Hospital of St John & St Elizabeth

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall summary

The Hospital of St John and St Elizabeth is one of the UK's largest independent charitable hospitals, with any profits used to fund the on-site hospice, St John's, which offers free care to more than 4000 patients and their families every year. The hospital was founded in 1856 with a Roman Catholic affiliation and is a registered charity.

The hospital has 73 beds and facilities, which include; four operating theatres, diagnostic imaging, a three-bed level two-care high dependency unit (HDU), outpatient department, and a walk-in urgent care centre, Casualty First. There is also a hospice of St John and St Elizabeth.

The hospital provides surgery, medical care, and outpatient and diagnostic services for children, young people, and adults.

We carried out this unannounced focussed inspection on 21 March 2019. The purpose of the inspection was to review patient safety and governance processes, in response to two separate concerns raised with the Care Quality Commission (CQC).

The planning of the inspection included a review of information held in our electronic database, including notifications.

During the inspection we visited the urgent care centre (UCC), Casualty First, the high dependency unit (HDU) and St Francis and St Elizabeth wards. We reviewed two historical patient incidents, and the associated records. We looked at the hospital's practices and processes at the time of the incidents and the changes made following the providers internal investigations.

Summary of findings

We interviewed the management team. We spoke with 12 staff including nurses, medical staff, housekeeping and support staff staff.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The Hospital of St John and St Elizabeth is registered to provide maternity and midwifery services, treatment of disease, disorder or injury, surgical procedures, diagnostic and screening procedures, and management of supply of blood and blood derived products.

We have provided guidance for services that we rate and do not rate. This was a focussed inspection we do not currently have a legal duty to **rate** them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- All staff were required to complete infection prevention and control training as part of their mandatory training.
- Staff kept themselves, equipment and the hospital premises clean. The hospital had improved control measures to prevent the spread of infection.
- We saw staff demonstrated appropriate hand washing technique. Hand hygiene audits for the urgent care centre, Casualty First, met the hospital's standards.
- The hospital was in the process of refurbishing wards and departments. There was building work in progress on a new urgent care centre, a new high dependency unit (HDU), new imaging department and seven new theatres.
- The hospital had introduced an online digital auditing tool to monitor the environment in the wards and departments. Results we viewed indicated the urgent care centre and HDU were meeting the hospital's environmental audit standards.
- Staff used the national early warning score (NEWS 2) to monitor patients for deterioration. If a patient's condition deteriorated and they could not be safely treated on site, a consultant used an unplanned transfer protocol to transfer the patient to a hospital they could be safely cared for.
- A team of resident medical officers (RMOs) provided medical cover 24-hours, seven days a week.
- There was a clear management structure which staff were aware of. This meant that leadership and management responsibilities and accountabilities were explicit and clearly understood.
- Staff spoke highly about their departmental managers. All staff said managers supported them to report concerns and said managers would act on them.

However, we also found the following issues that the service provider needs to improve:

- Staff in the urgent care centre, Casualty First, and housekeeping staff were not clear about their specific areas of responsibility in regards to the cleaning of bodily fluids.
- We found there had been a four day time period following an incident before house keeping staff had deep cleaned following an infection control risk in the urgent care centre.
- We found patient care records did not always clearly detail patients care and treatment. We also found patients records had not been updated in a timely way.
- We found delays in the reporting of an incident involving a patient on the electronic patient records system.
- Root cause analysis (RCA) investigation following an incident did not adhere to the hospital's policies and procedures for the investigation of incidents. As a result, there were gaps in the review of evidence and missed opportunities for learning.
- We found learning from incidents was not always shared with team's and staff across the hospital.

Following this inspection, we told the provider that that it should make improvements, even though a regulation had not been breached, to help the service improve.

Nigel Acheson

Summary of findings

Deputy Chief Inspector of Hospitals

Summary of findings

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Background to Hospital of St John & St Elizabeth

The Hospital of St John and St Elizabeth is a community based independent hospital. Services include adult medical and surgical care and treatment, level 2 high dependency unit (HDU), adult and paediatric outpatients, and urgent care.

The hospital covers the following specialties; orthopaedics, urology, plastics, general surgery, endoscopy, ENT, ophthalmology, gynaecology, breast surgery, spinal surgery, general medicine, stroke rehabilitation, palliative care, imaging, physiotherapy, occupational therapy, cardiology, pathology, respiratory physiology, pharmacy, nutrition and dietetic support for both in patients and out patients.

The hospital's private urgent care centre, Casualty First, was launched in 2011. Approximately 12,000 people per year are seen by the urgent care centre. The centre treats patients from the age of one year. The urgent care centre is open from 8am - 8pm, seven days a week. Patients can be referred to a specialist consultant and if required an admission facilitated. The hospital has surgical and medical wards, offering single en-suite accommodation, five operating theatres and a Level 2 high dependency unit (HDU). A resident medical officer (RMO) and a resident intensive treatment unit (ITU) fellow are on site 24 hours.

At the time of inspection work was in progress on a new hospital development. The plans are for this to deliver an expanded urgent care facility, seven operating theatres and a day care unit, a refurbishment of all wards, an admissions suite, a new HDU and a new imaging department.

The Hospital of St John and St Elizabeth primarily serves patients resident the communities of central, west and north London. The hospital also accepts patients from across London, the UK and overseas.

The hospital's current registered manager has been in post since 31 May 2018.

Our inspection team

The team that inspected the service comprised a CQC inspection manager and three other CQC inspectors. The inspection team was overseen by Nigel Acheson, Deputy Chief Inspector of Hospitals.

Information about Hospital of St John & St Elizabeth

The Hospital of St John and St Elizabeth has five inpatient wards, a day unit, high dependency unit (HDU), a hospice day centre and outpatients department.

The hospital is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Management of supply of blood and blood derived products
- Surgical procedures
- Treatment of disease, disorder, or injury
- Maternity and midwifery services

During the inspection, we visited the urgent care centre (UCC), Casualty First, the high dependency unit (HDU) and St Francis and St Elizabeth wards. We spoke with 12 staff including registered nurses, medical staff, and senior managers. We viewed a wide range of documents and data we requested from the provider. These included historic patient notes, policies, investigative reports, minutes of meetings, staff records and results of surveys and audits.

There were no special reviews or investigations of the hospital on-going by the CQC at any time during the 12

Summary of this inspection

months prior to this inspection. The hospital has been inspected on three previous occasions, with the most recent inspection taking place in October and November 2016. At the time we found that the hospital was meeting all standards of quality and safety it was inspected against.

Services accredited by a national body:

- SGS Accreditation for Sterile Services Department

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Deep cleaning
- Interpreting services
- Grounds Maintenance
- Laser protection service
- Maintenance of medical equipment
- Pathology and histology

Urgent and emergency services

Safe	
Well-led	

Are urgent and emergency services safe?

Mandatory training

The hospital provided mandatory training in key skills to all staff and made sure everyone completed it.

