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: 01483570122

Date of Inspections: 22 May 2013
21 May 2013
Date of Publication: August 2013

We inspected the following standards to check that action had been taken to meet them. This is what we found:

- **Consent to care and treatment**: Met this standard
- **Care and welfare of people who use services**: Action needed
- **Cleanliness and infection control**: Met this standard
- **Safety and suitability of premises**: Met this standard
- **Safety, availability and suitability of equipment**: Met this standard
- **Staffing**: Met this standard
- **Supporting workers**: Met this standard
- **Assessing and monitoring the quality of service provision**: Action needed
- **Notification of other incidents**: Action needed
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<td>Registered Manager</td>
<td>Ms. Eileen Scrase</td>
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<td><strong>Overview of the service</strong></td>
<td><strong>BMI Mount Alvernia Hospital</strong> is an acute independent hospital in central Guildford. It provides services to adults. 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 to check whether BMI Mount Alvernia Hospital had taken action to meet the following essential standards:

- Consent to care and treatment
- Care and welfare of people who use services
- Cleanliness and infection control
- Safety and suitability of premises
- Safety, availability and suitability of equipment
- Staffing
- Supporting workers
- Assessing and monitoring the quality of service provision
- Notification of other incidents

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 21 May 2013 and 22 May 2013, observed how people were being cared for and talked with people who use the service. We talked with staff, reviewed information given to us by the provider and were accompanied by a specialist advisor.

What people told us and what we found

We inspected this service in December 2012 and January 2013 and found that the provider had failed to comply with the essential standards of quality and safety for the following outcomes: consent, care and welfare, cleanliness and infection control, suitability of premises, suitability and availability of equipment, staffing, supporting workers and assessing and monitoring the quality and safety of the service.

We took enforcement action to ensure that the provider protected people's safety and welfare in relation to the following outcomes: consent, care and welfare, cleanliness and infection control, staffing and assessing and monitoring the quality and safety of the service.

We asked the provider to send us an action plan, specifying how and by when they would achieve compliance with the following outcomes: suitability of the premises, suitability and availability of equipment and supporting workers.

An inspection on 21 and 22 May 2013 was carried out to check whether the provider had taken appropriate action to protect people's safety and welfare and to achieve compliance.

During this inspection we spoke with nine patients who used the service. Their comments were all positive. Patient's comments included; "It is brilliant" and "Very good".

We found that the provider had taken action to change systems and practices and to
monitor the effectiveness of these changes in order to protect patients from risks associated with their care and treatment. However, we found that some patients remained at risk because not all the staff and/or consultants had followed the provider’s policies or ensured that safe practices had been implemented on every occasion.

Since the last inspection the provider had amended their statement of purpose. The provider informed us that they had ceased to provide services or carry out surgery for patients below the age of 18 years. We saw that the statement of purpose reflected this change to the services provided at this location.

In this report the name of a registered manager appears who was not in post and not managing the regulatory activities at this location at the time of this inspection. Their name appears because they were still a registered manager on our register at the time of the inspection.

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

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

**More information about the provider**

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

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

<table>
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<th>Consent to care and treatment</th>
<th>Met this standard</th>
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<tr>
<td>Before people are given any examination, care, treatment or support, they should be asked if they agree to it</td>
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**Our judgement**

The provider was meeting this standard.

The registered provider had taken appropriate steps to ensure that before patients received any care or treatment they had been asked for their consent and the provider had acted in accordance with their wishes.

Where patients did not have the capacity to consent, the registered provider had acted in accordance with legal requirements.

**Reasons for our judgement**

When we inspected this service in December 2012 and January 2013 we found that patients had been put at significant risk of harm because informed consent had not always been sought and recorded.

At the previous inspection the provider had not acted in accordance with legal requirements where patients did not have the capacity to consent. Proper assessment of capacity had not taken place.

We judged that this had a major impact on patients who used the service. We took enforcement action to ensure the provider protected patient's safety and welfare and acted in accordance with legal requirements.

During this latest inspection we spoke with staff about their understanding of how and when they were required to obtain written and verbal consent from patients. Consultants told us that they completed consent forms with patients during their outpatient appointment. They told us that prior to gaining a patient's written consent they had informed them about the proposed treatment and associated risks and provided them with information leaflets. We spoke with other staff who confirmed this.

Staff told us that since January 2013 they always followed the World Health Organisations 'Five Steps to Safer Surgery’ guidance. Staff said the staff coordinating the operation checklist verbally reviewed with the patient, when possible and with other staff during handover at theatres that the patient had signed their consent form.

Our theatre specialist who accompanied us on this inspection observed that staff completed these consent form checks. We spoke with one patient who used the service.
who told us "a member of staff in theatre checked it was my signature."

