with how staff treated them. One person said "I had my slippers on before I went to theatre and when I woke up they were missing. I have asked on three different occasions and I have still not had an answer." Another said "On one occasion I had my family visiting and the nurse came into my bedroom and loudly said 'have you had your bowels opened today', I was embarrassed and so were the members of my family." Patients were aware of how to raise any concerns.

The provider and the hospital had whistleblowing procedures for staff, however some members of staff we spoke with were unaware of them. This meant there was a risk staff would not know who to contact if they wanted to raise a concern anonymously.

When we spoke with staff about safeguarding children and vulnerable adults, most of the staff we spoke with were only aware of reporting concerns to their manager and were not aware of reporting to the local authority safeguarding team or the Care Quality Commission (CQC). Although the provider's safeguarding policy was up to date, the hospital's safeguarding policy was out of date as it did not refer to the CQC or the Disclosure and Barring Service (DBS), who now make criminal record checks and oversee the list of employees barred from working with vulnerable adults. Most staff were not aware of the London guidance document regarding safeguarding 'Protecting Adults at Risk: London Multi-Agency Policy and Procedure to Safeguard Adults from Abuse.' This meant that there was a risk staff would not deal with or report safeguarding incidents appropriately.

Cleanliness and infection control ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Patients were not protected from the risk of infection because appropriate guidance had not always been followed.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

All the patients we spoke with told us that they felt they were treated in a clean and tidy environment. When we observed the wards, outpatients and critical care units, they appeared clean and free from unpleasant odours. Personal protective equipment was available and worn when required. When we spoke with staff, they were aware of infection control procedures and told us that they had infection control training. In critical care, daily checks for cleanliness were completed.

There were not effective systems in place to reduce the risk and spread of infection. The theatres and endoscopy units did not have suitable processes for maintaining a clean and infection free environment. Some of the clinical storage units and shelving were dusty. There were dedicated cleaners for theatres, however the standard the cleaners had to adhere to was not specified in the area. An audit by the Infection Prevention and Control (ICP) nurse in the last quarter of 2013 found a number of areas of concern regarding the cleanliness of the theatre units but although members of the executive team at the time had been informed, no progress had been made against the concerns. We found no evidence of cleaning duties, specifications for cleaning or audits of cleaning for clinical staff in theatres other than the ICP nurse report. There had been a number of incidents reported in theatres where there was a risk of infection. These included an incident where an instrument was used after being dropped and soaked only in sterilising liquid as there was no autoclave.

In endoscopy, the layout of the washroom and clean room did not allow for equipment to process from dirty to clean appropriately, as it was all in one room. The unit had washer disinfectors but they were not in compliance with current professional guidance 'Choice Framework for local Policy and Procedure (CFPP) 01-06 for decontamination of flexible endoscopes'. We were shown evidence of a business case that the executive team said would address the compliance of the endoscopy unit but no physical work had yet started.

In outpatients, the cleaning and preparation check lists for each day and in between each

clinic were not always completed.

Management of medicines ✖ Action needed

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the storage and recording of medicines.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We assessed the management of medicines at the hospital by reviewing how medicines were prescribed, used and stored, and speaking with patients, ward staff and pharmacy staff.

We found that medicines were prescribed and administered safely. When we reviewed prescription charts on each ward, we saw that when people were admitted to the hospital, doctors recorded and prescribed medicines promptly. This information was checked by pharmacy staff, who visited each ward twice a day, to provide advice to both ward staff and patients. We followed a pharmacist undertaking a routine ward visit, and saw that they clarified each prescription, and added supplementary information to assist ward staff to administer medicines safely. When people had allergies, this was clearly recorded on their prescription charts. Most patients we spoke with on each ward told us that they were satisfied with the arrangements for their medicines, and that they received pain relief when they needed it. A resident medical officer (RMO) provided 24 hour cover. Nursing and pharmacy staff told us that if there were any queries with medicines, that this was logged in a communications book, and dealt with promptly by the RMO.