- Infection prevention and control was part of staff mandatory training. All staff were required to complete infection prevention and control training and training in the control of substances hazardous to health (COSHH) as part of their mandatory training. In April 2019 100% of staff in the urgent care centre and high dependency unit (HDU) had up to date mandatory training in infection prevention and control.
- Mandatory training for housekeeping staff included practical training and assessments which were signed by the housekeeping supervisor to demonstrate that staff were competent in cleaning tasks. We viewed four housekeeping staff training records and found assessments were complete and signed by supervisors.
- Housekeeping supervisors showed us a training manual all housekeeping staff were required to complete. This was based on the National Institute for Health and Care Excellence (NICE) Quality Standard (QS61): Infection prevention and control.
- Housekeepers mandatory training in infection prevention and control included: hand hygiene, healthcare associated infections and their role in preventing them, waste disposal and segregation, prevention and management of blood and bodily fluid exposure, multi-drug resistant organisms and anti-biotic stewardship.
- The housekeepers training manual contained step by step instructions on cleaning techniques. These included the use of fogging and yellow colour coded disposable equipment for isolation rooms. Fogging is a type of decontamination process that provides a final decontamination of a clinical area following certain infections, including but not limited to clostridium difficile (C Diff) and other multi-resistant organisms.
- All clinical staff were required to complete mandatory training in: adult and children's safeguarding, infection prevention and control, medication management, health and safety, advanced life support. Senior nursing staff and medical staff were also required to complete mandatory training in the Mental Capacity Act, and Deprivation of Liberty Safeguards.

Cleanliness, infection control and hygiene

Although staff controlled infection risks, they were unclear about their areas of responsibility in regards to cleaning. Deep cleaning by the hospital's housekeeping staff following an infection control risk was not always timely.

- All the areas of the hospital we visited looked visibly clean and tidy.
- Staff kept themselves, equipment and the premises clean. The hospital had improved control measures to prevent the spread of infection. However, policies and guidelines were not always clear about staff areas of responsibility.
- Infection prevention and control committee minutes, dated 20 March 2019, recorded that 20 staff hand hygiene observations were undertaken in each hospital area. The minutes recorded that although hand hygiene results had improved, there were still issues with a few staff wearing fleeces and watches. The minutes recorded that an executive walk around was completed weekly, and executives challenged any medical staff that were not compliant with the hospital's bare below the elbows policy.
- During our inspection we saw staff were bare below the elbows and demonstrated appropriate hand washing technique. This was in accordance with the 'five moments for hand hygiene', from the World Health Organisation's (WHO) guidelines on hand

hygiene in health care. Information was displayed near hand washing sinks demonstrating 'five moments for hand hygiene' to prompt staff in its use. Soap and hand towels were available next to the sinks.

- There were sufficient numbers of hand washing sinks available. This was in accordance with Health Building Note 00-09: 'Infection control in the built environment'.
- Sanitising hand gels were readily available. However, we found the hand gel dispenser at the entrance to St Francis and St Elizabeth wards was on a wall next to the lift, and we initially walked past this. Staff directed us to the gel dispenser when we asked. We also found a gel dispenser on the high dependency unit (HDU) desk which was empty. Staff replaced this when we drew this to their attention.
- We viewed monthly hand hygiene audits for the HDU and urgent care centre. We found between December 2018 and March 2019 the UCC had achieved 100% compliance with hand hygiene standards. Hand hygiene results for the HDU were above the hospital's 90% compliance standard, but, the audits identified issues with a few staff not following the hospital's policies on cleaning hands and medical staff not being bare below the elbows.
- In accordance with Health Building Note 00-09: 'Infection control in the built environment', there was sufficient space between patient beds and seating for activities to take place and to avoid cross-contamination.
- We saw personal protective equipment was available and staff used it in an appropriate manner. Housekeeping staff were responsible for ensuring personal protective equipment was available to staff and replaced when necessary.
- Waste in clinic rooms was separated in different coloured bags to identify different categories of waste. This was in accordance with Health Technical Memorandum (HTM) 07-01, and the Control of Substances Hazardous to Health (COSHH) and Health and Safety at work regulations.
- Sharps bins were available in treatment areas where sharps may be used. This demonstrated compliance with Health and Safety regulation 2013 (The sharps regulations), 5 (1) d. This required staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw labels on sharps bins had been fully completed which ensured traceability of each container. We reviewed an audit for the urgent care centre, Casualty First, dated 25 March 2019, this found the UCC had 100% compliance with the hospital's standards for sharps bins. However, infection prevention and control committee meeting minutes dated 20 March 2019 highlighted that audits had found the hospital needed a named member of staff to ensure sharps bins were signed and labelled.
- We saw clean equipment had high visibility 'I am clean' stickers attached to inform staff the equipment was clean and ready for use.
- We found that wards had well equipped sluice rooms, (these are areas in the hospital used for handling disposables such as incontinence pads, and where reusable equipment such as bed pans are cleaned and disinfected).
- We reviewed historic records involving a patient that had attended the hospital with community acquired virus.
- We found there was a four day time period in implementing the hospital's procedures for the 'management of outbreaks of communicable infections' policy. (It should be noted that the problem the patient presented with was not on the list of 'notifiable infectious diseases,' as listed in the Public Health (control of diseases) Act 1984, Public Health Infectious Diseases Regulations 1988. It was also not listed on the list of notifiable organisms identified by the Health Protection (Notification) Regulations 2010).
- Staff told us as the patient was symptomatic and the patient was put in a separate treatment room on admission to the urgent care centre, Casualty First. However, we found there was a four day time period between the patient's admission and the infection prevention and control team attending the department and advising on closure of the department and deep cleaning. This was not in accordance with the hospital's 'Organisational Policy for the Prevention and Control of Infection'. The policy identified the role of the infection prevention and control team as, "To make medical and nursing

decisions on a 24 hour basis about the prevention and control of infection, providing advice to all grades of staff on the management of infected patients and other infection prevention and control problems." However, following our inspection the hospital highlighted that these events had taken place over the weekend and the hospital had informed the infection prevention and control lead, on the 12 March 2018, when staff were due to return to work. The hospital highlighted that the intensive care fellow had discussed the patient with the consultant microbiologist in the interim period on the 10 March 2018. The hospital's staff commenced a deep clean of the urgent care centre, Casualty First, using sporicidal wipes on 12 March 2018.

