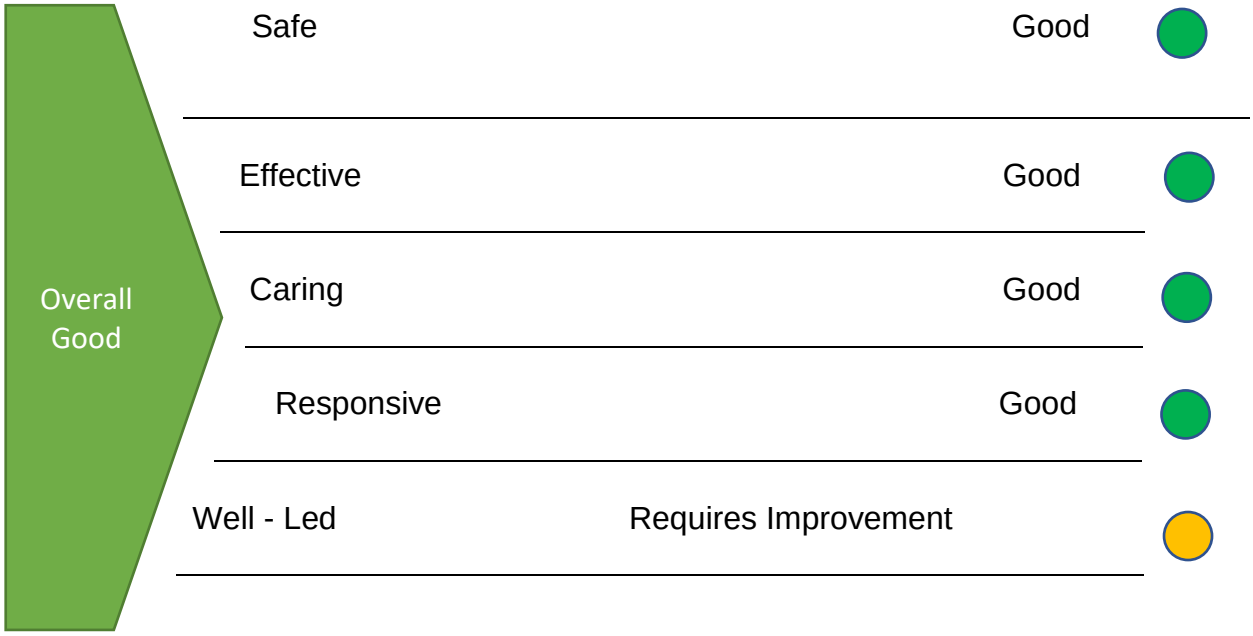
The Belvedere Private Hospital

Overview and CQC Mock Inspection



Our inspector's description of this service

Belvedere Clinic - Mock Inspection Report

Date of Visit - 25th August 2020

About the provider

Belvedere Clinic is an eight-bed inpatient facility. It has one operating theatre, anesthetic room and a recovery room. There are three consultation rooms. The Belvedere provides both surgical and non-surgical cosmetic procedures, such as b+

Background to the inspection

A mock CQC inspection was undertaken at Belvedere Private Hospital on 25th August 2020, at the request of the owner. The inspection was based on the findings of the CQC Inspection report dated 27th September 2019 when the hospital was awarded a Requires Improvement rating and enforcement action taken under Regulation 17 (Good Governance) by the Care Quality Commission. Deficits were identified in the hospital's management of incidents and complaints. Assurances around risk were not robust; and policies and procedures were not up to date or sufficiently accessible to staff. The hospital was required to make significant improvements in these areas.

Methods:

At this inspection, we referenced the CQC report, focusing on the areas of concern. Whilst making an assessment of the service based on the CQCs 5 key lines of enquiry. The hospital manager, two nurses and two patients were interviewed. We triangulated information collected from staff and patients with information gleaned from patient records, policies and procedures, and other relevant documentation.

Overall summary:

The hospital manager came into post a couple months prior to this inspection. An application has been made to CQC for registered manager, hence registered status is pending.

On the day of the mock inspection there were seven patients undergoing various surgical procedures at the clinic.

Is the service safe?

Mandatory training:

All staff are expected to complete mandatory training in a timely manner. We were informed that due to COVID-19 and the resulting social distancing measures, that face to face training had not been possible. Most training being online, meant about 80% of mandatory training had been achieved. This was born out upon review of the training matrix.

Systems and processes to safeguard people from abuse:

- The manager described systems and processes for safeguarding people from abuse and avoidable harm, and demonstrated a good understanding.
- Staff had a good understanding of safeguarding issues which they said came from their training received in NHS Trust they worked in.
- The staff on duty had never needed to raise a safeguarding concern. Information was displayed on the notice board in the nurse's office as to who was the safeguarding lead in case, they needed advice.

Cleanliness, infection control and hygiene:

- In accordance with the COVID-19 pandemic. The service has put in place a robust action plan which incorporates daily surface cleaning in theatre, with deep cleaning of entire clinic every six months. Everyone entering the premises has a temperature check and antibacterial gel is available throughout the clinic.