Appropriate arrangements were in place to record when medicines were administered, however risk assessments on a few prescription charts were left blank and some prescriptions were not written clearly. We inspected prescription charts on each of the wards, and these provided evidence that people were receiving their medicines as prescribed. We did note, however, that on a few prescription charts, the risk assessment sections on thrombosis and bleeding risks had not been completed. Ward staff told us that people had not been placed at risk as this information was recorded on another record, the Medical Pathway, or on an older prescription chart, however this meant that some prescription charts currently in use had not been completed fully. We also noted that on one ward, some prescriptions were not clearly written, and pharmacy staff were required to rewrite the drug name on these prescription charts. On this ward, some of the nurses were from an agency, and may not have been familiar with the doctor's handwriting; therefore

unclear prescriptions may have increased the risk of an administration error. Recording was also an issue in two outstanding incidents where the investigation had not yet been completed, one where the incorrect dose had been administered and another when a medicine was not administered at the correct time.

Medicines were stored securely, but not always at the correct temperatures. We saw that medicines and medical gases were stored securely on the wards and in theatres. The temperature of medicines storage areas and medical fridges were monitored daily. When we inspected the temperature records, we saw that on one ward, the temperature had been above the recommended storage temperature for medicines since 16 December 2013. This meant that there was a risk that the effectiveness of the medicines stored in this area had been compromised. When we raised this with the Practice Development Nurse (PDN), we were told that they were aware of this, and that this issue had been placed on the risk register. We also noted that the temperature of the medicines storage areas in theatre was not being monitored; therefore there was no assurance that these medicines were being stored at the correct temperatures to remain effective. We saw that medicines for cardiac arrest and anaphylaxis stored on each ward were checked daily to ensure they were available and in date. We did note, however that the oxygen cylinders attached to the emergency equipment trolleys bore a label "Needs reconditioning in April 2012", therefore the required checks to ensure these were working correctly may not have been carried out.

Appropriate arrangements were in place to order medicines. Each ward carried stocks of commonly prescribed medicines, to avoid delays in starting treatment. Pharmacy staff visited each ward twice a day to check prescription charts for newly prescribed medicines. If these were not kept as ward stock, these were dispensed promptly. The pharmacy was open seven days a week, with an on-call service if medicines were required outside of opening hours. Ward staff told us that they did not experience any delays in receiving medicines from the pharmacy. When people were discharged from the hospital, their medicines to take home were dispensed promptly, together with a leaflet containing information on their medicines. When the pharmacy was closed, a supply of commonly used medicines for discharge was available to avoid delays in discharge. We saw that a procedure was in place for this, and accurate records were kept when these medicines were used. We were told that a doctor's surgery had recently opened on site, and staff felt that this had increased the number of prescriptions dispensed by the hospital pharmacy although we were unable to ascertain if this was the case. Even so, prescriptions were still dispensed within an hour. However, although the cost and staff number implications had been assessed for this change, a full risk assessment had not been completed.

Appropriate arrangements were in place for the monitoring of the use and administration of medicines. Regular audits of activities involving medicines were being carried out, including audits of controlled drugs and prescription chart omissions. The most recent audit, in January 2014, showed that there were very few omissions on prescription charts. The Pharmacy Manager told us that a separate medicines governance meeting had been set up in December 2013. We saw from the minutes of this meeting that issues with medicines were raised with nursing staff and that these were dealt with promptly. All the staff we spoke with were aware of the procedure for reporting medicines incidents.

Safety and suitability of premises ✖ Action needed

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was not meeting this standard.

Patients, staff and visitors were not always protected against the risks of unsafe or unsuitable premises.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Most of the patients we spoke with were happy with the premises and the rooms they were in. Comments included "I am pleased to have the private space of the ensuite bedroom, especially as my family can visit and we can be together without being disturbed." We observed that all the bedrooms were clean and maintained to a good standard. There were no health and safety hazards in the critical care unit or wards we visited although an incident had been recorded that there was too few beds in the intensive care unit. Additionally there had been flooding in the materials department in December 2013 following unprecedented rainfall, which caused the drains to overflow.