- The 'Organisational Policy for the Prevention and Control of Infection' stated that there was a network of infection prevention and control nurses in wards and departments to facilitate liaison between clinical areas and the hospital's infection prevention and control lead. We found there were link nurses in all departments. However, records did not record whether an infection prevention and control link nurse was involved with the patient when they arrived in the urgent care centre, Casualty First. Furthermore, the patient had been moved between four wards and departments within 48 hours of admission. This posed a risk to staff and other patients. Although no other patients were infected during the outbreak.
- We spoke with the hospital's infection prevention and control lead. They told us the patient had been isolated on admission to the urgent care centre, Casualty First, but this had not been recorded in the patient's records.
- The patient was transferred to the high dependency unit (HDU). We found records recording that whilst the patient was in the HDU the patient had mobilised with a physiotherapist. Following our inspection the hospital sent an undated case reflection from the physiotherapist stating that the patient had mobilised in the HDU and had not left that space. The document said there were no other patients in the HDU at the time of the patient's admission.
- Staff told us patients with symptoms of diarrhoea and vomiting would be placed in a treatment room as a control measure. Staff also highlighted that the hospital had a new urgent care centre under construction and this would have dedicated isolation facilities for patients attending the urgent care centre, Casualty First.
- We viewed the urgent care centre, Casualty First, patient pathway, this did not contain guidance for staff on the pathway for patients presenting with diarrhoea and vomiting. However, following our inspection the urgent care centre, Casualty First, sent CQC a flowchart dated 28 March 2019, which outlined the pathway for a patient attending the urgent care centre, Casualty First, with symptoms of diarrhoea or vomiting. The policy stated that patients with symptoms should be immediately isolated in a treatment room and staff contact with the patient should be kept to a minimum, with staff using appropriate personal protective equipment.
- Nine members of staff reported symptoms of diarrhoea and vomiting following the patients admission. The hospital's infection prevention and control policy did not require staff to report diarrhoea and vomiting symptoms until the day they were due to return to work. This policy meant there was a delay in the hospital identifying a virus outbreak, as some staff were not rostered to work and did not report symptoms until they were due to return to work. There were no patients identified as developing symptoms as a result of the virus outbreak. Furthermore, all the staff affected by symptoms were from the urgent care centre, Casualty First, and another member of staff who had provided treatment to a member of the urgent care centre staff. Staff on the wards and HDU did not report any symptoms during the outbreak. Managers told us the hospital had not had any previous outbreaks. Following our inspection the hospital informed us there was a policy for the care of patients and staff with diarrhoea (including norovirus). The hospital provided a copy of the policy which was ratified in June 2018. The policy identified that any staff should alert their ward manager/nurse in charge of sudden onset of diarrhoea.
- Staff told us in response to the outbreak the hospital had introduced a policy of isolating all patients with

symptoms, until swab results were available. Staff told us that during the outbreak there were no further cases reported once the urgent care centre, Casualty First, had been cleaned by staff.

- We viewed the hospital's post infection (comprehensive) review (norovirus) dated 20 March 2018. The review recorded that a deep clean had been completed on the urgent care centre, Casualty First, four days after the patient presented at the urgent care centre. The urgent care centre was closed for cleaning and equipment was cleaned using sporicidal wipes. All rooms the patient occupied were also deep cleaned and fogging was used in these areas, but, fogging was not used in the urgent care centre, Casualty First. The post infection (comprehensive) review (norovirus) dated 20 March 2018 did not review reasons for the four day time period between the patient first attending and the deep clean of the urgent care centre. The infection control lead told us this was due to the hospital awaiting results from the patient's swab.
- The patient was transferred to the HDU. However, there was no en-suite facilities in the HDU isolation room. Staff told us the patient was provided with a commode whilst in the HDU and this was cleaned by HDU staff. The patient was moved from St Elizabeth to St Andrew's ward and their care records indicated they were mobilised along a corridor on 13 March 2018, although they were being barrier nursed and source isolated at the time.
- Housekeeping staff told us housekeeping always had a post-infection review with the infection prevention and control lead where a patient had been infectious. The infection prevention and control lead said the reviews would be linked to any root cause analysis (RCA) investigations involving an infectious patient. These reviews would be sent to the chief nursing officer, who was the hospital's director of infection prevention and control, independent consultant microbiologist, and discussed at the infection prevention and control committee. We viewed infection prevention and control committee meeting minutes dated 23 April 2018. The minutes recorded that a review of the incident was in progress.
- The infection prevention and control lead and senior housekeeping staff told us they were aware of notifiable diseases and notifiable organisms that were reportable to Public Health England (PHE). Staff said the hospital would always report any of the listed diseases or organisms.
- During our inspection we found staff in the urgent care centre, Casualty First, were not fully aware of the areas of the hospital they were responsible for cleaning. For example, staff in the urgent care centre told us the housekeeping staff were responsible for cleaning the urgent care centre reception area. However, the infection prevention and control lead told us the urgent care centre reception area was classed as a clinical area and urgent care centre staff would be responsible for this cleaning. The infection prevention and control lead said housekeeping staff would be responsible for cleaning public areas, such as corridors, but not the urgent care centre reception area.
- We viewed the 'Housekeeping Cleaning Standards Training Manual,' this included guidance for staff on cleaning areas of the hospital. This included treatment areas, ward corridors and communal corridors, the cleaning of day rooms, family rooms and internal balcony areas. However, the manual did not mention the urgent care centre reception area. It was therefore unclear in the handbook whether housekeeping or clinical staff were responsible for the cleaning of the urgent care centre reception area.
- We viewed the hospital's policy and procedure for 'Facilities: Standard Housekeeping Cleaning Procedures'. This identified procedures that applied to all 'in-house' housekeeping staff. We found the policy included general information stating housekeeping staff were responsible for cleaning clinical areas including treatment rooms and isolation rooms. However, the policy was not specific in identifying specific clinical or non-clinical areas that housekeeping staff were responsible for cleaning. For example, the policy did not specify areas in the urgent care centre that housekeeping staff were responsible for cleaning, such as the reception area. This meant the policy was not clear about which areas of the urgent care centre housekeeping staff would clean

and which areas would be the responsibility of urgent care centre staff. Following our inspection the hospital informed us that they were reviewing policies and procedures to refer specifically to hospital areas.