- The service does have an infection prevention and control policy in place with audits undertaken monthly. However, it refers to an infection prevention and control manual. The policy also states that an audit plan should be prepared annually by the infection prevention and control (IPC) lead. The manager advised there is not an audit plan in place, and the timescale for this to be in place was by the end of this year. All areas inspected were visibly clean.
- Staff were observed to be washing hands regularly and all were observed to be bare below the elbow. There were adequate hand washing facilities.
- There were robust processes in place for COVID-19 screening of patients. The process was observed on the day.
- Staff were observed to be wearing appropriate personal protective equipment (PPE).
- There is a kitchen based on the ground floor. One of the worktop services in the kitchen is damaged on one corner exposing the under layer. This could potentially harbour pathogens. Consequently, there is a risk (although relatively low) as we understand staff sometime prepare toast for patients.

Environment and Equipment:

- The service had suitable premises.
- All relevant equipment observed had valid electrical testing.
- We noted two sharps boxes in consulting rooms did not have the date label completed.
- The resuscitation trolley on the ward - all items (drugs, fluids and single use items) were in date. The trolley checklist indicated checks were made on the days surgery was undertaken.
- Emergency call bells on the ward were in working order.

- This cupboard is located on the ground floor so there is only a small risk of patients entering the room. However, the lock should be fixed urgently and in the interim some other measure to secure the door should be put in place, e.g. latch and padlock. Assessing and responding to patient risk:

- Nursing staff were observed to be regularly assessing patients post operatively and observations recorded. The service uses an early warning score (NEWS) which staff were able to accurately describe how it should be used in the case of a deteriorating patient.
- The 'to be' registered manager advised us that she thought a different deteriorating patient identification tool was being used even though she had signed the relevant policy showing that the one actually used was the one referred to in the policy (NEWS).
- We reviewed three sets of patient records and saw evidence venous thromboembolism (VTE) assessments had been completed.
  All three records contained a signed consent form; however.
- On the day of inspection, a patient's procedure had taken much longer than anticipated and the service responded appropriately by advising that the patient stay in hospital overnight to ensure they could be observed for any potential complications.

Nursing and support staffing:

- All nursing and support staff work on a self-employed basis.
- The service had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

- Staff reported that staffing levels were adjusted appropriately in relation to the number of patients.
- On occasion when theatre staffing is depleted, the hospital manager steps into support the surgical team.

Medical staffing:

- The service had enough medical staff to provide the right care and treatment. The Registered Medical Officer (employed via an agency) has only started the day before the inspection.

Records:

- Patients' records were detailed, clear and dated.
- The records are stored on a shelf in the nurse's office when patients are on the ward. The office is open, and it does not always have a member of staff in there; consequently, there's a potential all risk of the records being accessed by people who shouldn't have access to them.

Medicines Management:

- Controlled drugs (CD) were checked daily. This was confirmed by checking the CD recording book. Appropriate procedures for administering CDs were followed.
- A random sample of other drugs in the general drug cupboard was checked and all these were in date.
- Daily checks are undertaken of the resus trolley. All medicines on the trolley were found to be in date.

Incidents Management:

- Staff reported appropriately how they would record and report any incidents. One member of staff was aware of a least one diathermy burn incident in the past but was not aware of the outcome of any investigation and had received no feedback post investigation.
- In the last published Care Quality Commission inspection report, there is an indication that at least two diathermy burn incidents had occurred. The hospital manager reported at our inspection that another diathermy incident had occurred recently bringing the total to at least three in two years.
- The Hospital Manager was not aware of previous diathermy incidents, nor that the CQC had indicated this incident type as a 'never event'. Effective action has not been taken by the provider to prevent diathermy burns to patients.
- The services incident reporting process was very poorly development and needed urgent improvement, to ensure patients are protected from har**m**.

Is the service effective?

Evidence-based care and treatment:

- Nursing staff stated that they ensured evidence-based care following relevant policies and procedures that they assumed the service had developed with reference to relevant national clinical guidelines. However, it is not clear if the policies have all been reviewed with this level of robustness as no governance process is in place to ensure proper scrutiny of new or updated policies and procedures.
- Staff was not aware if any relevant audits had taken place to ensure policies and procedures were being adhered to.

Nutrition and hydration:

- Staff gave patients enough food and drink to meet their needs.

Pain relief:

- We observed appropriate prescribing of regular and as needed analgesia. We also observed pain management discussions between nursing staff and medical staff and appropriate adjustments to prescriptions as a consequence.

Patient outcomes:

- Staff monitored patient outcomes through follow-up out-patient consultations. However, no outcome measures were available regarding unplanned transfers and surgical site infection.

Competent staff:

- Nursing staff reported they received appraisals via their NHS employers. One member of staff worked in a completely different specialty in their NHS role, so their clinical competency for their work at Belvedere cannot be assured via this process. The member of staff reported that on commencement of her employment at Belvedere she received a lot of support and guidance to ensure she was competent in her role as a staff nurse on the ward.

Multidisciplinary working:

- Doctors and nurses on the ward were observed to work well together.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards:

- We saw consent forms signed in the three patient records reviewed.
- We saw information leaflets patients were given regarding the procures they were going to have.
- Staff was able to demonstrate a good understanding of the key issues of the Mental Capacity Act and how it related to their roles in ensuring patients were supported to give informed consent.