We asked staff what happened if they were not satisfied that a patient's consent form had been completed fully and legibly. They informed us that, should those circumstances arise, staff then spoke with senior colleagues. We were told that the process for recording consent had been improved and that patient consent forms had been audited monthly. We saw the results of the April 2013 audit which had recorded that 100% of the parts of the consent forms that had been reviewed had been completed for that month.

Staff told us that on a few occasions they had required consultants to amend a consent form that had not been correctly completed. Staff told us "They (consultants) have been reported to the Director of Nursing and their practice has changed; now they follow the process. If they don't I will address it or management will". We saw the minutes of a surgical unit team meeting held on 05 February 2013. The minutes recorded that staff had been reminded and encouraged to challenge consultants if consent forms were incorrectly or illegibly completed.

We reviewed the consent forms for six patients; we saw that the consent forms we reviewed were legible. They noted the type of procedure the patient was to undergo, they documented that this had been discussed with the patient along with any associated risks. We saw that all the consent forms we reviewed had been signed by both the patient and the consultant concerned.

The consent forms we reviewed demonstrated that before patients received any care or treatment they had been asked for their consent and the provider had acted in accordance with their wishes. We saw that the surgical consent forms we reviewed had a space to indicate the type of anaesthetic which had been planned; but this had not always been completed. Staff told us this part of the form was not routinely used as it was assumed that a general anaesthetic would be used unless the form recorded a different method. We did see a different method had been recorded on two of the forms we reviewed. An audit of records had been carried out in April 2013 but this had not included checks that the method of anaesthesia had been completed on the consent form. This meant that patients were signing an incomplete form and may have consented without having been made aware of the full implications of the anaesthetic procedures they were to undergo.

The provider may find it useful to note that not all the consultants had fully completed all parts of the consent forms we had seen.

We saw the consent policy dated March 2013 and staff confirmed that they were aware of the contents of the policy and where they were able to access this document for further guidance. This meant that there were processes in place to ensure that patients had provided their written consent to surgery and other treatments.

We spoke with patients who told us "The consultant made me fully aware of the risks of surgery before I signed my consent form". Patients told us that they felt they had been provided with sufficient information upon which to decide if they wanted to undergo the procedure. One patient said "I was given pre-operative leaflets on the surgery". We saw that there were patient leaflets in waiting areas and/or in consulting rooms. This meant that patients had been provided with sufficient information about their proposed procedure or treatment upon which they had been able to make an informed decision.

We spoke with staff about the circumstances within which they had been able to accept a patient's verbal or implied consent. The staff we spoke with demonstrated a sound
awareness of what processes this applied to. One staff member told us "I would introduce myself and explain the procedure and why it is required and ask if they consent." We saw examples where verbal consent had been recorded in patient's records. This meant that staff understood when they had been able to accept patient's verbal consent and how this was documented.

We spoke with staff about their understanding of the Mental Capacity Act 2005. Staff demonstrated to us that they understood the Act and they knew they needed to consult other colleagues and the patient's representatives if they believed that a patient lacked mental capacity. Staff we spoke with told us that they had undertaken training in mental capacity since January 2013. We saw records that confirmed this. We saw the mental capacity policy which was dated February 2013. This meant staff had been provided with training and guidance in relation to mental capacity.

We reviewed a sample of Do Not Attempt Resuscitation (DNAR) forms and saw that since January 2013 they had been correctly completed. We saw the minutes of the two resuscitation committee meeting minutes that had taken place since January 2013. These demonstrated that issues relevant to the completion and checking of DNAR forms had been discussed. We saw from the critical incident records that no new incidents of inappropriate resuscitation of patients with or without DNAR forms being in place had occurred since January 2013. This meant that systems for completing DNAR forms had been reviewed and procedures had been followed for the correct completion of these forms.
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 registered provider had not ensured that, where processes were in place to ensure that people experienced safe care and treatment that these had always been complied with.

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

Reasons for our judgement

When we inspected this service in December 2012 and January 2013 we found that the care and treatment provided to patients who used this service was unsafe and put patients at significant risk of harm. This particularly, but not exclusively, related to the risks associated with the care and treatment of children. Since that inspection, the provider informed us that they have ceased to provide a service to patients under 18 years old.

We judged that the risks identified at the previous inspection had a major impact on patients who used the service. We took enforcement action to ensure the safety of patient’s who used the service.

During this latest inspection we found that action had been taken to protect patients from unsafe or inappropriate care. However, we found evidence that these actions had not always been implemented by all consultants.