- We found all areas we visited had specialist cleaning kits for bodily fluids. Staff in the urgent care centre told us housekeeping staff would clean bodily fluids. However, staff on other wards told us clinical staff would be responsible for using the kits. However, the 'Organisational Policy for the Prevention and Control of Infection' did not specify whether clinical staff or housekeeping staff were responsible for cleaning bodily fluids. We viewed the hospital's, 'Management of blood, body fluid/clinical waste spillage,' policy, dated August 2016. This identified the methods the hospital used for the management of spillages of bodily fluids. The policy identified that nursing and clinical staff would be responsible for the initial cleaning of, "All wards, clinics, and patient treatment areas.' The policy stated that secondary cleaning of these areas would be completed by housekeeping staff. The policy identified that spillages of bodily fluids in hospital corridors and public areas were the responsibility of housekeeping staff.
- All wards and departments had cleaning schedules which were accessible to staff. The hospital 'decontamination and cleaning of the environment' policy, had a review date of October 2019. The policy had a list of typical daily cleaning tasks for a patient's room or a treatment room. The policy signposted staff to other policies for more detailed guidelines, such as the policy on managing spillages of bodily fluids.
- We checked the dates on curtains around bays in the HDU. We found curtains had been changed in March 2019. Staff told us housekeeping supervisors did a visual check on all hospital areas every morning. We checked high level areas such as the tops of curtain rails in the HDU and found these to be clean and free of dust. Staff told us the night housekeeping staff were responsible for cleaning high level areas.
- There was a housekeeping handover in the evening and in the morning to ensure housekeeping staff coming on shift were updated on any issues in regards to housekeeping. Staff on the wards and the HDU told us infectious patients were always identified during staff handovers to ensure incoming staff were aware of infection risks and the control measures for patients at risk of infection or infectious patients. Furthermore, staff told us the patient's electronic record would identify a patient if there was an infection risk, and the patient would not be moved to another ward or department without the input of the infection prevention and control lead nurse.
- Staff on the HDU told us in the event that a patient was in isolation they would use signage to alert visitors to speak with staff prior to entering the isolation room. Staff told us any visitors to a patient in isolation would be asked to use personal protective equipment, such as masks, gloves and aprons. We could not see this in practice as there were no patients in the HDU at the time of our visit.
- Staff on the HDU told us housekeeping staff always did a deep clean of the HDU isolation room following the discharge of an infectious patient. All housekeeping staff had received training in deep cleaning techniques. The 'Facilities: Standard Housekeeping Procedures, ' had a review date of August 2019. The procedures detailed actions staff should take in cleaning isolation rooms after a patient had vacated the room, including decontaminating the whole environment, including equipment and medical devices. The policy highlighted what colour cleaning equipment staff should use and how this equipment should be disposed of, using clinical waste procedures.
- Staff told us an external cleaning company was contracted to provide deep cleans at regular intervals. The external company risk assessed areas for cleaning and had a service specification for cleaning hospital areas. The contract and quality of cleaning by the company was monitored by the facilities manager. The company provided reports on deep cleaning which were reviewed by the infection prevention and control committee. We requested copies of the reports from the hospital, but, received a certificate from the external provider confirming that a 'high degree' deep clean of the urgent care centre had taken place on 1 July 2018.
- The hospital used a digital quality improvement tool to monitor infection prevention and control data. The infection prevention and control lead told us this data was reviewed at infection prevention and control link

nurses meetings and at the infection prevention and control committee meeting. The hospital's pass rate for the digital improvement tool was 90%. We viewed a range of audits from the urgent care centre, Casualty First, and HDU and found both areas regularly achieved the hospital's 90% standards.

- Housekeeping supervisors did monthly environmental audits. These were visual checks of the hospital environment. Housekeeping staff told us clinical staff would ask housekeeping to do additional cleaning if they thought an area of the hospital required cleaning.

Environment and equipment

The hospital had suitable premises and equipment and looked after them well.

- The hospital was in the process of refurbishing wards and departments. St Francis and St Elizabeth wards had been refurbished in 2018. The HDU had reopened in February 2019 following refurbishment.
- Infection prevention and control committee minutes dated 20 March 2019 recorded that equipment audits were much improved. However, the minutes were not detailed about the specific areas of improvement.
- The hospital had introduced an online digital auditing tool to monitor the environment in the wards and departments. We viewed results for the HDU audit dated 26 February 2019. The audit results recorded 89% compliance with the hospital's environment audit. This was close to the hospital's target of 90%. The audit recorded that there were no audits in place in regards to mattresses, although mattresses had been visibly inspected and found to be clean and in a good state of repair. Infection prevention and control committee minutes, dated 20 March 2019, recorded that the committee needed to think about a system of regular audit for mattresses. Following our inspection the hospital informed us that the hospital undertook regular mattress audits, and provided us with a mattress condition analysis that had been completed in May 2018 and a static mattress and cushion condition audit dated June 2018. Actions had been taken to address mattresses identified as requiring repair or replacement as a result of these audits. There was also a plan to re-audit static mattresses and cushions in June 2019.
- The urgent care centre, Casualty First, was located at the Grove End Road entrance of the hospital. It was comprised of: a reception area, storage facility for patient records, patient waiting area, two consulting rooms, a triage room, a treatment room, a toilet and a sluice. Accessible toilet facilities were provided for visitors with mobility impairment in the main reception area, behind the coffee shop. A water cooler was available to maintain patient hydration. Consultation rooms and the toilet were fitted with an emergency call bell system that would alert clinical staff in the event of a patient or consultant requiring assistance.
- The environment audit for urgent care centre dated 27 February 2019 found 96.7% compliance with the online environmental audit, this was better than the hospital's target of 90%.
- Housekeeping equipment such as buckets and mops were colour coded. For example, yellow cleaning equipment was disposable equipment and used for isolation areas. Housekeeping and clinical staff we asked were aware of the colour coding system and were able to tell us what areas the colour codes related to. Staff showed us yellow hazard signs that were used to warn patients and staff when cleaning was in progress.
- The hospital did not have any special (category IV) ventilated isolation rooms. Any patients requiring this level of isolation would be referred to an NHS trust. Staff told us the UCC were very aware of checking whether patients had recently been abroad as part of the management of infection identification and the management of infection risks.
- Electrical and biomedical engineering (EBME) was provided by an external company. The company provided a full-time on-site service engineer at the hospital. The external company was responsible for monitoring and servicing of equipment.
- The hospital had a water safety group to monitor the safety processes in regards to the hospital's water systems.
- The HDU had swipe card access for staff and an intercom for visitors. This ensured unauthorised people did not gain access to the unit.

Urgent and emergency services

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. However, staff did not always record patient early warning records consistently.

- Staff told us the hospital monitored patients time from arrival at the urgent care centre, Casualty First, to the patient being admitted to a hospital bed. Staff said this was an average of two hours. Staff said if a patient had arrived in the urgent care centre during normal opening hours, 8am to 8pm, and was still in the urgent care centre after 8pm, the urgent care centre would remain open until the patient had been admitted to a bed.
- Staff told us patients could not be admitted directly to the HDU from the urgent care centre, due to insurance companies having a policy whereby patients funded by insurance had to be admitted to a ward prior to admission to the HDU.
- Patients who required blood tests or other investigations had these arranged by the clinician seeing them in the urgent care centre. We were made aware of one incident related to a delay in results being reviewed by a consultant, which led to the patient not having the right advice to minimise risks to their well-being. We saw actions had been taken to ensure similar situations did not arise again.
- All nursing staff were trained in barrier nursing. This is a set of infection control techniques
- We asked the hospital if physiotherapy staff were trained in barrier infection prevention and control techniques. The hospital sent us a list staff had signed confirming physiotherapy staff had read the 'management of blood borne viruses' and the 'care of patients and staff with diarrhoea policy.' The hospital also sent data indicating that 100% of 19 therapy staff had completed training in infection prevention and control. This course had included classroom training on aseptic non-touch technique (ANTT).
- The hospital used the National Early Warning Score (NEWS 2) system. The NEWS 2 system is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, already recorded in routine practice, when patients present to, or are being monitored in hospital. The total score alerts staff if a patient is becoming very ill, prompting them to take urgent action to review the care of the patient and call for specialist help if necessary. The HDU clinical fellow told us they had trained staff in the use of NEWS 2. Nursing staff told us if they thought a patient was deteriorating they would contact the resident medical officer (RMO). If the consultant was busy they would escalate to the HDU.
- We viewed a NEWS 2 audit report for St Andrew's ward for quarter four 2018 and quarter one 2019. The report recorded that inconsistencies in documentation had been identified by the audit. The report recorded that the audit was discussed with staff, and mixed communication on how to document NEWS 2 was identified as the reason for the inconsistencies. A plan was in place in response to the audit which included placing a copy of a "gold standard" NEWS 2 chart in each patient's folder for staff to refer to as an example; and nursing staff to document in patients' health records the corresponding NEWS 2 score, as well as the management of the patient in response to their NEWS 2 score.
- Urgent care centre, Casualty First, staff told us patients were triaged on arrival at the urgent care centre and patients could be flexed around areas of the urgent care centre. The hospital had an acute emergency policy, this was used if a patient was assessed by the urgent care centre and a decision had been made that the urgent care centre could not meet their needs. The patient would be transferred by blue light ambulance to another hospital. The hospital also had a 'Policy and procedure for the transfer of a patient to another healthcare facility.'
- Staff we spoke with on the urgent care centre were unaware whether the hospital had a pathway for patients that attended the urgent care centre with diarrhoea and vomiting. Staff told us they would use, "Common sense." Staff said if patients telephoned the hospital and reported symptoms of diarrhoea and vomiting they would be advised to attend an NHS hospital. Following our inspection the hospital provided us with a pathway for a patient presenting at the urgent care centre with symptoms of diarrhoea and vomiting.

