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

BMI Mount Alvernia Hospital

Harvey Road, Guildford, GU1 3LX
Tel: 01483 570 122

Date of Inspections: 08 January 2013
19 December 2012

Date of Publication: June 2013

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

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<td>Registered Manager</td>
<td>Ms. Eileen Scrase</td>
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<td>Overview of the service</td>
<td>BMI Mount Alvernia Hospital is an acute independent hospital in central Guildford. It provides services to adults. Children are seen in the outpatients department from birth and children are admitted for surgery from 3 years of age. A range of paramedical services such as physiotherapy and medical imaging are available on site. The provider is BMI Healthcare Limited.</td>
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Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We reviewed all the information we have gathered about BMI Mount Alvernia Hospital, looked at the personal care or treatment records of people who use the service, reviewed information sent to us by other organisations and carried out a visit on 19 December 2012 and 8 January 2013. We observed how people were being cared for, checked how people were cared for at each stage of their treatment and care, talked with people who use the service and talked with staff. We reviewed information given to us by the provider, were accompanied by a pharmacist and were accompanied by a specialist advisor.

What people told us and what we found

Most people we spoke with were happy with the care and treatment they were receiving. The majority of people we spoke to had been admitted for planned surgery and were otherwise quite well. When we talked to them they told us about how nice the nurses were and how good the food was. As far as they were concerned there was no cause for complaint.

However, the staff we spoke to and the documents and reports we saw highlighted very serious failings. Medical, surgical and some nursing practices at BMI Mount Alvernia hospital were so poor that people were put at significant risk. This risk was, on some occasions, life threatening.

One of the most serious concerns was the care of children admitted for surgery. Staff were untrained and had very limited experience of caring for sick and post operative children. The hospital management team were dismissive of staff concerns and blocked action to improve the situation.

The provider, BMI Healthcare Limited, was not aware of the shortfalls and had not identified any concerns about this hospital.

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 30 April 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have taken enforcement action against BMI Mount Alvernia Hospital to protect the
health, safety and welfare of people using this service.

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

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

Our judgement

The provider was not meeting this standard.

Patients were not always asked for their written consent before they received any care or treatment and the provider could not demonstrate that the staff acted in accordance with the patient’s wishes. The clinical incidents reports that we saw did not show how the provider assured themselves that medical and nursing staff were seeking fully informed consent from people.

People were put at significant risk of harm because informed consent was not always sought and recorded.

The provider did not act in accordance with legal requirements where people did not have the capacity to consent. Proper assessment of capacity did not take place.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the ‘Enforcement action’ section within this report.

Reasons for our judgement

People we spoke with told us that staff asked for permission before they carried out any treatments or provided care. They also told us they had been asked to sign written consent for their operations and that the doctors had explained things in some detail.

We looked at people's medical records on two wards and saw that most had consent forms fully and accurately completed. Some were difficult to read and one was completely illegible.

We looked at the reports of several serious untoward clinical incidents. We found four instances where people had not given written consent for their operation or that of their child prior to surgery.

The hospital should follow nationally recognised safety measures to ensure that people have given written consent prior to surgery. We found this did not always happen.

In the World Health Organisation guidance it recommends that all operating theatre staff follow five simple steps to ensure patient safety. These include separate phases that the operating team should go through prior to the surgeon commencing the operation.

During “Sign In” before each patient is anaesthetised, the person coordinating the operation
checklist should verbally review with the patient (when possible) that his or her identity has been confirmed. They should also record that the procedure and operation site are correct and that consent for surgery has been given. If this guidance had been followed, as required, then the Operating Department Practitioner (ODP) or anaesthetist would have identified where patients had not signed consent prior to the procedure.

Staff, including consultants and anaesthetists, should have a pause (called Time Out in the guidance 5 Steps to Safer Surgery) when the team check verbally that it is the correct patient having the correct operation and that they have given consent to this. This often did not happen at Mount Alvernia hospital and mistakes were made. One person had a nerve block on the wrong side of their body. Another had abdominal surgery without any written consent and no record of verbal consent being given. This demonstrated a breach of the regulation as the consultant did not record that they had discussed the risks and potential complications of the procedure with the patients and did not seek consent in accordance with the General Medical Council (GMC) guidance and code of practice.

We saw a report of an incident where a patient was scheduled to undergo two procedures at the same time; they had consented to one procedure but not the other. We were told by a member of staff that the consent form had been changed after the incident was discovered. We saw the consent form had two different coloured pens throughout the document and scribbling out of some details.

On one occasion, due to problems with the main operating theatre facilities, two operations were moved from the main theatres to the ambulatory care unit (ACU). Nursing staff told us that they had voiced concerns about the suitability of the ACU being used for procedures under general anaesthetic because of potential risks. Our theatre specialist confirmed that the ACU was an unsuitable environment for procedures under general anaesthetic because the facility was not fitted with theatre standard ventilation. The lack of theatre standard ventilation poses a danger of infection to patients undergoing anything but very minor surgery. Additionally, the ACU was on a different floor from the main theatres and additional equipment required in an emergency was not readily available. Theatre staff were unfamiliar with the environment and this added to the level of risk.

If the full details of the risks of using this facility, should complications occur, had been explained to the patients involved, it is highly unlikely they would have consented to continuing with this procedure at that time. The records showed that a patient consented for the investigative procedure and that known potential risks of bleeding and infection were mentioned but there was no record that they were discussed in the context of the procedure being undertaken in an inappropriate setting which amplified the risks.

We have been told by three members of staff that a child was operated on without written parental consent. The child was brought in by a member of school staff, who signed the consent form. The guidance on consent issued by both the General Medical Council (GMC) and the Royal College of Nursing (RCN) states that only the child and/or the parent may give their consent to a surgical procedure and that this should be in writing. The incident record we saw indicated that a medical secretary told the investigating person that the consultant got verbal consent from the parents but this was not verified with the consultant. There was no record of this verbal consent being obtained. There was no record that the child was assessed and asked to consent if they were deemed competent in line with the Frazer guidance (House of Lords, 1985).

We spoke with theatre staff and they were unaware of the guidance around consent by a child assessed as competent and the impact this had on the rights of children to give their own consent. GMC guidance states “You can provide medical treatment to a child or young person
with their consent if they are competent to give it, or with the consent of a parent or the court." The guidance does not allow for the consenting to surgery by school staff. Neither the child’s consent nor an assessment of competency to give consent were recorded.

The Mental Capacity policy was last updated in April 2010 and was scheduled to be reviewed in December 2011. The policy had not been updated. The policy did not include reference to mental capacity and specific consideration of the needs of children admitted to the service. The policy needs to consider the support given to both children and their families to enable them to make decisions, where appropriate. The policy included a format for carrying out a mental capacity assessment. The second stage of the assessment required clarity in terms of how a decision regarding capacity, or a lack of capacity, was arrived at.
Care and welfare of people who use services

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

Our judgement

The provider was not meeting this standard.

The care and treatment provided to patients at BMI Mount Alvernia hospital was unsafe. People were put at significant risk of harm to a life threatening level. Children admitted for surgery were particularly at risk of unsafe and inappropriate care and treatment.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the ‘Enforcement action’ section within this report.

Reasons for our judgement

In general, the people we spoke with were happy with the care and treatment they were receiving. One person said “It is clear you get what you pay for. The food is good, I have a single room and en-suite facilities. I can’t complain.”

