HCA International Limited

The Lister Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

The Lister Hospital is a 64 bedded private hospital, based in Chelsea, London. In 2000, The Lister Hospital became part of HCA International joining The Harley Street Clinic, London Bridge Hospital, The Portland Hospital, The Princess Grace Hospital and The Wellington Hospital.

The hospital employs five whole time equitant (WTE) doctors, 66 WTE nurses and two WTE healthcare assistants. There were 521 doctors who have been granted practicing privileges at the hospital at the time of our inspection. The hospital undertakes a range of surgical procedures, provides medical and critical care and also carries out outpatient consultations. These are four of the eight core services that are always inspected by the Care Quality Commission (CQC) as part of its new approach to hospital inspection. The hospital has five operating theatres, 17 consultation rooms and 40 inpatient and 24 day case beds all with en-suite facilities. The hospital provides in patient care to male and female patients aged over 16 years of age. The out patients department sees patients of all ages. At the time of the inspection the hospital was not providing care to any NHS patients. The hospital was selected for inspection as an example of a medium size independent hospital in our wave 1 pilot.

The inspection team included CQC inspectors, doctors, nurses, patient representative and a senior manager from another private hospital. The inspection took place on 09 and 10 December 2014. Our key findings were as follows:

Safe:

- There was a electronic incident reporting system in place which most staff were aware of, most incidents were reported, incidents were investigated and findings fedback to most staff to ensure learning.
- The principles of the world health organisation (WHO)‘ five steps to safer surgery’ checklist were embedded into practice and surgical safety checklist were complete.
- All clinical areas and departments were clean and well maintained.
- There were effective infection prevention and control policies, procedures and practices in place.
- The national early warning score (NEWS) was in place to monitor patients conditions and there was 24 hour outreach support available from the critical care to assist staff in the management of patients whose conditions was identified as deteriorating.
- Risks association with the environment and equipment were managed well through checking processes and prompt repair or replacement when required.
- Safeguarding training was provided at the appropriate level for all staff, although the safeguarding children policy did not reflect up to date national guidance.

Effective:

- The hospital had a limited audit programme in respect of clinical practice and outcomes for patients.
- Patient’s satisfaction surveys were undertaken and action taken to address issues raised by patients or their relatives.
- There were processes in place to ensure adequate pain control and staff had access to a specialist pain control team.
- Staff participated in an annual appraisal and were provided with training opportunities to gain additional skills and knowledge.
- Therapy staff were providing support to orthopaedic patients to expedite recovery from surgery, but there was no monitoring of adherence to best practice in enhanced recovery.
- Consultants provided individual pre and post-operative care guidance for their patients. However, this guidance did not always refer to best practice guidelines and was not standardised.
- Staff had an understanding of the Mental Capacity Act 2005 in relation to informed consent and deprivation of liberty safeguards. However, staff were not aware of the hospital's restraint guidelines and did not consider restraint to be a deprivation of liberty or that the patient’s best interests needed to be assessed in this situation.
- Multidisciplinary team working was evident across the hospital.

Summary of findings

Caring:

- Staff were caring and treated patients and their relatives with dignity and respect at all times.
- Patients commented positively and were satisfied with the support and care provided to them and their relatives.
- Patients were involved in all aspects of their care, relatives and carers were welcomed and encouraged to be involved during the person's stay in hospital.

Responsive:

- Not all services were responsive to the specific needs of patients with cognitive impairment.
- Patient admissions were arranged in a timely manner with minimal delays for patients.
- Pre-operative assessments were undertaken in a variety of ways to meet patient's individual needs but there was no pre-assessment policy.
- There was a higher than national average number of delayed discharges from the critical care unit and some patients were moved between different wards during their stay.
- Staff had access to interpreters to facilitate communication with patients whose first language was not English.
- Patients received information about the service and their procedures prior to and during their admission.
- Complaints were usually responded to within the timescales identified in the hospital's policy and changes to practice implemented to prevent recurrence of similar issues.

Well-led:

- Staff were aware of the priorities for their wards and departments and shared the hospital and corporate vision.
- Wards and departments did not have a documented local vision and clinical strategy to support innovation and growth of the service.
- There was identified leaders who were visible and accessible and both department and hospital managers were said to be both supportive and approachable.
- Staff were patient focused and aimed to provide high quality care.
- Management encouraged an open culture so that the services could learn from incidents and complaints.
- The hospital risk register documented risks and assigned a manager to manage the risk.