- The infection prevention and control lead told us training in Sepsis recognition and awareness and aseptic non-touch technique (ANTT) had been added to all clinical staff mandatory training schedules in 2018.
- The facilities manager told us all facilities staff had received enhanced training in infection prevention and control in 2018. This training had included the care of patients in isolation.
- The HDU provided level 2 critical care. Staff told us patients requiring level 3 critical care could be ventilated in the unit, but, would be transferred by blue light to another provider with a level 3 HDU as soon as possible. This could be either a private hospital or NHS hospital, based on the patient's level of health insurance. The HDU had a transfer of the deteriorating patient policy and an inter-hospital transfer for level two and three patients' policy, both policies were in date. Staff told us the HDU was consultant led, a decision to transfer a patient would be made by the consultant. Medical staff told us they had worked with HDU nursing staff on escalation procedures. Staff told us they acted quickly if a patient appeared to be deteriorating.
- The hospital had a 'care of the deceased patient policy and procedure.' The policy required isolation precautions to remain in place following the death of a patient in isolation. The policy clearly described how infection control risks should be managed including procedures for post-mortem and reporting criteria. The hospital had a 'Free from infection notification' form for deceased patients. Staff told us this would be completed by medical staff and kept with the patient's notes.
- The hospital had given 129 flu vaccines to staff in 2018. This was an improvement on the previous year.

Staffing

The hospital had enough nursing and medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

- The urgent care centre, Casualty First, had one whole time equivalent (WTE) band 8 advanced nurse practitioner (ANP), this is a nurse
- The standard operating procedure (SOP) for the urgent care centre described staff roles. For example, the advanced nurse practitioner was responsible for assessing the patient and investigating their complaints by means of imaging and pathology if appropriate, treating or advising the patient or referring them to a suitable specialist for ongoing care. Nurses' responsibilities included triaging the patients and treating minor ailments such as dressings or vaccinations, taking bloods, doing ECGs, monitoring patients in the treatment room and coordinating admissions. The assistant practitioner was responsible for taking bloods, doing electrocardiogram (ECG), stocking the rooms, ordering supplies and supporting the doctors and nurses. Managers told us assistant practitioners received training and their competence was assessed in doing ECG and taking blood. (An ECG is a test which measures the electrical activity of your heart to show whether or not it is working normally).
- The hospital had a safe nurse staffing policy which was based on the National Institute of Health and Care Excellence (NICE) guidance on safe staffing. The policy gave staff clear guidance on escalating any staffing concerns. All wards and departments had a senior staff nurse in charge for each shift to oversee the running of the ward or department.
- HDU nurses worked flexibly, if there were no patients in the HDU nurses would be assigned as supernumerary nurses in the hospital's recovery unit. There were two allocated HDU nurses on the rota during the day and one at night. Staff told us if there were two patients in the HDU staffing would be increased at night to ensure patients received 1:1 nursing support. Staff told us there were occasions when the nurse to patient ratio was 2:1 due to the size of the HDU unit. Staff said all patients requiring level 3 care would receive a minimum of 2:1 care until the patient could be transferred to another hospital.
- St Francis and St Elizabeth wards conducted patient handovers twice a day. Staff told us handovers were attended by the ward manager, incoming nursing staff and health care assistants. Staff said handovers included a review of each patient on the ward,

including their clinical needs and risks, nutrition and hydration status and social needs. Patients in isolation, and any isolation procedures to minimise risks, were highlighted at the handover.

- Medical staff worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within the independent sector.
- The hospital had a Medical Advisory Committee (MAC). The MAC periodically reviewed existing practising privileges to ensure continued compliance with the practising privilege agreement and advised the hospital about continuation of practising privileges. We viewed MAC meeting minutes dated 5 December 2018. The MAC had reviewed applications from 16 medical staff for practising privileges. The committee also discussed 21 staff that had practising privileges withdrawn. The meeting minutes highlighted that a number of anaesthetists practising privileges were being withdrawn due to low activity. However, the minutes highlighted that in the event of an urgent anaesthetist being required the hospital could award temporary practising privileges.
- Resident medical officers (RMO) worked closely with the ITU fellows, senior nurses as duty managers and ward managers. RMO provided 24 hour medical cover through 12 hour shifts.
- The urgent care centre had five established WTE doctors. The urgent care centre had three doctors, or two doctors and the ANP, on duty with two nursing staff on Monday, Friday, Saturday, and Sunday. There were two doctors on duty and one nurse on other days. The urgent care centre manager told us all doctors were accident and emergency doctors with a background in the NHS. Some medical staff continued to work for the NHS as locum or bank staff.
- There was an intensivist, ITU fellow, on-site 24 hours a day, seven days a week. This is a suitably qualified person who specializes in the care of critically ill patients, most often in the high dependency unit (HDU). The intensivist provided medical support to patients that appeared to be deteriorating.
- Critical care consultants were required to live within 30 minutes travelling time from the hospital. Consultants were available to provide emergency advice 24 hours of the day, seven days a week. Consultants were required to attend the HDU within 12 hours of a patient being admitted and within 30 to 60 minutes if there was a patient whose condition was not under control.
- There was an anaesthetist on site from 7am to 6pm. There was an on-call anaesthetist rota from 6pm to 7.30am.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not always clear and up-to-date.