The provider had not taken appropriate steps to provide care in an environment that was suitably designed and adequately maintained. Although the theatres unit was designed in accordance with best practice guidance, it was compact and staff had to manage equipment to ensure the working environment operated efficiently. There were no preparation rooms and materials and supplies had to be stored in the corridor outside each theatre although this was well managed. There was a holding area for patients so the anaesthetic room could be used for patients coming out of theatres and so no equipment needed to be moved out of a patient's way. However, the holding area was a corridor and not suitable for the privacy and dignity of patients. Although the hospital was mostly in a good state of repair, a number of areas required redecoration due to peeling paint or damaged doors.

The washing and cleaning areas of the endoscopy unit were all in one room which was not appropriate as it meant there was not a clear flow from dirty to clean instruments. This meant it did not follow current guidance. The executive team were aware that the endoscopy unit was not fit for purpose and had started a business case for moving the unit to another area of the hospital. However although options had been costed, there had been no risk assessment on the benefits or effects of the business case.

The outpatient department had a risk register which noted that there were a lack of treatment rooms and storage space in outpatients. When we spoke with staff they

acknowledged there can be a lack of treatment rooms and that they were being asked to reduce them further for additional plaster rooms. The outpatient department carpets were worn and had trip hazards which had been taped down. The hospital manager acknowledged this required repairing.

Safety, availability and suitability of equipment ✖ Action needed

People should be safe from harm from unsafe or unsuitable equipment

Our judgement

The provider was not meeting this standard.

People were not always protected from unsafe or unsuitable equipment.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

There was not enough equipment to promote the independence and comfort of patients. When we spoke with staff, they told us that before each clinic started, they ensured that equipment was in stock and in working order. However records showed that these checks were not always completed. In addition, they told us some equipment, particularly endoscopes, broke or were having to be borrowed between outpatients and theatres and this sometimes caused an issue, although any breakages were usually replaced quickly. They told us that they had to use manual equipment in the Ear Nose and Throat (ENT) clinic for sterilising scopes as the machines for doing so were broken.

Records were completed for each type of scope used in the outpatients department and we found that equipment in outpatients was in stock in the treatment rooms we checked. However these records were unclear as additional sheets were completed before each type of instrument had been used. This meant it was unclear what instruments were running low in stock. In addition, a lack of equipment for the ENT clinic was noted on the outpatient risk register.

Although the intensive care unit had its necessary equipment in stock and checks such as crash trolleys were up to date, one of the suction machines on the crash trolleys we checked in outpatients had not been tested for nearly six years and two resuscitation trollies in other areas had gaps in its checks. This meant that there was a risk that equipment would not be in working order or complete when it was required.

There had been a number of incidents involving a lack or failure of equipment in theatres. This included a spinal cord machine failing to work when required despite having been checked and passed one hour prior to use, prosthetics not being in date, equipment not being on site and non-sterile equipment being used due to back ups not being prepared. These incidents had caused delays or cancellations in patient's surgery, risk of patient infection and a risk that equipment was not fit for patient use. Staff told us they did not always have enough equipment due to the complexity of the procedures they sometimes undertook but they were able to borrow or hire equipment in these instances. They also had duplicate sets of some equipment in case instruments were dropped but due to some procedures being complicated, this was not always possible. This meant that in some

instances, getting equipment at short notice was sometimes difficult particularly for metal work removal such as removing surgical pins. Lack of equipment for theatres was on the corporate risk register but the current action plan continued to require equipment being transferred from another site.

We were told by some members of staff that there were no PPM (plant preventative maintenance) records on site. They said these were held by the contracted engineer offsite but staff were unaware of the maintenance of PPM. We were later told these were actually available onsite. This meant responsible staff in theatres were not aware of their access to the records that showed their theatre equipment was checked and maintained as per medical device guidance. There were checklists for some equipment in theatres but these were not used or were last used in April 2013.

The disinfectors in the endoscopy unit did not meet current decontamination guidance. There was a particular issue with endoscopes as staff told us and incidents showed that there were sometimes not enough sterile scopes for procedures booked. Both these meant that some of the equipment did not meet current guidance for endoscopy units.

Staffing ✖ Action needed

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

There were not always enough qualified, skilled and experienced staff to meet people's needs.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Most of the patients we spoke with were happy with the staff who cared for them and that they could see staff when they needed to. Comments included "When I call for an assistant, the staff comes promptly and I see this as a mark of respect." and "All the time nurses are around."