Another said that the nurses were “kindness itself” and went on to say that they were treated with courtesy and respect at all times. They described the care as “faultless”.

However we saw that the provider had not ensured that proper policies were in place, known to staff and acted upon, in relation to ‘Do Not Attempt Resuscitation’ (DNAR) decisions.

We saw an incident report about a patient who had died after their condition had deteriorated unexpectedly. The consultant had directed staff not to attempt resuscitation although there was no DNAR form in place and the patient was being actively treated. No notes had been written since the patient was admitted and no assessment made of the person’s condition. There was an expectation from staff that a greater positive approach should have been taken. The patient was already under the care of another consultant and the admitting consultant had not treated the patient previously. This meant they were unlikely to have known the person’s present clinical condition and did not have an opportunity to discuss their wishes in relation to resuscitation.

Consent: patients and doctors making decisions together GMC 2008 states “You should discuss with patients the possibility of additional problems coming to light during an investigation or treatment when they might not be in a position to make a decision about how to proceed. If there is a significant risk of a particular problem arising, you should ask in advance what the patient would like you to do if it does arise. You should also ask if there are any procedures they object to, or which they would like more time to think about.” This patient was admitted whilst very unwell and a deterioration in their condition was foreseeable, so the opportunity should have been taken to ascertain their wishes in advance of the emergency.
We saw the root cause analysis investigation report for this incident. The root causes of this incident were given as the decision made by one consultant to transfer the patient from an NHS hospital when the patient was acutely unwell. The patient was not then reviewed by the admitting consultant and the patient’s condition deteriorated. There had been no recorded communication with the patient’s previous consultant. The assessment, planning and delivery of care of this person was not centred on them as an individual and failed to consider all aspects of their individual circumstances. It failed to identify significant risks and say how they would be managed for this patient.

Another incident report showed that on 20 November 2012 a patient stopped breathing. Resuscitation was started and the emergency team arrived but the attempt was stopped after the Resident Medical Officer (RMO) telephoned the consultant. Resuscitation had, according to the patient notes, been discussed verbally but no DNAR forms were available. A DNAR form was completed after the patient had died. This lack of discussion and assessment of patients is not in accordance with the GMC, Nursing and Midwifery Council (NMC) and RCN good practice guidance.

We asked for a copy of the Do Not Attempt Resuscitation policy. None was provided.

We looked at the Medical Advisory Committee Minutes dated 18 July 2012 which stated – The Registered Manager advised that the hospital does have a Do Not Attempt Resuscitation policy. “When a consultant comes to do the assessment, it is at this point he (the consultant) needs to make a decision and get document signed and in place. The consultant arrived as the death occurred. A member of staff suggested asking for a decision before patients get to hospital for oncology or palliative care patients.”

The Resuscitation Committee Minutes dated 14 August 2012 stated that there was no DNAR policy at BMI Mount Alvernia hospital.

“Each institution should have a written policy about resuscitation decisions (including do not attempt resuscitation (DNAR) decisions) that is available to staff and, on request, to patients and those close to them. Every decision about CPR must be made on the basis of individual assessment of each patient.” Cardiopulmonary Resuscitation standards for clinical practice and training; A Joint Statement from The Royal College of Anaesthetists, The Royal College of Physicians of London, The Intensive Care Society, The Resuscitation Council (UK)2008

We employed a theatre specialist to look at the care and welfare of people having surgery at BMI Mount Alvernia hospital.

We were told that the ACU was not fitted with theatre standard ventilation and waste anaesthetic gas scavenging system. The unit was therefore unsuitable for undertaking any procedures under general anaesthetic and the lack of theatre standard ventilation posed a danger of infection to patients undergoing anything but very minor surgery.

A member of the theatre management team told us that there had been an incident the previous week when, due to a ventilation failure in the main suite, theatres were unable to be used but a consultant surgeon had insisted two patients admitted for investigative procedures under general anaesthetic be transferred to the ambulatory care area. One of the senior nurses who was on duty at the time said they had been very upset by the whole episode as they had pointed out the risks and objected but the surgeon had gone ahead with the operation. The guidance in the Implementation manual WHO Surgical safety checklist (First Edition) WHO/IER/PSP/2008.05 says that surgeons and anaesthetists should listen to the concerns of other team members and act on them, where necessary. Theatre logs and the
clinical incident sheets confirmed that failure of the theatre ventilation was an ongoing problem and that this incident occurred.

A well documented complication of the investigative procedure happened to one of the patients resulting in large blood loss and a need to convert the procedure to major abdominal surgery.

As this area was away from the theatre suite this had caused considerable distress to the theatre staff because they knew they were putting a patient’s life at risk. There had been difficulty transporting equipment from the theatre which was on a different floor to the area and in obtaining additional blood supplies when the patient haemorrhaged. A senior theatre staff member told us that the patients had been put at significant risk and for one patient, there had been a real risk of them dying.

Nursing staff and whistleblowers had voiced concerns about the inappropriateness of this going ahead as the risks of doing so were considered too high. These were elective procedures and they could have been deferred without significant detriment to the patients. Our theatre specialist has confirmed this was an unsuitable environment for procedures under general anaesthetic.

There was inadequate equipment on the unit for the abdominal surgery and staff had to run upstairs to fetch items from the main theatres. One of the senior theatre staff had voiced concerns that were overridden but now there was an emergency this staff member felt they were placing the patient at less risk if they scrubbed than if they did not. Staff failed to locate emergency blood supplies when the patient haemorrhaged. The theatre staff who were on duty at the time were unaware of the process for obtaining additional emergency blood. As this patient was admitted for a simple investigation the patient did not have blood taken for cross matching pre-operatively.

Large volume blood loss is among the most common and important dangers for surgical patients.

On this occasion, people were not protected from the risks of receiving care or treatment that was inappropriate. The risk level was life threatening and the failure of hospital staff to access emergency blood supplies and no readily available equipment could easily have led to a catastrophic outcome for the patient. In this case, although massive blood loss was not expected with the initial procedure, the potential complications should have been considered.

The incident above demonstrated that the provider did not have procedures in place for dealing with emergencies in ACU 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.

A senior member of the theatre staff was asked about risk assessments and business continuity plans for theatre failures of this kind. This person told us that they were “working on these but they were not currently available and other staff would be unaware of them.”

On 8 January 2013 we asked for a copy of the business continuity plan for the theatre and were told it was unavailable.

When we observed in the theatre we saw practice that did not follow professional and national guidance and which we consider significantly increased risk to patient’s safety. For example, we saw multiple breaches of the guidance provided in the Implementation manual WHO
Surgical safety checklist. Our theatre advisor was not satisfied that the 5 Steps of Safer Surgery were routinely and robustly undertaken.

For example, we did not see a briefing and staff told us that neither briefings nor debriefings were undertaken routinely but were rather the exception done by some surgeons. The names of the team for the day were not on the board and the CQC theatre inspector was not asked to put her name on the board as a visitor.

It was noted that the peri-operative care plan did not include any prompts regarding checking pressure areas or any additional pressure relieving aids. This was confirmed by the theatre staff we spoke with at the time and subsequently a senior member of theatre staff. The theatre staff we spoke to said high risk patients could be communicated at handover by ward staff but that no such handover occurred. No pressure area risk assessment details were passed to theatre staff. We reviewed a number of patient notes and saw that the theatre documentation did not contain details of how people’s pressure areas were being protected in theatre. Many of the patients were elderly people; some were at high risk of pressure damage. Anaesthesia means people are immobile and this increases the risks of damage to fragile skin.