We saw several areas of outstanding practice including:

- Staff were caring and compassionate and focused on meeting individual patient needs.
- The infection surveillance data base was linked to the nursing electronic record and the microbiology/pathology laboratories to ensure there was adequate oversight of infection prevention and control issues.
- The hospital used an electronic system to record patient's observations and if the score triggered a NEWS alert the RMO and outreach nurse were alerted electronically.
- The hospital falls prevention programme incorporated innovative technology to reduce patient falls and minimise harm. This is in keeping with national patient safety initiatives.
- The patient menu had been planned with the input of a dietician and provided an extensive range of high quality food that met all patients needs.

However, there were also areas of poor practice where the hospital needs to make improvements.

Importantly, the hospital must:

- Ensure that all staff in the critical care unit have the appropriate skills, knowledge and competencies and that these are in line with national guidance.
- Implementation effective systems to monitor, review all patient death and disseminate the learning from these reviews.
- Implement formal systems and process to maintain a record to demonstrate all nurses accompanying medical staff hold an appropriate registration and have completed a Disclosure and Barring (DBS) check.

Summary of findings

In addition the hospital should:

- Ensure that practices and policies reflect up to date national guidance and best practice.
- Ensure that the process in place which ensures a consultant can be reached in unplanned situations should be explicit.
- Review its provision of care to patients with cognitive impairment such as dementia, to ensure staff have an understanding of how to assess and meet the needs of this group of patients.
- That all services such as the endoscopy unit are accredited with the appropriate body or have a plan in place to demonstrate how the unit is working towards accreditation.
- Review national audits and identify those that they are eligible to participate in.
- Take action to ensure all incidents are appropriately investigated and the outcomes shared with staff.
- Consider extending peer observational audits of the use of the WHO surgical checklist to include larger sample sizes and across all theatre lists.
- Continue to review the practicing privileges granted to consultants to ensure there is an accurate record of those consultants who regularly work at the hospital and that they meet the hospital's criteria for being granted these privileges.
- Ensure that there is evidence that MDT meetings take place across all specialities.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care		Staff received appropriate training and assessment to ensure safe, effective clinical practice. Incidents were reported and investigated and where learning was identified this was shared across the hospital. Policies and procedures followed national guidance and the electronic versions were in date however some paper versions available on the wards were out of date. Staff were caring and treated everyone with unfailing politeness, respect and dignity. Patients reported very high levels of satisfaction with all aspects of their care and treatment. Staff told us they were well supported by both their line and senior managers who were very visible and involved in all aspects of the service. Medical services were responsive to the identified needs of most patients however, the hospital and clinicians had not taken into account patients with cognitive impairment, such as those living with dementia.
Surgery		There were processes in place to reduce the risks of surgery. Nurses monitored patients after their operation and medical staff were available if there were any concerns. Pre-operative assessment was undertaken in a variety of ways, but there was no pre-assessment policy. There had been no reported incidents of venous thromboembolism reported in the year 2013/2014. The number of falls had decreased following the introduction of a falls programme. There were sufficient numbers of staff to care for patients and they received appropriate training for their role. The majority of patients provided positive feedback about their care and treatment. The hospital had a limited audit programme to monitor compliance with best clinical practice and there was limited data on the outcomes for patients treated at the hospital. There were an increasing number of people requiring surgery who had complex needs. Services were being adapted to provide appropriate pre-operative assessment and multi-disciplinary input into their care and treatment. The pharmacy department and ward staff had taken action to address concerns about the effectiveness of pain relief for patients on discharge following surgery.

Summary of findings

Senior management were approachable and responded to staff suggestions and concerns. The hospital risk register documented risks and assigned a manager to manage the risk.

Critical care

The critical care unit followed some safety procedures, infection control practices and patient risks were assessed and acted on appropriately. Local policies and guidelines had not been reviewed to ensure that these were in line with national guidance. Formal procedures to audit compliance with national standards had not been implemented. Patient outcomes data was collected for some, but not for all patients and therefore outcomes could not be demonstrated.

There were appropriate staffing levels but only 40% of staff held a critical care post registration qualification. Staff were supported by senior staff to undertake their roles but their competencies were not appropriately assessed. Staff had an understanding of the Mental Capacity Act 2005 in order to carry out their responsibilities in relation to informed consent and deprivation of liberty safeguards.

We observed caring and compassionate interactions between staff and patients, staff treated patients with dignity and respect. Patient feedback forms showed they were happy with the care they received and had been involved in decisions about their care. However this feedback did not relate specifically to their treatment on the critical care unit. There were no plans to capture information specific to critical care from patients and families at the time of our visit. Patients were admitted without delay to the unit but the number of delayed discharges were higher than the national average.