Front line staff had dedicated shift plans so it was clear what tasks staff were required to do and what areas they were covering for each shift. We were told that there was a ratio of five patients to each nurse in place on the wards with the flexibility to review if there was a staffing level concern. This ratio meets current professional guidance. When we spoke with staff, they told us they were happy with their induction, and the induction records we saw had a thorough induction process including a local induction to their department's policies and procedures as well as an induction to the hospital and provider.

There were not always enough qualified, skilled and experienced staff to meet people's needs. Most of the staff we spoke with told us there were concerns with staffing levels. We were told there was sometimes not enough agency or bank staff used in outpatients if staff were sick. Staff told us that additional staff time had been allocated in outpatients to fill some of the gaps, however this was not yet in place so we were unable to assess if this would alleviate the issue.

One ward had been closed due to a lack of permanent staff after concerns had been raised by staff about staffing levels and on the day of the inspection we saw another ward had a large number of agency staff. Ward staff on other wards told us most of the concerns reported to them were regarding quality of care came from the ward with mainly agency staff. Two patients on the ward covered by agency staff told us that they had concerns, one saying that they had used their buzzer to call staff but they were not attended. When we used buzzers on the same ward, they were answered. Another patient told us, and records confirmed that their medicine always came late. We were told this was due to the agency staff but we were not provided an explanation why this had occurred. The executive team acknowledged that they required more staff and were recruiting

additional nurses to cover the shortfall.

In theatres, the current staffing rota showed the department was well staffed, however it had previously been understaffed for most of 2013 due to sickness and staff leaving to train elsewhere so we were unable to assess whether their current staffing level could be maintained.

Outpatient staff told us they kept up to date with their training, however staff told us some training was difficult to complete as it was only available on the hospital intranet. Although their line manager tried to give them dedicated time to complete it, there were not enough staff to attend patient needs while other staff were in training. One staff member told us they had personally had to complete 12 months' worth of training in six months due to being recruited mid year. Recent exit interview records showed that two staff members felt their training could have been improved and one felt there was a lack of staff.

We viewed some of the training records for the hospital and although these showed a range of specialist training had been either undertaken or booked, a number of mandatory training modules had low completion rates. Life support, records, fire, moving and handling, Mental Capacity Act 2005/Deprivation of Liberties and infection control all showed completion rates of less than 60% of required staff.

Supporting workers ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were cared for by staff who were not always supported to deliver care and treatment safely and to an appropriate standard.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

The executive team members at the time of our inspection were fairly new as the Acting hospital Executive Director had only been in that post for a few days (having been promoted from the hospital Director of Operations role which she'd undertaken for the previous 9 months) after the previous hospital Executive Director had retired. The hospital Director of Nursing had been in post for 16 months. The team was currently supported by an executive director from another hospital and the regional director of nursing on a part time basis. The executive team felt that the provider was supporting the hospital and they were enrolled on an executive team development programme. We received a mixed response regarding the support from the executive team with some members of staff saying they felt confident in highlighting concerns with them. Others felt they had to address any issues within their own team or department as no action had been taken by the executive team after they had raised concerns. The executive team told us work was due to take place to address any concerns staff felt with their communication, including adding more transparency to the strategic direction of the hospital, team building events and holding direct meetings with front line staff.

Staff were able, from time to time, to obtain further relevant qualifications. We were told, and records showed, that staff were able to obtain qualifications in specialist training. For example, some healthcare assistants in outpatients were on NVQ or diploma courses.

Staff did not always receive appropriate professional development. Most of the staff we spoke with told us either they had not had an appraisal at all or not had an appraisal for a long time. The records showed that around a third of staff had not received an appraisal in the 12 months prior to our visit, and some records showed staff had never received an appraisal despite working with the hospital for many years. Records showed that some departments had particularly low numbers of staff that had an appraisal. We were told that appraisals had been booked for all outstanding staff to take place by at least May 2014 but we were did not see the plan for how this was to be achieved.

We viewed a number of one to one meetings between staff and although all of these

addressed performance related issues, some of them did not address other professional development issues such as training needs or staff concerns.