- We reviewed two separate patient records related to the two matters which had been raised with the CQC.
- The first set of records pertained to concerns related to the safety of a patient in the period up to their death and the subsequent reporting of their death.
- The clinical notes completed by medical staff were detailed and provided evidence of the individuals presenting problems, the assessments carried out, and reviews of results. Information had been recorded of treatment, medicines and regular reviews. We observed contribution to the patients' treatment plan by a consultant microbiologist.
- Nursing notes were not always clear, with some gaps in recording of dates and times when the written entry was made. A formalised general care plan was used when the patient was cared for in the HDU. This had generic care related problems stated, and was not individualised. As a result, there was a missed opportunity to specify exactly what the patient's needs, choices and preferences were. The patient was moved from St Elizabeth to St Andrews ward on 13 March 2018, when the patient was still subject to barrier nursing and source isolation. There was a recorded entry in the notes we viewed indicating the patient was mobilised along a corridor by physiotherapy staff. It was not clear in the records what infection prevention and control measures the physiotherapist took during the mobilisation or how they minimised the risk of cross-contamination.
- The hospital had an infection prevention and control lead. We noted however, there was a delay in the

infection prevention and control lead advising of the need to strictly barrier nurse the patient for several days. The patient had been moved between nursing areas several times. These points suggested there was a lack of recognition of the potential and actual risks to staff and others who used the service.

- The second patient records reviewed related to the management of a patient through the urgent care walk-in service and subsequent management of blood test results. Records demonstrated a clear record of initial consultation, request for investigative blood tests and on-ward referral to a specialist consultant. The latter was arranged very quickly and took place in a short time after the initial presentation on the same day.

Incidents

The hospital did not always manage patient safety incidents well. Incident were not always reported on the electronic system in a timely way. Investigating staff did not always adhere to the hospital's process for investigating incidents.

- Staff used an electronic incident recording system to report incidents. Senior staff discussed incidents during monthly medical governance committee meetings and identified any potential changes to practice or policy as a result of incident investigations. Every member of staff, regardless of role or seniority had access to the reporting system.
- Staff had access to a range of policies and procedures. This included: Incident reporting and management policy and incident reporting and management procedure. These were in date and had been either revised or written in the summer of 2018. There was a clear process for staff to report incidents or near misses. This was via an electronic system.
- We asked if staff who undertook the investigative processes related to the two separate matters we were interested in had been trained in the root-cause analysis (RCA) procedure. A list of 24 names was provided to us indicated they had been trained in RCA, although some had received their training when employed at previous organisations.
- We reviewed one incident procedure end to end for poor communication around blood test results. This had occurred in 2017 but was raised with CQC in recent whistle blower correspondence. The incident review was opened four days after it was reported (three-working days after the incident occurred), and closed 28 working days later. Action and lessons learned taken from the investigation included six points of reference. These included by example an update to the doctor's orientation pack and various actions around the checking and communicating of blood test results. In accordance with best practice related to learning from adverse event, there was no suggestion of blame made within the electronic incident process.
- We followed up on the learning from this incident and noted there was some delay in updating the services urgent care centre, Casualty First, Doctors Information Pack. This had been reviewed in October 2018 following the incident review described above. Information contained therein was detailed and covered a range of areas related to the service. This included the arrangements around test results and pathology. Clinicians working in the department were required to check patient results before the end of the day and to ensure abnormal results were communicated to the consultant whom the patient was referred to.
- A copy of the root-cause analysis (RCA) investigation was provided to us for the above incident. We noted the investigator did not outline the process of their review, whether it included any discussion with medical staff or relied solely on written medical notes. Because of this it was not known if the opportunity had been given for all medical staff to present information, which would have assisted in understanding the patient pathway and possible contributory factors. The RCA documentation did not identify all the detail around the management of the patient and therefore opportunities to learn from the process were not as strong as they could have been. Further, there was no evidence of medical staff having a copy of the report and therefore being aware of the learning arising from the RCA. We did however see an email which was sent to the Casualty First staff on 11 May 2017, informing them that results from blood tests requested in the department were not accessible to consultants who patients were referred onto.

- Urgent care centre, Casualty First, team meeting minutes dated 19 June 2017 showed discussion had taken place regarding various issues and included a reference to a complaint being upheld with respect to the delayed blood test results communication.
- The duty of candour policy, February 2017, stated clearly its scope and principles. We reviewed information which demonstrated the policy had been followed for the matter relating to poor communication around blood test results for one patient. An apology had been written and the individual was invited to meet if they wished to discuss the matter further.
- The second matter we reviewed related to a patient who had presented with vomiting and diarrhoea. A death certificate had been completed for the individual who the whistleblower had raised concerns about. We found relevant information had been entered as expected. We did note however, the space asking for other significant conditions contributing to death had not been completed. The provider acknowledged the addition of information in this area should have been considered. However, its absence did not change the primary and secondary causes.
- We saw there had been a full mortality review of the patient who had died. This was done in accordance with the providers internal arrangements and followed their usual procedures.
- Following our inspection the hospital informed us that the hospital had a range of governance and quality and risk meeting that regularly reviewed incidents. These included: a weekly incident review meeting which was attended by the chief nursing officer (CNO), deputy CNO and director of governance and risk. The hospital also informed us that there was a weekly consultants complaints, litigation, incidents and patient feedback (CCLIP) meeting which was attended by the chief executive, medical director, CNO and director of governance and risk. Further, the hospital added that monthly feedback and discussion of incidents occurred at the hospital management board, sisters meeting and department meetings.

Are urgent and emergency services well-led?

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

- There was a clear management structure which staff were aware of. This meant that leadership and management responsibilities and accountabilities were explicit and clearly understood.
- A board of trustees oversaw the hospital management board. Staff we spoke with told us the hospital's senior management team were highly visible across the hospital.
- The hospital's medical directorate consisted of resident medical officers (RMO), clinical and research fellows, and clinical leads for designated services across the hospital. RMO worked closely with ITU fellows, senior nurses as duty managers and ward managers.
- We saw a flowchart detailing the lines of accountability for the urgent care centre, Casualty First, from ward to board. Medical and nursing staff were accountable to the ward manager. The ward manager was accountable to the chief nursing officer. The chief nursing officer was accountable to the chief executive officer (CEO).
- Staff we asked spoke highly about their departmental managers, and about the support they provided to staff and patients. All the staff we spoke with said managers supported them to report concerns. Staff said they thought their managers would act on any concerns they raised. Staff told us their managers regularly updated them on issues that affected their departments and the rest of the hospital.
- Some staff told us they had been supported by the hospital to gain skills and qualifications in leadership and management. A housekeeping supervisor told us they had been supported by the hospital in

completing a national vocational qualification (NVQ) level 3 in management, supervision and leadership. The head of facilities had completed a course in the British Institute of Cleaning Standards (BICS).

Vision and strategy

- Staff we spoke with told us that the hospital was committed to delivering safe and effective clinical care.
- We viewed the standard operating procedure (SOP) for the urgent care centre, Casualty First. This identified the aims of the service as "To provide a high quality, safe and efficient service for the patients attending the department. This is achieved by recruiting competent staff that maintain standards and deliver a professional service."

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose.