We asked staff about how they would recognise that a patient's condition had deteriorated. They explained to us that they used the National Early Warning Score (NEWS). This is a system that enables staff to recognise very sick patients whose condition is deteriorating and who might require more intensive nursing or medical care. They informed us that they had also attended 'deteriorating patient training' which was confirmed by the records.

We saw a policy and procedure which staff were able to access that guided them in recognising patients that required transfer to an acute health care setting. There was another document that guided staff in arranging an urgent patient transfer to another setting. This meant that staff were able to recognise when a patient had deteriorated and take appropriate action.

We spoke with consultants about the processes in place for hospital staff to contact them when they were off-site. They informed us that staff had been able to contact them via their mobile phone or their bleep. We spoke with staff who told us that it was easy to
contact the Resident Medical Officer (RMO) if they had concerns about a patient's condition. They informed us that they also felt confident that they could contact the consultant or anaesthetist if required.

We asked staff about the processes in place to respond to medical emergencies and they told us that there was an emergency system in place including the use of emergency calls. Staff told us that there had been changes to the resuscitation team. They informed us that on each shift five staff had been allocated to hold a bleep and respond in the event of an emergency. Staff said that the revised system had ensured that there had been a more co-ordinated response to emergencies since January 2013.

Staff informed us that they had attended life support training and that emergency scenarios had been practised. During this inspection we witnessed an emergency 'crash' call and saw that all staff involved responded calmly and efficiently. Staff told us that staff who were responsible for holding the emergency bleep had all been trained to advanced life support standards and this was confirmed by the records we saw. This meant that there were arrangements in place to deal with foreseeable emergencies.

We spoke with staff with regards to the basic care they provided to patients on the wards. Staff explained to us the procedures for patient's post-operative observation through the night. We reviewed one patient's post-operative records and saw that appropriate checks had occurred.

Staff told us the processes in place to monitor patient's food and fluid intake. We saw an audit dated April 2013 which demonstrated that staff had identified patients at risk of malnutrition or dehydration and monitored their intake. Staff told us that food and drink was available to patients at night.

We reviewed six current patient records. These included risk assessments relating to their care and treatment. The assessments identified when patients had been at risk of falling, developing pressure sores or of dehydration and malnutrition. The nursing assessments included the actions that needed to be taken to minimise the risks to patients. The notes demonstrated that these actions had been taken.

We were told that, since January 2013, a new standard operating procedure had been implemented for the recording, storage and collection of specimens from theatre. We saw a copy of this procedure. Staff explained to us the correct procedure for managing specimens. A recent audit had taken place and we saw that this demonstrated 100% compliance with the procedures for the samples that were checked. We observed the handling of one specimen in theatres and this was done in accordance with the standard operating procedures.

We found that patient's rooms had been safely prepared and that oxygen and suction were connected and ready for use.

We saw a record that confirmed that since January 2013 the arrangements for ensuring patients had a chaperone available for their examination had changed. Staff had completed relevant training for this role. This meant that patients could choose to be accompanied during any examination or treatment.

Staff, in the diagnostic and imaging department, explained to us that the policy regarding patient's sedation for scanning had changed since January 2013. They told us that qualified staff were now required to attend and complete observations and checks on the
patient throughout the procedure. They also told us that there was a requirement that consultants had to remain within the department throughout the procedure. The policy we saw confirmed this. This meant that processes had been amended to ensure patient's welfare and safety during these procedures.

Staff informed us, and we observed that the procedures for taking patients to and from theatres had changed since the last inspection to reduce the potential risks. Staff told us "This has improved the level of communications, the patient's experience and has minimised the risks". We observed that a comprehensive handover regarding the patient took place.

We saw a policy that had been introduced since January 2013 which related to which procedures could be carried out in different areas of the location. No procedures under general anaesthetic had been carried out in the Ambulatory Care Unit (ACU) since January 2013. The staff we spoke with gave a clear explanation of which procedures could be carried out in theatres and which in the ACU. We saw a letter from the provider which had been sent to all consultants. This letter clarified the expectations of where procedures were able to be performed.

We spoke to staff regarding the availability and access to blood supplies. They were able to explain the system for obtaining blood and for storage and retrieval of supplies for planned procedures and during an emergency. We saw there was a procedure in place regarding this to which staff had access.

Our theatre specialist told us they saw that the booking system in theatres which identified patients who had been admitted for surgery had changed since January 2013. They said no 'booking in' of patients was confirmed without confirmation that a pre-assessment had taken place. Staff confirmed this new booking system was in place.

Our theatre specialist observed that the World Health Organisation's Safer Surgery Checklists and 'time out' steps that were required to ensure safe surgery practices had taken place. This meant that procedures were in place and had been followed, which were intended to reduce the risks of patients not being cared for safely.