We were told by twelve nursing staff, of varying levels of seniority, that no handover from ward to theatre staff took place prior to our visit on 19 December 2012. Staff said that there had been a nurse escort for patients going to theatre until early 2012 but we were told that this had been stopped for logistical and financial reasons. This meant only a porter accompanied patients and so no handover of clinical details took place.

At the end of the procedure there was not a verbal two person swab and instrument count and the surgeon was not informed that all was correct. This was raised by the theatre expert as soon as possible with both the theatre manager and his deputy as this was unsafe practice. There was no ‘sign out’ undertaken. We were told by a support worker that it was usual practice for this to be checked, ticked and signed by the scrub practitioner.

Retained instruments, sponges and needles are uncommon but persistent and potentially calamitous errors. The scrub or circulating nurse should therefore verbally confirm the completeness of final sponge and needle counts. In cases with an open cavity, instrument counts should also be confirmed to be complete.

The surgeon, anaesthesia professional and nurse should review the postoperative recovery and management plan, focusing in particular on intra operative or anaesthetic issues that might affect the patient. Events that present a specific risk to the patient during recovery and that may not be evident to all involved are especially pertinent. The aim of this step is the efficient and appropriate transfer of critical information to the entire team.

Another clinical incident report showed that a patient was admitted and gave consent for a nerve block on one side of their body under epidural anaesthetic. The consultant performed the operation on the wrong side. This was unlikely to have happened had the correct safety measures been properly carried out before and during the operation.

Inadvertent wrong-sided nerve blocks are uncommon but can have serious consequences including complications from the unnecessary block such as nerve injury and local anaesthetic toxicity. At worst, a wrong-sided nerve block may lead the team to continue to wrong-site surgery.
We looked at the report of another serious incident that occurred because a high risk patient was admitted for surgery. In the report the theatre manager questioned whether the admission was appropriate.

The report from the anaesthetist showed that a life threatening emergency occurred whilst the patient was being anesthetised. Theatre staff needed to take emergency action to ensure patient safety. However, the required equipment such as a difficult airway trolley and tracheotomy set was not readily available and staff were unfamiliar with some of the emergency equipment that needed to be used.

There was no root cause analysis undertaken but the report suggested that lack of equipment and staff not being competent in managing difficult airways or in the use of the equipment were issues. There did not appear to have been any consideration as to whether this person was a suitable candidate for surgery where specialist support resources were not available.

We saw several reports of incidents where samples taken in theatre were not correctly labelled. One report showed that samples of internal washings were taken in theatre and sent to pathology. The pathology form was not completed, no date or time documented, and sample name details not written on the sample.

Another report showed that samples of pelvic abscess washings from one patient were taken in theatre and sent to pathology. The pathology form was not completed, no date or time documented and sample name details not written on sample.

This put patients at risk of not having correct treatment for infections or tumours and at risk of suffering a detrimental effect upon their safety and wellbeing.

An internal email shared with us confirmed that patients were not accompanied back to the ward from recovery with a trained member of staff. It also showed that people were collected from their rooms by a porter and that no handover of clinical information took place. We were shown an email that had been sent between members of the management team that said “The easy answer is that no patient comes to theatre without a nurse, a cost fortunately that I won’t need to carry. The issues relating from that will be pissed off surgeons and time wasting, both in theatres and on the wards.”

There was a trail of discussion about untrained staff accompanying patients from theatre and a comment from the recipient that showed the hospital management were made aware that the use of untrained staff was putting patients at risk and contravened all published guidance.

Patients should be transferred to the ward accompanied by a suitably trained member of staff and porter. The anaesthetic record, together with the recovery and prescription charts, must accompany the patient. The recovery nurse must ensure that full clinical details are relayed to the ward nurse with particular emphasis on problems and syringe pump settings. (Immediate post anaesthetic recovery, Association of Anaesthetists of Great Britain and Ireland 2002)

There were also examples of where poor care and treatment outside of the operating suite compromised patient safety.

Theatre records showed that one patient who was admitted for major surgery experienced a very significant drop in haemoglobin levels which could only have occurred in such a short space of time due to extremely heavy bleeding. The patient’s records did not record any source of bleeding which showed it either went undiagnosed or the surgeon felt it was not important.
Another patient returned to the ward from the recovery area with a very low blood pressure. Theatre staff reported to the ward staff that the patient was “fine.” This resulted in the observation of this patient being less frequent and placed them at risk of further deterioration in their condition.

Records seen showed that another patient was not observed properly during the post operative period. This meant that any deterioration in their condition would have gone unnoticed and therefore untreated.

We were concerned by several incident reports relating to the safe management and administration of blood products at BMI Mount Alvernia Hospital. One patient was given two units of non irradiated blood despite irradiated blood being ordered. Another patient was given two units of blood that were past the transfusion time. A clinical incident report showed that a nurse failed to follow the corporate and hospital policy for preparation, administration and documentation of blood transfusions. Staff spoken to on 8 January 2013 were unfamiliar with the processes for properly managing blood supplies and were unclear about the supply of additional blood in an emergency. One member of the management team told us that the arrangements for managing blood supplies were “far from ideal”.

The hospital management team had not ensured staff had learned from adverse events and that this learning was disseminated to reduce the risk of recurrence of similar incidents. The number of incidents related to the management of blood administration products demonstrated that people were not protected from the risks associated with inappropriate treatment.

Across the hospital surgical services there was poor attention to detail. For example, the notes from one patient’s operation were found in another person’s medical records.

Another incident report showed that the handover sheet said one patient was admitted for a PIP implant removal (breast surgery) but the theatre list said that the patient was for bilateral lower blephoroplasty (eye surgery).

We saw a list of incidents related to chemotherapy administration. They highlighted that chemotherapy was sometimes delivered via a peripheral line cannula rather than the preferred peripherally inserted central catheter (PICC) line or Portocath. This resulted in lines becoming dislodged and chemotherapy agents causing damage to patient’s skin. It is also more painful and increases the risk of permanent damage to people’s veins.

We have an internal email sent between two senior members of staff that discussed a consultant who was described as having administered sedation and left patients without an appropriately trained member of staff. There was also confirmation that a staff nurse was the person who managed the actual sedation process and administered the drugs. Several members of staff have agreed that they would be willing to provide witness statements to this effect.

The staff spoken to reported that the same consultant had also, on more than one occasion, answered their phone in theatres, turned up late and kept patients waiting for several hours. These behaviours put people at risk of significant harm and did not comply with the corporate policy.

Staff also told us that on one occasion, this consultant brought an unannounced and unidentified visitor to theatre. The consultant insisted that the order of the list be changed
because this visitor had to leave early. This increased the risk of errors over patient identity and the procedure.

We have another internal email that showed that a senior member of nursing staff refused to have emergency equipment connected and ready for use with patients as it "looks like an NHS hospital".

We visited one ward and entered a room that had been prepared for a person who was in the operating theatre. The oxygen and suction equipment was not connected and remained in sealed plastic bags. We spoke to a senior member of nursing staff about this who said they were uncertain as they only usually worked nights. This does not follow best practice. We spoke with a senior nurse manager about this. They were unaware this happened but was aware it was not best practice.