Some staff told us that they felt they were not supported by other colleagues. For example we were told senior members of staff sometimes did not help out outpatients' administrative staff if a patient had a concern that front line staff could not resolve. In addition, some members of staff alleged that they were bullied and this was corroborated by Quality and Risk reports. When we spoke with the executive team, they acknowledged this might be happening between some junior members of staff and either consultants or senior nurses. In the exit interview records we saw, there were some concerns regarding the hospital's culture and a lack of support for staff. However, other staff we spoke with were happy with the immediate line management and told us that they felt supported and confident to raise any concerns.

Assessing and monitoring the quality of service provision ✖ Action needed

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 not meeting this standard.

The provider did not have an effective system to regularly assess and monitor the quality of service that people receive.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People who use the service, their representatives and staff were not always asked for their views about their care and treatment. When their views were sought, they were not always acted on. When we spoke with patients, some of them told us they felt unable to express their views on the service. One person told us "I feel unable to make any suggestions, when I do eat my meal after she (physiotherapist) is finished, it is cold." Staff told us that they were able to feedback any concerns they had in team meetings although some staff said it was difficult to arrange or attend these due to patient commitments. However the hospital had an annual staff survey and some patients told us they completed questionnaires to provide feedback.

The provider did not have an effective quality monitoring process. Front line staff told us that they conducted some of the checks in their department, such as crash trolleys, however some of the records for these showed there were gaps in these checks. Checks were also in place for equipment stocks and cleaning between clinics but there were gaps in these checks as well. There was no evidence of benchmarking for the hospital either between similar NHS hospitals or other hospitals under the same provider. The executive team told us learning from other hospitals was taking place, such as visits to Ealing Hospital but we were provided no evidence of how any of this learning had been put into practice.

Although an audit plan was in place for 2014 which included checking records and each department, we saw no evidence of audits taking place within services. For example, no audit of theatre practices had been undertaken such as consent form completion, safety checklists or records.

Learning from incidents / investigations did not always take place and appropriate changes were not always implemented. We had concerns with the recording and management of incidents. We had concerns with the recording and management of incidents. There were two processes, an electronic system and two types of paper forms depending on the type

of incident if clinical or non- clinical, but some staff we spoke with were sometimes unsure what category of incident should be recorded on which form. We saw that a number of incidents had been reported days after the incident had occurred and one incident report where no date had been entered at all. There were a large number of incident investigations that had taken place in the last year that had not been signed off as completed despite a number of them being serious incidents that occurred over a year ago. We saw that some incidents were being investigated by the senior staff of the department in which the incident occurred. Although this meant the investigator may have had the clinical expertise, there was a concern that they would not be objective. We were told and shown that when investigations were first completed, there were a number of errors and gaps in the investigation which meant there was further delay and a concern staff were not trained to complete them. We saw that incident investigation training had taken place and booked for senior staff to undertake.

A clinical governance meeting was scheduled every two months to ensure incidents and their investigations were tracked and learning from these took place. However, apart from one set of incidents regarding specimens, no other trend analysis had been presented despite a number of the incidents occurring in theatres. This included a number of moderate and severe incidents. The executive team acknowledged that although action plans from incidents were being put in place, the learning was not necessarily going back to the relevant department. We noted from records seen that learning from incidents at a team meeting included how to complete an incident report and investigation but not how to learn from the incidents that had occurred. The clinical governance meeting had only been held five times in 2013 and some staff were concerned that not enough clinical representatives attended. A new style of committee was due to be set up which planned to discuss incidents, complaints, claims and other patient feedback at a senior level but this had not occurred by the time of our visit so we were unable to assess if this would be valuable.

The provider did not have a robust process to take account of complaints and comments to improve the service. Appropriate arrangements were in place to deal with informal complaints. Outpatient administrative staff told us they had been trained to deal with informal complaints face to face and could call a senior member of staff if they could not deal with the concern or if the issue escalated. They did say that sometimes they were not helped when they requested assistance. One patient told us they had made a complaint and it had not been responded to appropriately. We were unable to find a leaflet or information display on how a patient could formally complain about the service, or how they could obtain advocacy support.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not always protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not always maintained.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People's personal records including medical records were not always accurate or fit for purpose. There had been some incidents where patient documentation was incorrect. For example, one patients' record gave conflicting information about the site of their surgery. Other incidents recorded included information from a patient's previous hospital not being checked or requested on transfer. We did not see evidence of an audit of theatre records. Staff told us and records showed that pre admission referral forms were not always complete and they spent time chasing the relevant patient information.