Staff explained to us that patients received a pre-assessment appointment before their surgery. The procedure was discussed with patients as well as pain relief options and the routine on the ward. Tests were carried out at this pre-assessment appointment including, blood tests, electrocardiograms and X-rays. Staff told us that on the day of admission the staff explained the routine, the pre-operative checklist was completed and patient's observations were taken. We saw patient's records that confirmed that staff had completed these pre-assessment checks and test results had been recorded.

An incident on 8 May 2013 recorded that a patient had been admitted for care without any pre-admission assessment despite the patient having a relevant medical history which may have impacted upon their treatment. An assessment and tests were carried out on the day of admission. Since this incident the senior staff had spoken to the consultant concerned with regards to the need to include more detailed information on the pre-admission booking form. This would mean that staff would have had access to the relevant information related to this patient at the appropriate time.

Staff told us that consultants had not always completed the medical history records as part of the pre-admission assessment at this location. Staff said that sometimes consultants saw patients at a different location and their assessments and medical histories were not
always made available to the staff involved in their treatment at this location.

We saw a sample of six patient's records. Of these six records two had a recorded history completed by a consultant. The other records included blank medical history sheets. There were nursing assessments included in the notes we saw. This meant that, despite having an assessment system in place, not all the information relevant to patient's treatment had been made available to staff. Therefore, patients had been put at risk of receiving inappropriate treatment.

A recent example of the impact caused by the lack of a full medical history and access to the latest results putting a patient at potential risk occurred in May 2013. A patient was admitted for a procedure but developed complications which required their urgent transfer to an acute health care setting. At the time of this inspection staff were in the process of analysing the root causes of this incident and conclusions had not been reached.

In one of the four surgical procedures we observed, our theatre specialist reported that practices had taken place which had not complied with the safer surgery guidelines. Although the theatre team had carried out a count of instruments and cotton wool balls, that had been used during a procedure, this count took place after the procedure had finished and after the person had been transferred from the operating table to a trolley. This meant that normal procedure had not been followed and the patient had been put at risk of harm. Our theatre specialist communicated this to a member of staff. We saw that this issue was addressed with the staff. It was not clear if this feedback had also been communicated to the consultant member of that team. We were informed by the provider after the inspection that this concern had been addressed with all the staff involved and the incident was in the process of being reviewed.
Cleanliness and infection control

Met this standard

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

Our judgement

The provider was meeting this standard.

The registered provider had taken appropriate steps to protect people from the risk of infection because appropriate guidance had been followed.

People had been cared for in a clean, hygienic environment.

Reasons for our judgement

When we inspected this service in December 2012 and January 2013 we found that the essential standards for cleanliness and infection control care were not being met.

We judged at the previous inspection, that the risks identified had a major impact on patients who used the service. We took enforcement action to ensure the provider protected patient's safety and welfare.

During this latest inspection we found that staff knew who the infection control lead member of staff was for the location and that they were able to seek their advice. The lead member of staff for infection control told us they had been supported for two days per month, for policy development and staff training, by the lead infection control nurse from an NHS hospital. This meant that professional guidance and good practice had been used to develop infection control practices.

We saw records which demonstrated that a monthly hand hygiene audit had taken place since January 2013 and the results had been included for discussion at a recent infection control committee meeting. The committee had strengthened its membership to include appropriate members of staff. The minutes recorded that an analysis of any relevant incidents had taken place. The minutes also recorded that the World Health Organisations '5 moments of hand hygiene' chart and the hand hygiene policy had been sent to all consultants.

Staff told us they had completed training related to infection control and records we saw confirmed this. Our observations demonstrated that the staff we saw were following the correct infection control procedures in order to protect patients from the risk of infection.

Our theatre specialist reported that all the staff they had observed had followed the 'bare below the elbows' guidance from the Department of Health. They said that all staff had used the correct procedures for 'scrubbing up' prior to surgery, for the use of protective clothing and equipment and for cleaning their hands between tasks. They said that there was an adequate supply of hand sanitiser in the theatres and they saw this was used.
appropriately by the staff. We observed that hand washing and sanitising equipment was available throughout the location and we saw that staff used this equipment appropriately to prevent the risk of infection.

We spoke with patients and several commented that staff used the hand wash gel. One patient said "They always use the gel when they enter my room". This meant that staff had been observed to clean their hands in accordance with the hospital's infection control policies.

We observed in ward areas and in theatres that staff had been bare below the elbows in accordance with the guidance. We spoke with a patient who commented "Doctors are bare below the elbow." This meant that staff had been observed to have followed hospital guidance.