Another senior nurse told us about a male surgeon who repeatedly refused to allow chaperones to be present when performing intimate examinations on women. The registered manager confirmed she was aware of this, as were other staff. They said the surgeon had been "spoken to about it". A senior nurse said that “after he had been spoken to he improved and sometimes had chaperones for a week or so but then went back to his old ways."

This places women in a vulnerable position at a difficult time and means they are unsupported through the examination and investigations by another woman.

A senior nurse told us that there was sometimes confusion over the emergency call bells and crash calls and this might be why some bleep holders failed to respond to emergency calls.

This view was supported by a clinical incident dated 3 May 2012 which showed that the Resident Medical Officer (RMO) failed to respond to an emergency call on his bleep. They had to be called from the restaurant to attend.

We have seen several internal emails that corroborated this and showed that the failure of resuscitation team members to attend an emergency call was not an isolated incident.

In an email dialogue between two senior members of staff we read: “Yet again, only the RMO and I responded to a cardiac arrest call. I will be submitting an incident form naming the Theatres and Bleep holder non response. It is not acceptable on any level to assume that an emergency buzzer is a "mistake" and fail to respond.” The response was “You don't know the circumstances for anyone else’s areas, theatres may well have been busy and the ODP unable to get out, they can happily respond and leave the anaesthetist to run the show by himself, hey what the heck, we can then put out a crash for theatres too.”

We asked for reports of all resuscitation attempts and training scenarios but were not provided with any. We were told by senior nursing staff that there were no reports or debriefs after resuscitation attempts and that there had only been one resuscitation training scenario in 2012.

The lack of staff responding to their emergency calls puts people at risk from inadequate response to a cardiac or respiratory arrest or other serious emergency.

A clinical incident report showed that a child was admitted for minor surgery but developed very serious complications. The child was not transferred to a more appropriate setting with paediatric critical care staff for seven hours. No paediatrician was involved in their care whilst they remained at BMI Mount Alvernia hospital.
This demonstrated that the service did not provide safe care to children. The child should have been transferred to a more appropriate setting when they first became ill but this was not done. The staff did not follow the corporate policy on transfer in an emergency. The hospital put this child at significant risk of serious harm and did not manage the risks associated with their deteriorating condition safely. Whilst there was evidence that such a situation only happened once, this was a factor in the incident and risks to the child as staff do not regularly deal with very sick children.

We asked for the Emergency Transfer of Patients policy and were given a corporate template that had not been localised to BMI Mount Alvernia hospital and which did not mention the emergency transfer of children. We spoke with several staff including theatre staff and the paediatric nurse about the transfer of children and were told there was no policy or guidance for the care of children.

We asked the lead paediatric nurse, ward nurses and theatre staff about an early warning system for identifying children who were deteriorating. We were shown the adult early warning system. This does not assist staff working with children. There was no system in place designed to identify deteriorating children.

All areas in which children are seen should have a mechanism for identifying a deteriorating child and protocols for alerting appropriately trained personnel as necessary.

Arrangements for the care of the acutely or critically sick or injured child must be in place in any unit treating children. These will include robust transfer arrangements where services cannot be provided locally. Agreed and robust arrangements should be in place for paediatric assistance and transfer if required.

We spoke with members of nursing and theatre staff and were told that there was no policy on pain management for children at Mount Alvernia hospital. There were no analgesia guidelines available. Theatre staff told us this was up to the individual anaesthetist.

All units must have effective pain management policies for children. Analgesia guidelines appropriate for children should be readily available and pain scoring should be performed routinely in any child who has undergone an operation. (Report of the Children's Surgical Forum July 2007 Royal College of Surgeons)
Cleanliness and infection control

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.

Whilst patients were cared for in a clean environment, some people were not protected from the risk of infection because appropriate guidance had not been followed.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the ‘Enforcement action’ section within this report.

Reasons for our judgement

When we spoke to patients, they were generally happy with the standard of cleanliness throughout the hospital. One or two said their rooms looked tired and in need of refurbishment.

However, there were inadequate and ineffective systems in place to reduce the risk and spread of infection. The hospital employed a lead nurse with responsibility for infection prevention and control but their advice was not always followed by staff. Policies were not adhered to and patients were put at significant risk of serious harm due to poor infection control practice.

We saw a clinical incident report that said a patient had developed very low levels of white blood cells (neutropenia) and the planned inpatient procedure under general anaesthetic had to be cancelled. The consultant decided to continue with the procedure in an outpatient setting with no pain relief or anaesthesia.

The report said the patient reported this to a member of staff and was ‘shaken by the incident’. They described the patient as being shaky, pallid and uncomfortable. Neutropenia means the patient was at very high risk of contracting an infection and might not have the immune system capacity to fight it. This condition could be life threatening. Surgery increases this risk by destroying the integrity of the skin which usually forms a natural barrier to infection.

We saw another clinical incident report that showed that the consultant performed a surgical procedure but refused to wear sterile gloves or aprons when undertaking the procedure. The assisting nurse had gloves and aprons available and offered these but they were refused. The surgeon wore long shirt sleeves with blood on them whilst performing the procedure.
The hospital policy called ‘Professional Image and Presentation’ stated that “All clinical staff must be bare below the elbows and if necessary use personal protective equipment such as disposable sleeves if available.” The consultant mentioned in the incidents above did not follow the hospital policy. This procedure should have been carried out using an aseptic technique. This placed the patient at significant risk of contracting an infection.

We saw another clinical report that showed that the surgeon involved refused to wash his hands between patients and did not change his personal protective clothing. Guidance called ‘Surgical site infection - prevention and treatment of surgical site infection National Collaborating Centre for Women’s and Children’s Health 2008.’ states that “The operating team should wash their hands prior to the first operation on the list using an aqueous antiseptic surgical solution, with a single-use brush or pick for the nails, and ensure that hands and nails are visibly clean. Before subsequent operations, hands should be washed using either an alcoholic hand rub or an antiseptic surgical solution. If hands are soiled then they should be washed again with an antiseptic surgical solution.”

We were told by several registered nurses that when they challenged this consultant they had received a dismissive response. Several members of staff told us that this was not an isolated incident and that the consultant justified this behaviour saying he had “low infection rates”. The hospital management responded by writing to the consultant enclosing a copy of the hand hygiene policy but no further action was taken.

The above incidents highlighted that the care and welfare of patients was compromised through lack of proper implementation and monitoring of infection control procedures in the theatres and across the hospital.

We looked at the hospital policy called ‘Professional Image and Presentation’ and saw that it did not follow published guidance about infection prevention and control. It gave contradictory advice and said “All staff must be bare below the elbows.” It mentioned further on in the document that staff wearing white coats must change them daily whilst acknowledging that the use of white coats is “not approved by the infection control nurse specialist due to the inability to wash hands and lower arm thoroughly between each patient contact.”

During both of our visits we observed staff who did not adhere to the ‘bare below the elbows’ guidance from the Department of Health. Our theatre specialist said “I noticed that not all staff were compliant with the bare below the elbows best practice guidelines with some staff wearing wrist watches. I fed this back to [a senior member of staff] who I noted was himself wearing a charity wrist band which I do not consider to be bare below the elbows compliant.” We saw three consultants in the outpatients area calling patients in for consultation. All three had long sleeves and one was wearing a jacket. This prevents them washing their hands properly between patient contact and puts people at risk of contracting infections.