Staff were not aware of the vision and strategy to expand the service but identified with the need to provide excellent care. Quality and patient experience were seen as priorities and everyone's responsibility. The nursing leadership on the unit was considered by staff to be supportive but they were not supernumerary and often worked clinically to cover for staff shortages. There was limited evidence of quality monitoring processes or monitoring of the actions taken on identified risks.

Summary of findings

Outpatients and diagnostic imaging

The outpatient, physiotherapy and diagnostic imaging departments followed procedures to ensure that patient care was safe and effective. There was managerial leadership within all the OPD departments at a local level; staff reported that the senior management team were visible and accessible. Staff participated in appropriate mandatory training and were aware of how to report and deal with incidents and complaints. All incidents and complaints were investigated and where necessary clinical and administrative practice was changed to prevent recurrence. Radiology staff followed national guidance and equipment was appropriately maintained and tested. Imaging regulations were followed and staff received the necessary training and competency assessment to ensure patient safety. Patients were able to access the service easily and the outpatient services opened Monday to Friday 08.00-20.00 and 08.00-13.00 Saturday. Patients were positive about their experiences and reported staff were caring and treated them with dignity and respect. Information leaflets and an interpreting service was available. Although leaflets were available, these were only in English. Patients and relatives told us they felt involved in the decisions about their treatment and that staff communication and the information provided was good.

The Lister Hospital

Detailed findings

Services we looked at
Medical care; Surgery; Critical care; Outpatients and diagnostic imaging

Contents

Detailed findings

Background to The Lister Hospital

The Lister Hospital based in Chelsea, London, is a 64 bedded private hospital, which provides medical, surgical services for patients over the age of 16 years, it has an adult critical care unit and outpatient department which sees both children and adults. In 2000, The Lister Hospital became part of HCA International joining The Harley Street Clinic, London Bridge Hospital, The Portland Hospital, The Princess Grace Hospital and The Wellington Hospital.

The hospital has five operating theatres, 17 consultation rooms and 64 en-suite patient rooms. In the last 12 months the hospital had 8,557 visits to the operating theatre.

Our inspection team

Our inspection team was led by:

Chair: Sir Professor Norman Williams

Head of Hospital Inspection : Siobhan Jordan, Care Quality Commission (CQC)

Inspection manager : Fiona Wray, Care Quality Commission (CQC)

The team included CQC senior managers, inspectors, doctors, nurses, experts by experience and a senior manager from another private hospital.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team inspected the following four core services at the Lister Hospital:

- Medical care
- Surgery
- Critical care
- Outpatients and diagnostic imaging.

We carried out an announced inspection visit on 09 and 10 December 2014. We spoke with a range of staff in the hospital, including nurses, consultants, administrative and clerical staff.

During our inspection we spoke with 32 patients and 95 staff from all areas of the hospital, including the wards and the outpatient department. We observed how people were being cared for and talked with patients and reviewed personal care or treatment records of patients.

Facts and data about The Lister Hospital

Context

- Registered for 40 inpatient and 24 day case beds.
- 521 doctors have practicing privileges.
- The hospital employs five permanent doctors.
- Employs 66 whole time equivalent (WTE) nurses and two health care assistants.

Activity

- Around 33,085 outpatient attendances per annum
- Around 1,924 overnight patients per annum

Detailed findings

- Around 9,839 day cases per annum
- Around 8,557 visits to theatre per annum.

Key intelligence indicators

Safety

- No incidence of MRSA, C.difficille or MSSA in the last 12 months
- No never events (a serious, largely preventable patient safety incident that should not occur if proper preventative measures are taken) in the last 12 months.
- There have been no whistle-blower enquiries for the last 12 months.
- There have been no safeguarding alerts in the last 12 months.

Effective

- The hospital reported that there had been no unexpected patient deaths in the last 12 months. However, notifications held by the CQC reported one unexpected patient death in May 2014. The provider had not update CQC post coroner's findings that this was not an unexpected death.

Caring

- Similar to other private providers, the hospital is not required to submit data for the national friends and family test (FFT).

Responsive

- The intensive care unit bed occupancy rate varied between 34%-71% between February and July 2014.

Well led

- Between April 2013 and July 2014 the vacancy rate at The Lister hospital was around 10%. Exceptions were 6% for allied health professionals and 15% for theatre staff.
- Staff turnover for nurses in inpatient departments was at 32% between April 2013 and March 2014 and 24% for theatre staff. These figures dropped to 4% and 5%, respectively, between April and July 2014.

Inspection history

The hospital has been inspected three times, with the most recent inspection in December 2013 at which we found the hospital was compliant with all regulations inspected..

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Urgent and emergency services and Outpatients & diagnostic imaging.