Since the previous inspection, the provider told us they had taken action by temporarily suspending the practising privileges of one consultant whilst a review of their infection control practices took place. Following letters, which we saw, and a meeting, their practising privileges were reinstated. Following this inspection the provider sent information to demonstrate they had taken action to ensure that patients were being protected against the risk of infection. These actions included staff having been asked to monitor this member of staff's hand hygiene and to report any concerns to the clinical governance committee and the medical advisory committee. No further concerns had been raised.

This meant that the provider had taken action to address the issues of infection control risks identified at the last inspection.

We observed that safe procedures were in use for preventing the spread of infection with regards to the use of the sluices. We observed on one ward that housekeeping staff had been cleaning throughout the course of the day. The infection control specialist reported that all of the equipment they examined was clean. We spoke with a patient who said "Staff come in and clean daily." We observed that the hospital environment appeared to be clean.
Safety and suitability of premises

Met this standard

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

Our judgement

The provider was meeting this standard.

The registered provider had ensured that people who used the service had access to safe, accessible surroundings that promote their wellbeing.

Reasons for our judgement

During the previous inspection we had found that the provider was not compliant with this outcome. We set a compliance action. During this latest inspection we found the provider had taken action to achieve compliance. However during this inspection we found one new area of concern regarding the availability and storage of portable oxygen and suction.

We were told that no work had been carried out since our last inspection to ensure the environment would be suitable to provide paediatric services. This was because the provider had ceased to offer a service to any patient less than 18 years old. We saw an amended statement of purpose which confirmed this change.

We saw that a blind had been fitted to the window in physiotherapy room 6 and this now provided patients with privacy during their treatments.

Our theatre specialist reported that they had seen evidence and talked to staff which confirmed that a 'shut down' had taken place in theatres in February 2013. During this time maintenance and servicing had taken place. This meant that this area of the premises had been checked to ensure it was safe and suitable.

We saw a record which demonstrated that the ventilation systems in theatres had been checked and serviced. There had been no stoppages to theatre lists due to breakdowns in this ventilation system since January 2013. This meant that patients were protected from unsafe care as their procedures had been carried out in an appropriate setting where staff had access to appropriate equipment.

The building work reported during the last inspection was continuing during the latest inspection, and as a consequence one ward had the piped oxygen and suction decommissioned for each bedroom.

Staff told us that there had been two portable suction units available but one had recently been removed from the unit and not returned. Staff were able to only show us one suction unit at the time which was located on the resuscitation trolley.

We saw that there were approximately six portable oxygen cylinders placed around the
ward. The cylinders were free standing outside patient rooms and were not securely attached to the wall. The provider may find it useful to note that the inappropriate storage of the oxygen cylinders and the lack of adequate portable suction may have meant that this area was temporarily unsuitable to meet people’s care and treatment needs.
Safety, availability and suitability of equipment

Met this standard

People should be safe from harm from unsafe or unsuitable equipment

Our judgement

The provider was meeting this standard.

The registered provider had ensured that people who used the service were not at risk of harm from unsafe or unsuitable equipment.

Reasons for our judgement

During the previous inspection we had found that the provider was not compliant with this outcome. We had set a compliance action. During this latest inspection we found the provider had taken action to achieve compliance.

During this latest inspection staff told us that, since January 2013, they had begun a new contract for the supply of resuscitation equipment. We saw six resuscitation trolleys in different areas of the location. We found the equipment on these trolleys had been standardised since the previous inspection and they all contained appropriate equipment. We found that one of the six trolleys contained defibrillator pads that had been opened and required replacement to prevent the gel drying and therefore possible poor skin adhesion when they were used. This was raised with staff at the time.

We saw minutes from two resuscitation committee meetings that had taken place since January 2013. These minutes had recorded that resuscitation equipment had required updating and checking and that action had been taken to ensure this had taken place.

Our theatre specialist reported they had seen that appropriate emergency and resuscitation equipment had been made available in theatres.

Staff were able to tell us the location and contents of the emergency equipment. We saw that staff had been supplied with a list of emergency equipment throughout the location.

We saw a trolley containing equipment specifically for effectively managing patients who presented with 'difficult airways'. This equipment trolley had been inspected by a representative of an NHS hospital and they had praised the staff for the effectiveness of the equipment that had been prepared. This meant that staff had the equipment they required and had been trained to use this equipment.

We found that one suction unit on one trolley was plugged in and "charging". However, when we removed the plug and tested the unit, the unit was not charged. This was because the battery was not correctly inserted. Staff had recorded that they had tested the suction unit and had ticked the "suction appears functioning" on the May 2013 Resuscitation Check List for 1-15 May 2013. We asked a member of staff to demonstrate how they checked the unit was working. They turned the suction unit on whilst it was
plugged in. We demonstrated that the battery was not correctly inserted which prevented the unit from working when unplugged. The provider may find it useful to note that this one unit may not have been fit for purpose when it was required for use.