Several of the hand gel dispensers on the ward areas were empty. We saw that clinical staff were not using hand gel when entering or leaving patient’s rooms.
Management of medicines

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

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

People spoke very highly of pharmacy staff. They told us that pharmacy staff gave them clear information about their medicines. One person showed us a discharge medicine printout provided by a member of pharmacy staff from a previous visit to this hospital and told us that all their medicines were explained to them by the pharmacist.

All ward staff, and the resident medical officer, regarded the pharmacy service and pharmacy staff highly. One comment was “the pharmacist is very attentive and knowledgeable”.

Medicines were handled appropriately. We saw that the management of medicine was under the control of a pharmacy department. All medicines were ordered, stored, supplied and disposed of in a safe manner. There was an aseptic unit to prepare chemotherapy medicines. This unit allows chemotherapy medicines to be made up in a bacteria free, clean space. Once prepared the prepared medicine has a shelf life of 24 hours. The pharmacy staff prepared the work sheet for chemotherapy in advance to assist in workload management. They gave assurance that the medicine itself was not prepared until prescribed by the doctors.

Chemotherapy treatment record charts were not kept with the medical notes and were kept within the pharmacy. We were informed by ward staff that this was a problem to them when people or relatives phoned if they had any concerns about their treatment as these could not be accessed. The provider may find it useful to note that it is accepted practice to keep people’s medical and treatment notes together.

We saw records of audits and checks for controlled drugs and the maintenance records of the aseptic unit. We saw records of the regular checks of medicines kept in the resuscitation trolley. We noted that there were no records of prescription pads for controlled drugs. This meant the provider would not be able to check if there was any misuse of these prescriptions.

The pharmacy department gave full support to the ward areas but did not get involved in supporting the theatre, outpatients or diagnostics apart from a supply function. With regards to ward areas we were told by one ward manager that they had not been informed or
consulted on what stocks would be held on their ward.

On the wards, medicines were stored and given safely. We looked at incident forms and saw some related to errors with medicines. The majority of these were staff not following policy and in most cases no harm had come to people. There were a couple of serious errors which the hospital had investigated internally. We were shown the pathway used to disseminate learning from these errors. However when we spoke to ward staff, they were less aware of any learning from incidents. Staff were also less familiar with ‘new’ medicine administration record charts. The provider may find it useful to note that their system for disseminating information to staff was not efficient.

We saw that not all staff took responsibility for processes. When we spoke to staff several comments were “I think we have something in place for this but I don’t get involved with that” or that “I don’t know anything about that”, going on to name a person who might have some more information.

We noted that the service had no Medicines Governance Committee. This meant that no checks were in place for ensuring treatment followed current methodology and there was no forum to discuss and address any concerns raised that might present a risk.
Safety and suitability of premises

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.

In general, the environment was adequate to meet the needs of short stay patients having elective surgery.

The facilities were not appropriate for the care of children.

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

When we visited we found that the hospital was in the middle of building a linear accelerator bunker and refurbishing an oncology ward. Building works were very noticeable but most patients told us they were not unduly troubled by them. However, one patient said “Had I known about the noise levels prior to admission I would have booked in elsewhere.”

In general, the hospital appeared reasonably well maintained. There was a small coffee bar near the entrance and outpatient areas for patients and visitors to use.

When we were walking around the hospital, we noticed that in the physiotherapy suite there was a room used for women needing pelvic physiotherapy that had a fire door opening out on to the main car park area. This fire exit door had a large window that had a plastic film to distort the view. There was no blind at the window. Whilst the view was not clear, we could make out the types of cars parked outside and see what people were wearing. Most women would not feel comfortable with this level of exposure.

All patients were cared for in single en suite rooms. Most were happy with the standard of the environment, although some described it as “tired” or “needing a lick of paint”.

When we looked at the theatre suite and recovery area we saw it was not suited for the care of children post operatively. There was no separate recovery area and children were cared for in the corner of the adult recovery area. This meant young children were likely to be further distressed at a time when they had undergone a traumatic event.

In “Just for the Day”, standards for day care surgery for children are defined. These include a dedicated day care unit for children. BMI Mount Alvernia hospital did not have a dedicated day care unit for children. (Paediatric Surgery: Standards of Care. Published by the British Association of Paediatric Surgeons, May 2002)

Children should be cared for in designated rooms or areas, separate and distinct from adult

There should be a separate designated recovery area for children. (Royal College of Anaesthetists. Post operative care of children 2004).
### Safety, availability and suitability of equipment

#### People should be safe from harm from unsafe or unsuitable equipment

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<th>Our judgement</th>
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<td>The provider was not meeting this standard.</td>
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Equipment was not properly maintained to ensure that it was ready in an emergency. Staff were not always familiar with where emergency equipment was kept and how to use it.

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.

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<td>A senior member of staff told us that he “assumed” the paediatric nurse had the necessary equipment. He said there were adult grab bags containing emergency equipment that the staff accompanying patients back from theatre could use.</td>
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We looked at resuscitation equipment and checks on St Ethelbert ward. There was a separate paediatric trolley and adult trolley. The suction on the paediatric trolley was broken and we were told by the surgical sister that they “shared” the adult suction. The adult suction machine was on another trolley and was too heavy to lift easily.

There was no defibrillator and again we were told they “shared” the adult machine. Children’s defibrillator pads were kept on the paediatric trolley separate to the defibrillator machine which was on the adult trolley. They were not easy to find. A senior nurse on one ward was uncertain where the paediatric resuscitation equipment was and needed to go and ask.

The choice of resuscitation equipment should be defined by the resuscitation committee and will depend on the anticipated workload, availability of equipment from nearby departments and specialised local requirements. When we visited on 8 January 2013 we asked for the minutes of all the meetings of the resuscitation committee. We were given one document that related to one meeting held in August 2012. There was some discussion about the resuscitation equipment but we were told by the resuscitation officer that none of the recommendations made by the committee were implemented.

Responsibility for checking resuscitation equipment rests with the department where the equipment is held and checking should be audited regularly. The frequency of checking will depend upon local circumstances but should ideally be daily. We looked at the records that showed how often the resuscitation equipment was checked. The hospital guidance attached to each trolley listed what should be checked daily and what should be checked weekly. This had not always been done. The trolley on St Ethelbert ward had a checklist and chart that was signed to show it was not checked on December 17.
Where resuscitation equipment is not readily available and checks are not undertaken to ensure it is complete and ready for use, delays may occur during an emergency and compromise patient safety.

We looked at a clinical incident report where a written statement from an anaesthetist showed that a patient had been put at very serious risk of death or brain injury because essential emergency equipment was not available in the operating theatres.
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 enough qualified, skilled and experienced staff to meet people’s needs.

In particular, there were inadequate staffing arrangements to allow for the safe care of children having surgery.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the ‘Enforcement action’ section within this report.

Reasons for our judgement

Patients who we spoke with said the nurses were "lovely but very rushed". One person told us that they had to wait a long time, in pain, before their call bell was answered.

We asked patients how well the surgeons and resident medical officer explained things to them both before and after surgery. Most were content with the level of explanation. However, a few people said that the surgeon was not good at providing details about what to expect and what the surgery involved. One person said "My consultant isn't really a great talker and is a bit unapproachable. I suppose how well they operate is what is important." We were told that the resident medical officer was kind and helpful but "stretched, really stretched - they seem to be the only doctor in the hospital."