- The hospital had regular departmental and team meetings where staff felt able to contribute and raise issues and concerns. Staff told us they felt able to contribute to meetings and raise concerns if necessary. We saw minutes from team meetings which indicated this was occurring.
- We viewed seven team meeting minutes for the urgent care centre dated from February 2018 to March 2019. The meetings regularly reviewed incidents and complaints. The meetings also reviewed infection prevention and control data and environmental audit data. For example, meeting minutes dated 26 February 2019 and 27 March 2019 recorded 100% compliance with hand hygiene audits. Minutes for 26 February 2019 recorded that the environment audit was not completed in January 2019. There was no explanation in regards to why this had not been completed in the minutes. However, in the subsequent month's minutes dated 27 March 2019 environment audits were recorded as 96.7% compliance. Staff told us any national patient safety alerts (NPSA) were shared with staff at these meetings.
- Staff we asked told us clinical supervision was provided for doctors, nurses and healthcare professionals in accordance with the hospital's clinical supervision policy.
- Staff told us supervision was provided on an ongoing basis and included meeting regularly with their line managers. Staff told us they could also request ad hoc supervisions as required. Staff received a formal appraisal annually.
- Staff told us there was a monthly meeting for staff working in the estates team.
- The infection prevention and control lead told us they had taken up their role in September 2017. They said at the time of their appointment there were a number of infection prevention and control policies that required updating. The lead told us they had updated the hospital's infection prevention and control policies and identified any gaps. For example, the hospital's policy on ANTT had been ratified on 20 March 2019.
- The service had a policy which supported staff to speak up and disclose information which was in the public's interest
- Learning from deaths reviews were carried out through the mortality review committee, which was part of the governance arrangements.

Governance

Although managers were monitoring staff compliance with the infection control policy and processes by use of an online tool, the hospital's governance frameworks did not always support the delivery of infection prevention and control strategies.

- The hospital's 'Organisational Policy for the Prevention and Control of Infection,' detailed the hours the infection prevention and control lead was available, these were 9am to 5pm Monday, Tuesday, Thursday and Friday. The policy detailed that out of hours staff must initially refer to the infection prevention and control policies on the hospital intranet, or leave a message on the infection prevention and control lead's extension or the bleep holder, who would then contact the appropriate person. However, the policy did not indicate who the appropriate person would

be, or the procedure for staff requiring infection prevention and control advice during office hours in the absence of the infection prevention and control lead. Although a senior member of the urgent care centre staff told us they would refer any infection prevention and control issues or concerns to the duty manager in the absence of the infection prevention and control lead.

- We asked about oversight of clinical risks such as patients with infections or otherwise. We were told about and saw the provider used a resuscitation team and safety briefing to record general information at various times during the day. We viewed four of these which covered the time when a patient would have been expected to be nursed in isolation. The completeness of information on this record varied, with gaps in patient names, no infection status recorded, and lack of reference to one patient.
- A separate Infection Prevention and Control update was provided to us, dated 23 March 2018. This had some information summarising patient status. However, we were told this was not at the time embedded in practice as a regular communication tool.
- We viewed infection prevention and control committee meeting minutes, dated 20 March 2019. The meeting was chaired by two consultant microbiologists, and had in attendance: the infection prevention and control lead, head of facilities, chief pharmacist, director of clinical services, theatre manager and chief nursing officer. The meeting reviewed the group's terms of reference and agreed that ward managers would be invited to the meeting in the place of the infection prevention and control link nurses, together with the director of clinical services.
- The infection prevention and control committee minutes date 20 March 2019 recorded that there had been no cases of hospital acquired clostridium difficile (C diff) positive infections in the hospital in the previous year and there had been no hip or knee arthroplasty surgical site infections. It was suggested at the meeting to add a review of spinal surgical site surveillance data to the meetings. The meeting reviewed infection prevention and control audit data and found some outcomes could be improved. The minutes did not clarify the areas for improvement. The minutes also recorded that all infection prevention and control link practitioners had completed their allocated audits.
- The hospital had a medical governance committee. Attendees included the director of governance and risk, clinical audit lead/governance coordinator, chief nursing officer, deputy chief nursing officer, director of clinical services, and the incident report lead, together with a variety of different staff at different meetings. The infection prevention and control lead was not an attendee at any of the medical governance meetings we reviewed. Following our inspection the hospital told us infection prevention and control was a standard agenda item at the meetings and the meetings outcomes were reported to the chief nursing officer (CNO), who was the hospital's director of infection prevention and control.
- We reviewed a range of committee meeting minutes dating from February 2018 to January 2019. The meetings reviewed: incidents, audits and key performance indicators (KPI). The KPI included unplanned transfers to the HDU, unplanned transfers to other providers, reportable infections, and complaints. The meetings also reviewed safeguarding, the hospital's risk register, and any new guidance from NICE or the Medicines and Healthcare Products Agency (MHRA). Infection prevention and control was not discussed at every medical governance committee meeting. However, it was discussed at the meeting on 11 April 2018 as 'any other business'. Infection prevention and control committee meeting minutes, dated 17 October 2018, reviewed hand hygiene data and discussed having separate hand hygiene audits for consultants.

Managing risks, issues and performance

Although the hospital had systems to identify risks, plan to eliminate or reduce them. Infection risks were not always given sufficient priority.

- The Hospital of St John & St Elizabeth had quality and risk assurance meetings. These tracked various risk and performance systems. This included the hospital's

quality and risk assurance committee that tracked corporate and departmental risks. The committee was chaired by a professor of medicine who was a trustee of the hospital and member of the board

- The process of reviewing adverse events as a means of minimising risks and improving performance was not as strong as it could be. Because of this, some of the gaps in procedures and records were not identified, and there were missed opportunities for learning as a result.
- Even though the hospital were monitoring infection prevention and control risks. We noted in the meeting minutes that the management of community acquired infections in the urgent care centre, the point of patient entry, was not highlighted in the corporate meetings.
- The Medical Advisory Committee (MAC) meeting minutes, dated 5 December 2018, noted that an outbreak had been discussed in a previous MAC meeting and all guidelines had been adhered to. However, we found from our review of records that the hospital's guidelines had not been fully adhered to during the outbreak in 2018. We also found that the post infection review recorded that the infection prevention and control lead did not attend the urgent care centre promptly after a symptomatic patient had presented at the urgent care centre. This was not in accordance with the procedure in the hospital's 'Management of outbreaks of infections' policy, dated August 2016, which advises staff to inform the infection prevention and control team "immediately of any suspected outbreaks/infection control concerns.'
- We reviewed minutes from the quarterly quality and risk assurance committee meetings dating from 15 January 2018 to 20 February 2019. The meetings were attended by a range of staff including: the professor of medicine, chief nursing officer, health and safety risk manager, head of business services, clinical audit lead/governance, clinical educator, theatre manager, head of human resources, imaging services manager, a patient representative, director of clinical services and the hospice director. However, we noted that the infection prevention and control lead did not attend any of the quality and risk assurance meetings in the period. Following our inspection the hospital informed us that the infection prevention and control lead had not been present at the meetings due to sickness. The hospital further informed us that the meetings were attended by the chief nursing officer (CNO) who was the director of infection prevention and control.
- Quality and risk assurance committee minutes recorded that the corporate risk register was a standard agenda item. Major risks were discussed at the meetings, these included a discussion on 6 November 2018 on actions the hospital were taking to reduce the risk of hospital acquired infections.
- Minutes from the meeting dated 16 July 2018 recorded that the infection prevention and control lead was conducting reviews on all infections at the hospital and stated that infections at the hospital were small in number. Minutes from the meeting dated 6 November 2018 recorded that the meeting had reviewed minutes from the infection prevention and control committee meetings. However, infection prevention and control committee meeting minutes were not reviewed at every quality and risk assurance meeting. The meeting on 16 April 2018 did not mention infection prevention and control. Following our inspection the hospital informed us that it was not a function of the meeting to review minutes at every meeting. But, reports from committees were reviewed by the quality and risk assurance committee.
- Minutes from the quality and risk assurance meeting dated 20 February 2019 reviewed "bacteraemia, C.diff infections, and surgical site infections (SSIs) reportable to PHE and CQC", of which there had been two in the period. These were a case of klebsiella bacteraemia and a case of escherichia coli bacteraemia (E-coli). But, there were no records in the minutes on actions the hospital had taken in regards to the hospital's response to these cases, or what the discussion in the meeting on the 20 February 2019 entailed. Following our inspection the hospital informed us that these were community acquired infections and post infection reviews were in progress at the time. This was not recorded in the minutes.
- Each department had a risk register. We viewed the urgent care centre risk register. The risk of patients presenting at the urgent care centre with diarrhoea and vomiting was added to the risk register on 20 March 2019. The register recorded actions to mitigate