The other resuscitation equipment we saw was in good working order. We saw that daily and weekly checks had been carried out and recorded.
### Staffing

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<td>There should be enough members of staff to keep people safe and meet their health and welfare needs</td>
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#### Our judgement

The provider was meeting this standard.

The registered provider had ensured that there were enough qualified, skilled and experienced staff to meet people's needs.

#### Reasons for our judgement

When we inspected this service in December 2012 and January 2013 we found that the essential standards for staffing were not being met.

We judged that the risks identified had a major impact on patients who used the service. We took enforcement action to ensure the provider protected patient's safety and welfare.

During this latest inspection staff, told us that the number of staff in all areas of the location had increased since January 2013 and we saw staff rosters that confirmed this. Staff said that they were better able to meet patient's care and treatment needs.

We spoke with staff about the staffing levels on two wards. They explained to us that staffing levels had been reviewed daily and amended according to the number of patients that were due to be admitted. Staff showed us the staffing rosters for the week before the inspection. We saw that adequate numbers of both qualified and unqualified staff had been on duty. Staff told us they were satisfied with the level of staffing and if they required extra staff they had been able to contact the senior member of staff on duty. We saw incident forms where staff had reported low staffing levels. It was clear that appropriate action had been taken at the time to ensure adequate staff were provided to meet patients' needs.

Staff told us that, since January 2013, a new system had been put in place to monitor that the correct number of qualified staff were deployed around the location. We observed a regular daily meeting where staff numbers and suitability were discussed. Staff had made changes which ensured adequate staffing had been made available for the following 24 hour period. This meant that staffing levels had been regularly monitored and adjusted to meet patient's needs and responsive rostering had been used which had enabled staff to attend training.

We spoke with staff from the oncology unit, who told us that they felt that they would benefit from more staff in their department. They told us however, that the hospital management had actively listened to staff concerns and had been trying to recruit more oncology staff. They told us that in the interim there had been active management of the treatment lists to ensure that there had been sufficient staff on duty. Staff said "They now
look at patient dependency and ask is staffing at a safe level?" Staff told us that they did not feel that the difficulties with the recruitment of oncology staff had put patients' safety at risk. We saw documents which demonstrated that the provider had made and continued to make efforts to recruit staff with suitable qualifications.

We spoke with nine patients who told us they were happy with the staffing levels. One patient said "Staffing is fine" and another commented "Loads of staff". Only one patient told us "I sometimes have to wait a bit when I press the buzzer. Sometimes I buzz and staff aren't qualified to deal with my issue". When we walked around the hospital we noted that there were plenty of staff responding to patient's needs. We did not hear buzzers ringing for excessive periods of time and staff did not appear rushed in their work.
Supporting workers

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

Our judgement

The provider was meeting this standard.

The registered provider had ensured that people were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

During the previous inspection we found that the provider was not compliant with this outcome. We set a compliance action. During this latest inspection we found the provider had taken action to achieve compliance.

During the latest inspection we spoke with staff about the support that they received to undertake their role. Every member of staff we spoke with made positive comments about the support they had received since January 2013. Staff comments included; "We feel cared for" and "We now provide good, safe care". Staff informed us that in the oncology department they had received de-brief sessions since January 2013 that had enabled them to reflect upon any lessons learnt from incidents. Staff told us that group supervisions had taken place. Staff informed us that they had received an annual appraisal or that this had been arranged. We saw records that confirmed this. We saw records that demonstrated that staff had been given opportunities to attend one to one meetings with senior staff to discuss their role and their training needs. This meant that staff had received regular supervision and appraisals.

Staff told us that there had been monthly ward meetings. They told us that members of the management team came to the ward daily to check that staff were alright. Staff informed us that they felt well supported by the senior staff who had encouraged them to be open. Staff told us "We are being listened to when we voice a concern. It has made a huge difference." Staff commented "The new management are excellent and I feel I can voice my concerns". We observed that senior staff walked around the location on several occasions to speak with and listen to staff. These routines appeared to be normal practice and staff confirmed that they regularly saw senior staff. This meant that staff felt that they had been supported and listened to.

Staff told us that since January 2013 they had been enabled to attend a range of training. Theatre staff commented that the increase in staffing numbers had resulted in an improvement in staff completing e-learning training. Staff said the total of those having completed training had risen from 29% in 2012 to 86% up to the date of the inspection for theatre staff.
The records we saw confirmed staff attendance at regular training courses. This meant that staff had been supported to attend training and staff received appropriate professional development.