A senior member of theatre staff told us about the staffing and skill mix in theatres. They explained that he had inherited an under resourced establishment which did not enable them to allocate sufficient staff to comply with the Association for Perioperative Practice guidelines of three registered staff and one support worker per theatre team. Consequently, short notice absence created extra pressure on the team. Staff allocation was managed on the day according to list complexity and by asking staff to cover additional hours if a full team was not available for all theatres. The staff member told us they had negotiated with his manager for increased establishment and that this had been agreed but funding had not yet been finalised.

We spoke to two operating department practitioners (ODPs) and one theatre support worker who all raised concerns about staffing levels. One senior member of the theatre staff team told us “The staffing levels are not safe. If people are off sick it is very difficult to cope’. They talked to us about a serious incident she had witnessed and told us there had been no
debrief or support for staff after this.

We have an internal email from a staff member that demonstrated the theatres were understaffed. It provided evidence that porters were left alone with women in anaesthetic rooms and that no escort was available. It also said that recovery ward staff sometimes accompanied patients back to the wards as there were insufficient nurses around but that this caused problems as one recovery staff member was then left with multiple post-operative patients. The email suggested that the management team was looking at potentially training health care assistants (HCAs) for this role. In the e-mail the staff member pointed out he only had one HCA with a formal NVQ level 3 qualification. In that e-mail he said one other person was "technically a HCA but with a chest certificate from when Noah was a lad." The only other person mentioned was a bank HCA who was starting HCA foundation training.

We were shown a vacancy approval form dated 30 October 2012 completed by a senior member of staff requesting funding for a trained escort for patients going to theatres. It shows that nurse escorts were stopped in early 2012 and recognised that this was putting patients at risk of harm. The form was submitted to the registered manager in October 2012. This request was only considered for action on 19 December 2012, following our visit. The emails showed that it is only since we visited that the escort funding was authorised.

As this facility undertakes surgery on children, we asked one of the senior theatre staff how they ensured staff allocated to paediatric lists were appropriately trained, for example, in paediatric life support. They told us there was no system to support this and they would not be aware of who was paediatric trained before allocating them to a paediatric list.

We asked a senior member of staff about whether there was a supernumerary anaesthetist in the theatre suite when children were being operated on as is recommended by the Royal College of Anaesthetists guidance on peri-operative care of children. We were told there was not and that if a child became unwell the anaesthetist in theatre would have to leave the child on the operating table to the care of an ODP and attend the deteriorating child.

We asked the lead paediatric nurse and other senior nursing staff who the paediatrician was who was available for advice and were told that there was not one. Where operations are performed in a day unit there should be a named paediatrician available for liaison and immediate advice and cover. (Report of the Children’s Surgical Forum July 2007 Royal College of Surgeons). Following our inspection we were informed by the provider that there was a paediatrician employed by the hospital to carry out this role at the time of our inspection. However our discussions with staff showed that the nursing and theatre staff were not aware of this.

We spoke with the one nurse with responsibility for the care of children and asked who provided cover on the ward during breaks and when they were taking or collecting a child from theatre. They explained that they did not take breaks and that the other ward staff provided cover when they were in the theatre. They confirmed they were the only nurse working at BMI Mount Alvernia hospital with responsibility for the care of children. This meant that there were times when children were left without a suitably qualified and experienced nurse in attendance on the ward. This demonstrated that there were not sufficient staff who had the essential skills to manage the care of patients, and in particular children, who deteriorate and therefore the provider failed to ensure that, at all times, there were sufficient numbers of qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.
A minimum of one registered children’s nurse should be on duty on the ward at all times to provide care to children throughout their stay, and whenever children are admitted. Ideally there should be two such nurses on duty whenever there is a children’s list. (Caring for children - Guidance for nurses working in the independent sector. Royal college of Nursing 2009)

We saw a clinical incident record that showed us that a patient had to remain an excessive time in recovery as the ward nurse was not available to collect them. The recovery nurse was unable to assist as they were caring for three post operative patients.

The Association of Peri-Operative Practitioners guidance suggests each patient should be cared for on a one to one basis during the immediate post operative period.

The published guidance suggests this is unacceptable staffing arrangements and that “No fewer than two staff should be present when there is a patient in the recovery room who does not fulfil the criteria for discharge to the ward. All patients must be observed on a one-to-one basis by an anaesthetist, recovery nurse or other appropriately trained member of staff until they have regained airway control and cardiovascular stability and are able to communicate. (Immediate post anaesthetic recovery, Association of Anaesthetists of Great Britain and Ireland 2002)

We looked at several clinical incident reports that showed that errors had been made on the wards because of low staffing levels and the use of agency staff who were unfamiliar with the needs of the patients. For example, one report showed a patient was not properly observed post operatively because two agency nurses who were unfamiliar with the hospital were providing care to the patients. When we spoke to a senior member of the nursing management team on 8 January 2013 we were told that the hospital didn’t really use agency staff.

Errors in implementing the assessed plan of care put this patient at risk of harm from an undetected deterioration in their condition. Two agency nurses working together led to mistakes. The provider failed to ensure that, at all times, there are sufficient numbers of qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.

We also saw another incident report that said that the incident was due to lack of trained staff with the patient. The patient was going for a scan from the ward and was reported as being “very unwell, on oxygen and yet no nurse or notes accompanied the patient.” This situation put the patient at significant risk of harm.

We spoke to a senior member of nursing staff and asked who was responsible for which patients. The nurse said they were not sure and said the allocation of patients was chaotic and confusing. This nurse was nominally in charge of the ward but did not know which staff had responsibility for which patients and said they were just allocated as they were admitted.

We spoke with another senior member of nursing staff who told us there was an ongoing issue with staffing levels. We were told that a new staffing tool had been introduced but what happened was not always a clear reflection of the staffing levels suggested by the staffing tool. For example, the bleep holders should be supernumerary to allow them to address urgent issues across the hospital but were often not able to be. They said this was an issue particularly on the late shift when there were more post operative patients.

The staff member explained that in surgery there were two senior sisters who were meant to oversee everything but that they were usually required to work clinically and cover direct
patient care on the surgical wards. The staff member said they hadn’t even got time to do the
off-duty rota and this meant that they sometimes had to phone someone in the morning to
cancel their late shift in the afternoon. We were also told it was difficult to release people for
training – even for half an hour.

The staff member told us that if a member of ward staff collected patients from recovery they
sent a trained nurse but if the recovery team provided a post-operative escort when the wards
were ‘short’ then they used an untrained HCA. We were told that, if the wards were staffed
properly, then a nurse could take patients to theatre rather than an unaccompanied porter.
This would allow a proper handover of clinical information and reduce risks. We were told it
used to be a nurse but they were kept waiting too long in theatre so the idea of using a porter
was introduced in early 2012 to save money.

We looked at the surgical wards staffing rota for September 2012. This gave the required
number on each shift each day and details of which staff worked on which days.

On Monday 10 September 2012 the rota showed the ward required five staff on an early shift
and five on a late shift. The record showed that only three staff worked in the morning and
three in the afternoon. The rota suggested two staff should be on duty at night but only one
was recorded.