Is the service Caring?

Compassionate care:

- We interviewed one patient on the day of inspection. They fed back that all staff she had encountered had been caring, polite and knowledgeable, and had spent time as needed to explain anything they needed clarifying.
- 30 patient feedback forms were reviewed which include questions about, information, consent, individual needs, care, cleanliness, waiting times and overall experience. The vast majority of forms were graded as 'Excellent' for all aspects with only a couple forms graded slightly lower as 'Good'.

Emotional support:

- The patient who was interviewed said all staff had been very patient and supportive.

Understanding and involvement of patients and those close to them:

The patient we interviewed said this was not applicable in her situation as relatives had not been allowed to consultations due to the Covid-19 restrictions. However, they did report that they were confident that the staff would have involved those close to them if they had wished this in the circumstance of not being in a pandemic.

Is the service Responsive?

Service delivery to meet the needs of local people:

- All admissions are pre planned.
- The patient we interviewed said her individual needs were assessed and responded to.

Meeting people's individual needs:

- The last Care Quality Commission inspection report states that staff had a telephone-based translation service to assist with non-English speaking patients. However, the one member of nursing staff who was asked about this was not aware of this service.
- Patients were given information leaflets directly related to the surgical procedure they were to undergo.

Learning from complaints and concerns:

- There is a complaints policy in place.
- A member of staff gave an example of a complaint where a patient's operation had been cancelled because she took a medication on the day of her operation that could have caused an interaction with her anesthetic. The patient complaint was that she had not been informed that she should not take the medication. As a consequence, the service developed a new pre-assessment medication check list to ensure patients are now informed of all medication they should not take on the day of their operation.
- Staff thought the numbers of complaints to the service are very low.
- The hospital manager advised that there were many complaints of a financial nature, due to patients wishing to cancel surgery and get refunds following COVID-19 lock down restrictions. As a result, many customer service-related complaints had also been received. There were no complaints regarding clinical care.

Is the service well-led?

Leadership:

- The leadership at the clinic comprises the hospital manager who will hold Registered Manager status; and the theatre manager, who is the Nominated Individual. Reportedly, the professional relationship between the two managers is strained at best and dysfunctional at worst. These circumstances are unfortunate, because it impacts staff morale negatively, and compromises the operational efficiency of the clinic.

Vision and strategy:

- One member of staff thought the service might have a written vision and list of values but could not direct us to where they would find this. Another member of staff said there definitely was a service vision and values statement and that it was normally visible to see on the staff notice board in the nurses office. The staff member did not know why this had been removed when we went to find it. They were able to describe what they thought was in the mission and values statement but this could not be corroborated by seeing a copy.

Culture:

- Staff felt supported and valued by both the manager and matron.
- They did report that the service had had four different managers in the past twelve months. They were not aware of the reasons for previous manager leaving. Staff were complimentary about the new manager saying she was very supportive and listened to ideas about change and supported change.
- Opportunities for career development were not provided by the service but staff did not see this as a concern as they were self-employed and had other substantive jobs elsewhere.

Governance:

- Policy folder on the ward was not well organized. It did not have a contents list, so it was difficult to find policies. It would be difficult for staff to know if a policy exists as there is not a contents list.
- There is list at the front of each policy for staff signatures to indicate they have read the policy. Some policies have a number of signature and others only a few. The manager was asked how this process was managed and she indicated it was a challenge as staff don't work constantly. She indicated she would like to implement an email system where staff could reply to indicate they had read the policy. No indication was given as to when this process might be set up.
- The last Care Quality Commission inspection report states that the nominated individual said they were using an external consultancy to review the policies. It is not clearly evident that this has happened or if it did happen, that this was robust as policies are written in many different styles and to different levels of comprehensiveness.

Engagement:

- All patients are asked to complete a feedback form before they are discharged home. All thirty forms reviewed gave excellent or good feedback. Because patients are asked to complete these forms during their admission it is possible, they could feel uncomfortable to give negative feedback. Thus, the value of the current process is questionable.
- Engagement with staff is a challenge as the majority are bank staff. However, there was no evidence of a staff survey or newsletter etc to engage staff.

Learning, continuous improvement and innovation:

- Ward based staff were not able to give any examples of innovation.
- Smaller changes to process (e.g. pre-assessment medication checklist) were evident.
- The staffs were not able to state that any meaningful clinic audit was undertaken.
- The concept of cultural change to ensure an environment of continuous improvement is currently a big challenge for the organization. The last Care Quality Commission inspection report states that the nominated individual felt that improvements that were required would be completed by the person they employed as the next manager. In the interim there have been three (possibly four) new managers so there is little evidence yet of improvement. This situation is likely to continue unless the organization can identify the reason or reasons for such high turnover of their manger position.

Summary:

The issues highlighted by the enforcement action in the last CQC report, still prevail; with limited progress having been made. All issues presented in this report arise from the need for improved governance practices in the clinic. Unless the following recommendations are implemented; it's unlikely that the clinic will make any meaningful improvements or improve the current CQC rating.