At the time of this inspection six consultants had their practising privileges temporarily suspended at this location. We were informed that this was because they had yet to submit requested evidence that they had completed relevant training which included training in the Mental Capacity Act 2005. We were told that if they were unable to demonstrate they had undertaken training at their NHS trusts then this location would make arrangements for training to take place and relevant consultants would be expected to attend.
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 registered provider had a system to regularly assess and monitor the quality of service that people received. However that system had not always been effectively used to improve some aspects of the quality of the service provided.

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

Reasons for our judgement

When we inspected this service in December 2012 and January 2013 we found that the essential standards for assessing and monitoring the quality of the service provision were not being met.

We judged that the risks identified at the previous inspection had a major impact on patients who used the service. We took enforcement action to ensure the provider provided a safe and well led service.

During this latest inspection we found the provider had taken significant action since January 2013 to assess and monitor the quality of the service provided.

Serious incidents that had been identified during the previous inspection and any that occurred since, that had involved consultants, had been referred to the General Medical Council (GMC). We were told there were two on-going investigations, with a further three reviews taking place prior to any referral to the GMC.

Since January 2013, the terms of reference for the medical advisory committee had been changed. We saw minutes which reflected these changes and ensured that future meetings included a review of incidents and challenge to any poor medical practices that had been identified. The membership of this committee had been strengthened to include a range of consultants from different disciplines. This meant that the provider had made changes to this committee for the purpose of challenging poor practice by staff or consultants.

We saw that learning from incidents had been communicated to staff in the minutes of departmental staff meetings. These minutes included a record of changes to policies, procedures and practices. They also recorded that staff had received support to continue
to challenge any poor practice and report any concerns to senior staff.

The provider informed us that consultants had been involved in clinical reviews of any incidents which had either been communicated via a meeting or by telephone to discuss any lessons to be learnt or changes to practice. This meant that staff had received support and guidance when it had been identified that changes to their practice had been required.

All the staff we spoke with were extremely positive with regards to the change of culture that had taken place since January 2013.

The provider told us that they assessed and monitored the compliance with policies and practices in a number of ways. These included the immediate reporting of known or observed deviations from policy or good practice by staff members or consultants to senior managers and, where necessary, to their head of department or to senior staff to enable intervention to occur. Other methods included reporting of incidents via the computer reporting system, and a review and sign-off process for each incident form by senior staff. Other methods included, monitoring of the type, nature and number of all incidents at the clinical governance committee and the medical advisory committee and monthly audits. We were told, and we saw records, that periodic provider visits had been undertaken by the corporate governance team. This meant that processes were in place to monitor the quality of the service provided and that learning from incidents had been disseminated to staff.

We found however, that despite these systems and support, not all staff and/or consultants had always followed the provider's policies or challenged poor practices. Although staff and consultants had been provided with revised policies not all consultants had consistently adhered to these. Where issues with regards to clinical practice had been identified they had not always been addressed promptly or sufficiently robustly to ensure that improvements had been embedded into practice.

Our theatre specialist observed that one consultant had worn, what appeared to be, nail varnish whilst they carried out a procedure, although, gloves had been worn. Consultants were bound by the contents of the hand hygiene policy of which the wearing of nail varnish would be a contravention. This policy had been issued to consultants on the 19 March 2013.

Staff told us that when they had previously challenged the consultant staff who wore nail varnish the consultant had responded by saying they needed to go to a clinic after conducting surgery. There was no record related to staff having formally raised this concern. This meant that on one occasion we observed that one consultant had not followed procedures and continued to put patients at risk of either injury or infection during surgery.

We were informed by the provider after this inspection that the consultant had been spoken with and denied wearing nail varnish. This is contrary to our observation and what staff told us during this inspection.

We saw a letter which had been sent to all consultants in April 2013. This letter reminded them of the relevant provisions of the 'GMC's Good Medical Practice guidance' and the requirements of the 'Practising Privileges Policy' with regards to completing records. The letter stated that where an audit identified concerns or issues regarding specific consultants this would be addressed individually and the results shared at the subsequent clinical governance and medical advisory committees.
We were told by a senior member of staff that inadequate record keeping related to patient’s care and treatment had been an on-going issue and consultants had been asked at an April 2013 meeting to suggest ideas as to how compliance could be improved. We were told consultants had stated at the meeting that it had been difficult to access records as they did not always see staff when they reviewed patients on the wards. Consultants had been instructed that they must inform staff when they reviewed a patient using the service and then make a record in their notes at the time or as soon after as possible. Staff told us that, although compliance regarding this issue had improved since April 2013, consultants had not routinely followed the expected standards and guidance. We saw that patient’s medical histories and notes had not always been completed. This meant that, despite the action that had been taken, some consultants continued to fail to comply with the provider’s requirements and good professional practices. This meant that although the systems in place to monitor the quality of the service had identified that there was an issue in relation to record keeping by consultants this had not been addressed promptly or effectively by the provider.