On Tuesday 11 September 2012 the rota suggested there should be five staff in the morning
and five in the afternoon with two people on duty at night. The rota showed that four staff
worked in the morning and four in the afternoon. There were two people on duty at night.

Records for other months in 2012 showed similar patterns where the staffing level did not meet
the hospital’s own assessed minimal staffing levels.

The night staff member appeared to be covered by an HCA and on some dates no member of
staff was designated for the night cover. When we spoke with the registered manager about
low staffing levels she was very dismissive and said that “the hospital used a staffing tool.”

When we spoke with staff, they were unclear about who should respond to an emergency
alarm and who the bleep holders for the resuscitation team were. The Minutes from
Resuscitation Committee dated 14 August 2012 show that when the RMO’s bleeper failed
they were given one used by another member of the resuscitation team, leaving that person
unable to respond. The same minutes showed the composition of the resuscitation committee
was a staff nurse, the theatre manager, a physiotherapist, a radiographer, the Quality and Risk
manager, and the resuscitation officer. Staff we spoke with confirmed that this was the make
up of the group and that no medical staff attended.

Guidance issued by the resuscitation council states that the essential members of the
resuscitation committee include a physician, the senior resuscitation officer, an anaesthetist or
intensive care doctor, and a senior manager. This meant that there were not always adequate
numbers of appropriately trained staff available to attend to patients in an emergency or to
oversee the arrangements for resuscitation within the hospital.
Supporting workers

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 not always cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard. Staff training was inadequate in key areas and this compromised patient safety.

We have judged that this has a major 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

On 8 January 2013 we asked the registered manager for details of all staff who worked in the hospital, in any capacity, who had completed training about the Mental Capacity Act and Deprivation of Liberty Safeguards. We were given a printed copy of a training record that showed forty two staff had completed this training. This did not include staff such as the RMO who would be the most likely person to undertake any assessment of capacity prior to discussing people’s wishes in relation to resuscitation. We asked the registered manager if there were any other records of staff training in these topics and were told there were no other records.

A printed copy of the safeguarding children training dated October 2012 to 8 January 2013 showed the majority of clinical staff had completed the basic online training. We asked for details of any consultants who had completed the training and were given a piece of paper stating that consultants had been asked to do the training but none had. It is consultants that, according to policy, make the decision to refer child protection concerns. No member of staff, including the two designated safeguarding children’s leads had completed any more comprehensive training. There were insufficient staff with appropriate training to ensure that children are safeguarded. The provider failed to ensure that, at all times, there are sufficient numbers of qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.

No staff had completed training in identifying and managing the care of deteriorating children. The guidance of the Resuscitation Council and Royal College of Surgeons states that this is an essential requirement for staff working with children having surgery.

The Minutes from Resuscitation Committee dated 14 August 2012 show paediatric basic life support training had an allotted 30 minutes. The committee raised concerns about the content and length of course. It was agreed that the 30 minutes was not adequate but this has not been addressed. We have been supplied with the Curriculum Vitae (CV) of the bank paediatric nurse. It showed that they completed Advanced Paediatric Life Support training in...
March 2000 and Advanced Life Support training in April 1999. No current certification was listed. We asked if there was any additional evidence of more recent training. None was provided. We were told by the registered manager that she was the only person providing Paediatric Basic Life Support training. We spoke with other staff including the paediatric nurse who confirmed that the bank paediatric nurse was the person who delivered the training. This meant that all paediatric basic life support training was delivered by someone who did not have current training themselves. The guidance on paediatric resuscitation has changed significantly since 2000 and this meant staff were not being provided with the latest guidance. The course content did not follow resuscitation council guidance and was not delivered by someone with appropriate skills to do so.

We looked at the corporate Emergency Transfer of Patients policy dated 02/12 and saw that it stated that all registered nurses must complete training in the management of the deteriorating patient annually. There was no local policy. We were provided with a list which showed just seven registered nurses had completed this training. The policy recommended scenarios on emergency transfers were held annually. This had not happened.

A senior member of staff from the radiology department told us that there was no-one in the radiology department (where people were often sedated) who had completed training in the care of a deteriorating patient (adult or child). This person also said the paediatric nurse was not involved in the care of children in the radiology department, with the radiologist sitting cannulas but that this was rare. This senior staff member was unsure where paediatric resuscitation equipment was kept in the hospital.
Assessing and monitoring the quality of service provision

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 have regional and national reporting systems of some key indicators. There was trend analysis of complaints and compliments, for example. However the monitoring systems failed to identify serious shortfalls in the quality of care people were receiving and this meant they were ineffective systems.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the ‘Enforcement action’ section within this report.

Reasons for our judgement

Reported breaches of both the Nursing and Midwifery Council (NMC) and General Medical Council (GMC) guidance and Code of Conduct have occurred and been brought to the attention of the registered manager and another member of the hospital management team.

We were told by the other manager on 8 January 2013 that no referrals to the GMC or NMC have been made in the past twelve months. Given the evidence detailed above we would expect disciplinary action to have been taken and referral to the professional bodies considered.

It is likely that some incidents should have been reported using safeguarding procedures. We were told by a member of the hospital management team, who was also the safeguarding lead, on 8 January 2013 that no safeguarding referrals had been made in the previous 12 months. Given the evidence detailed above we believe that referrals using adult and child safeguarding processes should have been made.

One of the hospital management team told us that they had not been allowed to attend Medical Advisory Committee meetings and had been told that they may not see the minutes of the meetings as these were “private”. This person told us that they felt unable to carry out their role effectively without this access as they was unable to see that incidents were properly followed up.

We asked for all Resuscitation Committee meeting minutes. We were given one set of minutes dated 14 August 2012. We were told by a senior manager that no other meetings have taken place. There was no medical representation on the Resuscitation Committee.

Clinical incident reports mentioned above gave details of serious incidents that had resulted in actual or potential harm to patients. The overwhelming majority of these incidents were
closed following a brief investigation with no dissemination of learning and nobody being held to account for their actions. For example, where a nurse reported a surgeon was refusing chaperones the registered manager spoke with him. This was not recorded and there was no evidence or record of any action being taken, other than the word of the registered manager.

We asked, in writing on 8 January 2013, for a copy of the Audit Plan and action plans from this. This was not provided.

We asked for copies of all resuscitation and paediatric resuscitation scenario reports from the previous 12 months, in writing on 8 January 2013. One report was provided. There did not appear to have been any dissemination of learning or completion of action plans from this.

We asked for a copy of the DNAR policy, in writing on 8 January 2013. This was not provided.

We asked for a scoping document for the Ambulatory Care Unit and High Dependency Unit detailing the admission criteria and use of these facilities. None was provided. If such a document is not available and the admission criteria and permitted procedures are not made explicit then patients are put at risk of having inappropriate care and treatment in an unsuitable setting.

We asked for Minutes of any Medicines Governance Committee meetings in writing on 8 January 2013. None were provided. There were many medicines errors recorded on the Clinical Incident System, including those involving controlled drugs. No action appeared to have been taken to address these issues and disseminate learning. Clinical Governance reports for the year showed a Medicines Governance Committee has been suggested but no action had been taken in respect of this.

The CQC theatre specialist found that there was never any feedback of incidents to theatre staff. This was also what staff we spoke with said.