Staff records and other records relevant to the management of the services were not always accurate or fit for purpose. A checklist for equipment cleaning and use and records for frequently used equipment in theatres was not being completed. Although our check showed that the pre surgery safety checklist for theatres was being completed, there had been an incident in the last three months where the checklist had not been fully completed. Theatres had policies and procedures that were signed as read by staff, however, they had not been reviewed since 2011. There was no evidence any new staff had read and signed them. Other hospital and department policies such as infection control, health and safety and resuscitation were in place but they had not been reviewed and were out of date. Incident records and their investigations were not always complete.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The provider was not compliant with regulation 9(1)(b)(ii)(iii) and (2) as the provider was not making proper steps to ensure that each service user was protected against the risks of receiving care or treatment that is inappropriate or unsafe as the planning and delivery of care and treatment did not always ensure the welfare and safety of service users, did not reflect published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment. The provider did not have reasonable procedures in place for dealing with emergencies which are reasonably expected to arise from time to time and which would, if they arose, affect, or be likely to affect, the provision of services, in order to mitigate the risks arising from such emergencies to service users.
Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: The provider was not compliant with regulation 11(1)(a) as there were not suitable arrangements to ensure service users were safeguarded against the risk of abuse by means of taking

This section is primarily information for the provider

	reasonable steps to identify the possibility of abuse and prevent it before it occurs.
Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control**
	How the regulation was not being met: The provider was not compliant with regulation 12(2)(a)(c)(ii) as service users were not always protected against the identifiable risks of acquiring such an infection by the means of an effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of a health care associated infection and there was not adequate maintenance of appropriate standards of cleanliness and hygiene in relation to equipment and reusable medical devices used for the purpose of carrying on the regulated activity.
Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: The provider was not compliant with regulation 13 as service users were not always protected against the risks associated with the unsafe use and management of medicines by means of appropriate arrangements for the recording and safe keeping of medicines.
Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: The provider was not compliant with regulation 15(1)(a) and (c)

disease, disorder or injury	as service users and others having access to the premises were not always protected against the risks associated with unsafe or unsuitable premises by means of suitable design and layout or adequate maintenance.
Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety, availability and suitability of equipment**
	How the regulation was not being met: The provider was not compliant with regulation 16(1)(a) and (2) as suitable arrangements were not always in place to protect service users and others who may be at risk from the use of unsafe equipment as they did not ensure that equipment provided was not always properly maintained and suitable for its purpose, and equipment was not always available in sufficient quantities in order to ensure the safety of service users and meet their assessed needs.
Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: The provider was not compliant with regulation 22 as appropriate steps were not always undertaken to ensure that there are sufficient numbers of suitably qualified, skilled and experienced persons employed.
Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: The provider was not compliant with regulation 23(1)(a) as staff

disease, disorder or injury	were not appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard as they did not receive appropriate professional development, supervision or appraisal.
Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The provider was not compliant with regulation 10(1)(a)and (b), (2)(b)(i), (c)(i) and (e) as there was not an effective operation of systems designed to regularly assess and monitor the quality of the services provided particularly in regard to complaints. Changes were not always made to the treatment or care provided in order to reflect information relating to the analysis of incidents that resulted in, or had the potential to result in, harm to a service user. The views of service users, persons acting on their behalf and persons who are employed in relation to the standard of care and treatment provided to service users were not always sought.
Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: The provider was not compliant with regulation 20(1)(a) and (b)(i)as service users were not always protected against the risks of unsafe or inappropriate care adn treatment arising from a lack of proper information about them as there was not an efficient maintenance of an accurate record in respect of each service user or records in relation to the management of the regulated activity.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

The provider's report should be sent to us by 03 April 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

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 other services less often. 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.

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. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). 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.

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