The senior staff told us that they recognised that a culture change and a change to staff and/or consultant performance had been required since January 2013. During this inspection senior staff said that the changes were taking time especially with regards to a small number of consultants failing to work in accordance with the provider’s policies and procedures. For example we spoke with one consultant and they said "I suppose you’re going to tell me I should be keeping records; I know I should and I am getting better at this." This, along with our observations that medical histories had not always been completed, demonstrated that although the provider had taken action in accordance with their quality monitoring systems, and this consultant had started to improve their practices the need to improve the record keeping and monitoring of this had not been improved sufficiently to achieve compliance.

We saw a report from a provider visit which had identified good practice and areas that required improvements. The actions recorded had been implemented.
Notification of other incidents

The service must tell us about important events that affect people's wellbeing, health and safety

Our judgement

The provider was not meeting this standard.

The registered provider had not ensured that people could have always been confident that important events that affected their welfare, health and safety were reported to the Care Quality Commission without delay so that, where needed, action could be taken.

We have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We assessed this outcome because we became concerned during this latest inspection with regards to the provider's compliance.

We saw a copy of all the critical incidents that had been recorded between 03 January 2013 and 10 May 2013. We then compared this record with the notifications that the provider had sent to the Commission. We found that not all of the incidents that had occurred had been sent as required. Incidents which had not been notified to the commission included an incident dated 01 March 2013 whereby a patient had suffered unintentional damage to the body as a consequence of surgery. Another incident recorded as having occurred on 25 March 2013 stated that a patient had a prolonged anaesthetic time as a consultant had requested a piece of equipment that needed to be obtained from another hospital during surgery. This had an adverse effect on the patient and put them at increased and unplanned risk. On 25 January 2013 a patient suffered a complication during a surgical procedure that resulted in an adverse outcome for that patient. The Commission had not been notified of these incidents. Following this inspection the provider informed us that in their view and following review of the incidents these did not require notification to the commission within the regulations. The commissions view is that incidents of this type did require notification.

During a recent meeting the commission were informed of a serious incident that resulted in harm to one patient during surgery. The patient had required emergency transfer to another health care setting. The provider did notify the commission but not without delay regarding this incident.

We spoke with senior staff during the inspection with regards to the system for notifying the commission and they told us they had systems in place for notifications to be forwarded to the Commission.

The provider had notified the Commission with regards to deaths that had occurred and an event that had temporarily suspended the service.
This meant that the provider had informed the Commission as they were required to do for the majority but not all of the notifiable incidents that had occurred. Where the Commission had not been notified we were unable to assess whether patients had been put at risk or whether further action had been required.
This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation</th>
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<tbody>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>Care and welfare of people who use services</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>The registered provider has 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. Regulation 9(1)(a)(b)(ii)</td>
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<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>
<tr>
<td></td>
<td>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. Regulation 10(1)(b)(2)(b)(iii)(c)(i).</td>
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<tr>
<th>Regulated activities</th>
<th>Regulation</th>
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<tbody>
<tr>
<td>Diagnostic and</td>
<td>Regulation 18 CQC (Registration) Regulations 2009</td>
</tr>
</tbody>
</table>
### Notification of other incidents

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

The registered provider has failed to notify the commission without delay of incidents which occur whilst services are being provided in the carrying on of a regulated activity or as a consequence of the carrying on of a regulated activity. Regulation 18(1)(2).

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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 23 August 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.
About CQC inspections

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

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

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

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

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

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

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

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

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

You can tell us about your experience of this provider on our website.
How we define our judgements

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

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

✔ Met this standard

This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

✖ Action needed

This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

✖ Enforcement action taken

If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.
How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

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

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

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

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
Glossary of terms we use in this report (continued)

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Registered) Provider</td>
<td>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'.</td>
</tr>
<tr>
<td>Regulations</td>
<td>We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.</td>
</tr>
<tr>
<td>Responsive inspection</td>
<td>This is carried out at any time in relation to identified concerns.</td>
</tr>
<tr>
<td>Routine inspection</td>
<td>This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.</td>
</tr>
<tr>
<td>Themed inspection</td>
<td>This is targeted to look at specific standards, sectors or types of care.</td>
</tr>
</tbody>
</table>