The minutes of the Medical Advisory Committee (MAC) did not demonstrate the MAC discussed clinical incidents in any depth or addressed poor practice. There was no recorded learning or action from any clinical incident recorded.

We were supplied with an untitled spreadsheet 2011/2012 that detailed the alerts and guidance updates from external agencies such as the National Institute for Clinical Excellence and the Department of Health. The chart was incomplete but provided evidence that some alerts were read and the need for any action considered. However the majority of alerts did not appear to have been considered nor had action been taken to implement the recommendations or guidance. The chart had a column for the name of the person responsible for review but this was not completed. The last two pages had comments made about updates to national guidance and clarified that the hospital did not have all the necessary guidance and that consultants followed their personal choice rather than published guidance.

We spoke with a member of the nursing management team about staff not connecting emergency equipment when preparing rooms for post-operative patients. This person said they were unaware this was happening but was aware it was not good practice. Another senior staff member told us this senior member of staff “never” visited theatres.
The staff we spoke with told us they had not received any clinical supervision or had opportunities for reflection on practice. We spoke with several staff that were very distressed following involvement in traumatic events. They told us that there had not been any debriefing or opportunity to discuss the incidents. They said that they felt there was very limited learning from incidents and a lack of openness.

Several senior nursing staff talked to us about a culture of tolerating totally unacceptable and intimidating behaviours by consultants. They said that they felt that when they raised valid concerns about serious risks they were dismissed. A member of the management team told us they had been concerned about one surgeon performing an operation on a very young child. We were told that the surgeon’s personnel file had been checked and there was no confirmation that the surgeon’s practising privileges extended to children. We were told there was no list maintained of who could or could not operate on children. When we spoke about this with the registered manager, we were told that she “was very clear that they can only do procedures they do in the NHS.”

There was no documentary evidence of this provided to us.

We found that no auditing of services for children had taken place and this had led to significant shortcomings in the safety of paediatric care. For example, paediatric resuscitation scenarios did not take place; the corporate paediatric resuscitation policy was not adhered to; the paediatric resuscitation policy was not localised to Mount Alvernia Hospital and staff spoken to were unfamiliar with the policy.

The single paediatric nurse had no local contacts in the NHS children’s unit and was working in professional isolation. This did not allow for practice to be updated and sharing of good practice. It reduced the ability of the nurse to seek professional guidance and advice on the care of sick children.

Child protection arrangements were not followed; the paediatric nurse had not completed the required level of safeguarding children training as defined in the corporate safeguarding children policy. The training records indicated there were no staff at the hospital who had done any more training in child protection than the corporate level one online awareness course.

There were no environmental audits and risk assessments undertaken in the theatre or recovery area in relation to children. The recovery area was not suited to the care of children.

We spoke with representatives from BMI Healthcare Limited on 14 January 2013 and wrote to them on 18 January 2013 about our findings. They told us they were unaware of many of the incidents detailed above. We asked how they had missed these serious failings. They were unsure at that time about where the monitoring of the hospital by the provider had failed but agreed that the issues raised were unacceptable.
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.

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Safety and suitability of premises</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td>The registered provider had no</td>
<td></td>
</tr>
<tr>
<td>ensured that service users were</td>
<td></td>
</tr>
<tr>
<td>protected against the risks</td>
<td></td>
</tr>
<tr>
<td>associated with unsafe or unsuitable premises, by means of suitable design and layout; and adequate maintenance and the proper operation of the premises.</td>
<td></td>
</tr>
<tr>
<td>Surgical procedures</td>
<td></td>
</tr>
<tr>
<td>Treatment of disease, disorder or</td>
<td></td>
</tr>
<tr>
<td>injury</td>
<td></td>
</tr>
<tr>
<td>Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td></td>
</tr>
<tr>
<td>Safety, availability and suitability of equipment</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td>The registered provider did not ensure that equipment provided for the purposes of the carrying on of a regulated activity was properly maintained and suitable for its purpose; and used correctly.</td>
<td></td>
</tr>
<tr>
<td>The registered provider did not ensure that equipment was available in sufficient quantities in order to ensure the safety of patients.</td>
<td></td>
</tr>
<tr>
<td>Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td></td>
</tr>
<tr>
<td>Supporting workers</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td>The registered provider had not made suitable arrangements to ensure that persons employed for the purposes of carrying on the regulated activity were appropriately supported to enable them to</td>
<td></td>
</tr>
</tbody>
</table>
deliver care and treatment to service users safely and to an appropriate standard, including by receiving appropriate training, professional development, supervision and appraisal.

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

The provider’s report should be sent to us by 30 April 2013.

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.
Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

<table>
<thead>
<tr>
<th>Diagnostic and screening procedures</th>
<th>Regulation or section of the Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td></td>
<td>Consent to care and treatment</td>
</tr>
<tr>
<td></td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>The registered provider failed to have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users, or the consent of another person who is able lawfully to consent to care and treatment on that service user’s behalf.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnostic and screening procedures</th>
<th>Regulation or section of the Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td></td>
<td>Care and welfare of people who use services</td>
</tr>
<tr>
<td></td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>The registered provider had not taken proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnostic and screening procedures</th>
<th>Regulation or section of the Act</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>procedures</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td></td>
</tr>
<tr>
<td>Surgical procedures</td>
<td></td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td></td>
</tr>
</tbody>
</table>

**Cleanliness and infection control**

**How the regulation was not being met:**

The registered provider has failed to follow the guidance in the Department of Health’s publication: The Code of Practice for health and adult social care on the prevention and control of infections and related guidance. The systems in place to reduce the risk and spread of infection were not adhered to by all staff and this was not challenged by the management team.

**We have served a warning notice to be met by 01 April 2013**

This action has been taken in relation to:

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation or section of the Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>Staffing</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>How the regulation was not being met:</td>
</tr>
</tbody>
</table>

The registered provider has not ensured that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.

**We have served a warning notice to be met by 01 April 2013**

This action has been taken in relation to:

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation or section of the Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>Assessing and monitoring the quality of service provision</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>How the regulation was not being met:</td>
</tr>
</tbody>
</table>

The registered provider failed to protect service users, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered provider to regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity.

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.
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:

<table>
<thead>
<tr>
<th>Essential Standard</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respecting and involving people who use services</td>
<td>17</td>
</tr>
<tr>
<td>Consent to care and treatment</td>
<td>18</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>9</td>
</tr>
<tr>
<td>Meeting Nutritional Needs</td>
<td>14</td>
</tr>
<tr>
<td>Cooperating with other providers</td>
<td>24</td>
</tr>
<tr>
<td>Safeguarding people who use services from abuse</td>
<td>11</td>
</tr>
<tr>
<td>Cleanliness and infection control</td>
<td>12</td>
</tr>
<tr>
<td>Management of medicines</td>
<td>13</td>
</tr>
<tr>
<td>Safety and suitability of premises</td>
<td>15</td>
</tr>
<tr>
<td>Safety, availability and suitability of equipment</td>
<td>16</td>
</tr>
<tr>
<td>Requirements relating to workers</td>
<td>21</td>
</tr>
<tr>
<td>Staffing</td>
<td>22</td>
</tr>
<tr>
<td>Supporting Staff</td>
<td>23</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>10</td>
</tr>
<tr>
<td>Complaints</td>
<td>19</td>
</tr>
<tr>
<td>Records</td>
<td>20</td>
</tr>
</tbody>
</table>

**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.
(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.