the risk as: the hospital's infection control policies, isolation of patients who were symptomatic, minimisation of staff contact, and effective disinfection of environment and equipment.

- The risk register had a matrix to guide staff in deciding on the likelihood and impact of risks identified on the register. The risk of patients presenting at the urgent care centre with diarrhoea and vomiting was rated as "moderate" and "unlikely." However, it was possible that a patient could present as a 'walk in' patient at the urgent care centre. Therefore, the risk register score had potentially underestimated the likelihood of a patient walking in to the urgent care centre with symptoms. Furthermore, the risk was amber rated on the red, amber, green (RAG) rated risk register. The risk register's residual exposure guidance indicated that risks rated as "moderate" and "unlikely" should have been green rated. There was no explanation on the risk register on how the amber rating had been reached. This meant it was unclear as to how often the risk should be reviewed by using the RAG rated residual risk exposure tool for a "moderate" and "unlikely" rated risk. The risk register recorded that an amber risk should be mitigated and treated. However, this did not conform to a rating of "moderate" and "unlikely" as the risk matrix identified this level of risk rating as being "tolerated and acceptable".
- The urgent care centre had taken actions to mitigate the risk and recorded on the risk register further actions to address the risk as: a new unit being built will have more rooms to enable isolation; the introduction of a diarrhoea and vomiting pathway in March 2019; all staff in the urgent care centre being up to date with infection prevention and control training; and to ensure patients transfer sheets identifying risks of cross-infection were completed and travelled with the patient when the patient was moved.
- We viewed the HDU risk register. This identified a risk of cross-infection from patients in the HDU isolation room to other HDU patients. The risk had a green RAG rating. The risk register recorded mitigating actions as: patients with known infections or at risk of MRSA being admitted to the side room and barrier nursed until their status was clear; clear signage on the isolation room door to indicate that the patient was in isolation; regular hand hygiene audits to be completed; and annual infection control training for staff and housekeepers. Further actions identified in response to residual risks were identified as a new build HDU project to create three individual patient rooms in the HDU.
- During our previous comprehensive inspection in November 2016 we noted that risk registers did not state a date when a risk had been identified and put on the register. During this inspection we reviewed the corporate risk register and found this had been addressed by the hospital and the date of entry on the register was recorded. This meant there was an audit trail to follow the length of time risks had been on the register.
- The "Potential hospital acquired infection – as a direct result of healthcare intervention or being in a healthcare setting," was on the risk register. The outbreak in the urgent care centre had been included in a review of the risk register in 2018. The dates of reviews were not recorded on the risk register. The risk register did not include risks relating to community acquired infections and the specific risk of patients presenting at the urgent care centre with community acquired infections.
- The risk relating to hospital acquired infections recorded actions the hospital had taken to mitigate risks. These included: infection prevention and control policies; quarterly reviews of incidents; patient led assessments of the care environment (PLACE) audits; leadership walk arounds; cleaning schedules and deep cleaning; and induction and mandatory training for staff.
- Following the virus outbreak the risk register recorded that there was a programme of targeted training for specific staff. However, the specific staff that had received the training was not recorded. The risk register also recorded specific actions the hospital had taken in response to the risk as: reviewing and strengthening the link nurse role and responsibilities; quarterly environmental audits using an online inspection tool; and a review of infection prevention and control policies. We reviewed the online audits and found these were completed regularly. The infection prevention and control lead also told us they were in the process of reviewing all infection prevention and control policies and procedures.

- The hospital had twice daily safety briefings. Any infectious patients were identified and staff were informed of any infection prevention and control procedures that were in place. At the time of our visit there was one patient identified as posing an infection risk. Isolation procedures were in place for this patient, including barrier nursing to reduce risks to other patients and staff.
- An external cleaning company was contracted to provide deep cleaning services. This included quarterly deep cleaning of theatre's and endoscopy and six monthly deep cleaning of clinical areas and kitchens. The cleaning provider provided a report following deep cleans and these were reviewed by the infection prevention and control committee.
- There were structures to maintain infection control risk management. For example, monthly link practitioner meetings and a quarterly infection prevention and control committee meeting.

Managing information

The hospital collected, analysed, and managed information, using secure electronic systems with security safeguards.

- The Medical Advisory Committee (MAC) meeting minutes dated 5 December 2018 discussed the staff survey feedback. The minutes noted that overall the results were positive, but it was noted that the hospital needed more investment in computer systems and technology.
- Quality risk assurance meeting minutes dated 6 November 2018 recorded that the hospital had undertaken a GAP analysis and completed work relating to each area of the General Data Protection Regulation (GDPR). This included testing security around access to files and a review of the email system around auto-fill capability.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

- The Medical Advisory Committee (MAC) meeting minutes dated 5 December 2018 noted that feedback from the staff survey found that staff stress levels at work were higher following this survey than they had been in the previous survey in 2016. In response the hospital was looking to appoint mental health first aiders.
- The quarterly quality and risk assurance committee included patient representatives at some meetings. This meant the patient 'voice' was included and heard at these meetings and patients were included in planning services.
- We saw copies of the hospital's magazine for Spring 2019 were readily available in public areas and wards we visited. The magazine provided information on the hospital's services and contact details for individual wards and departments. The magazine also carried information on the hospital's educational programme, including training sessions for external doctors.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that all staff are clear about their areas of responsibility in regards to cleaning.
- The provider should ensure deep cleaning by the hospital's housekeeping staff following and infection control risk is timely.
- The provider should ensure patients at risk of infection or infectious patients are isolated and policies on managing infectious patients are implemented without delay.
- The provider should ensure staff keep detailed records of patients' care and treatment, and these are clear and up-to-date.
- The provider should ensure incidents are reported on the electronic incident reporting system in a timely way.
- The provider should ensure incident investigations adhere to the hospital's policies and procedures for investigating incidents.
- The provider should ensure learning from incidents is shared across the team and wider service.