2. If you have not followed the ratings principles, please highlight this here using a footnote with a brief explanation of the rationale. This information should also be included in the main text of the core service report

Medical care

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

In patient medical services were provided on level five of the hospital. The hospital had an urgent care service which was based on the critical care unit. This is a rapid access and assessment service, where local GP's can refer medical patients seven days a week, 24 hours a day. The hospital also provides an endoscopy facility.

The service had admitted 174 medical patients during the period January to November 2014 which was less than 1% of the total inpatient overnight activity. At the time of our inspection there were eight medical patients. The endoscopy unit is not accredited by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG), 1,596 diagnostic and therapeutic endoscopic procedures had been carried out in the previous 12 months.

We spoke with five patients, two relatives, 14 staff including medical, nursing, domestic, housekeeping and administration staff. We looked at the premises, equipment and observed staff and patient interactions. We also looked at eight patient records and 12 policies and procedures.

Summary of findings

Staff received appropriate training and assessment to ensure safe, effective clinical practice. Incidents were reported and investigated and where learning was identified this was shared across the hospital. Policies and procedures followed national guidance and the electronic versions were in date, however some paper versions available on the wards were out of date.

Staff were caring and treated everyone with unfailing politeness, respect and dignity. Patients reported very high levels of satisfaction with all aspects of their care and treatment. Staff told us they were well supported by both their line and senior managers who were very visible and involved in all aspects of the service.

Medical services were responsive to the identified needs of most patients however, the hospital and clinicians had not taken into account patients with cognitive impairment, such as those living with dementia.

Medical care

Are medical care services safe?

Patients were protected from avoidable harm and abuse. Incidents were reported, learnt from and fed back to staff. Medical care was provided in wards and departments that were clean, well maintained and had been recently refurbished. There were effective infection prevention and control policies and procedures in place and there was good staff adherence to hand hygiene practices.

The hospital had implemented the national early warning system (NEWS) to monitor patient condition and there was 24 hour outreach support available from the critical care unit to assist staff in the management of patients with a triggering NEWS score which suggested their condition was deteriorating and action may need to be taken.

The wards/departments were staffed to meet patient's needs and staff told us they could increase their numbers if the acuity or dependency changed and this would be supported by their managers. There was an expectation that consultants would see their patients daily and there was 24 hour Registered Medical Officer (RMO) presence in the hospital.

Incidents

- Data provided by the hospital showed a total of 306 incidents had been reported in the previous 12 months of which six were categorised a high risk, 86 were moderate, 97 were low and 117 were ungraded. Medical care service incidents were not separately identified within the data. Managers reported they had seen an increase in low or no harm incidents being reported, this was attributed to a raised staff awareness and familiarity with the system.
- Staff demonstrated their understanding and use of the incident reporting system. Individuals gave examples of the types of clinical incidents such as drug related incidents or patient falls that they had reported. Staff confirmed they received an acknowledgement email and feedback from the handler/investigation lead for any incidents they had reported.
- Learning from incidents was cascaded from the hospital clinical governance committee through the Heads of Departments and at ward meetings. Staff gave the example of the implementation of a multidisciplinary discharge care plan for complex discharges as a result of learning from an incident.
- Senior staff reported they were involved in the investigation of incidents and in providing remedial support or training to staff as a result of the investigation. We were told the hospital operated a system of 'peer review' with a manager from another department carrying out the investigations and root cause analysis of serious incidents when required.
- We saw no evidence of the formal review process that took place following a patient's death. However the number of deaths in the hospital was low, four in the last 12 months. We were told that the medical director had reviewed the deaths that had occurred in the hospital between July and September 2014, but it unclear if any learning had been shared.

Safety thermometer

- The hospital carried out audits of performance against the possible harms identified in the NHS Safety Thermometer, which is an improvement initiative for measuring, monitoring and analysing patient harms and promoting 'harm free' care. The hospital monitored incidents of falls, pressure ulcers, Venous Thromboembolism (VTE) and catheter associated UTIs. The hospital used a system of safety crosses to demonstrate ward performance in the monthly audits.
- There had been no reported cases of hospital-acquired VTE between April 2013 and June 2014.
- The results for risk assessment completion on level 5 (the medical floor) for 13 days in November 2014 showed over 90% of falls, VTE and Waterlow risk assessments were completed.
- In data provided by the hospital before our inspection the VTE risk assessment rates were reported to be 54.1% for the period April 2013 to June 2014. However during our inspection senior staff told us this was due to two different monitoring processes. Recent results provided by the hospital showed 100% of VTE risk assessments were completed.
- We saw VTE risk assessments were documented in the electronic nursing record system and on the patient prescription chart. We looked at five patient's records and saw the sections were all fully completed and the action taken to prevent a VTE was documented for example anticoagulant injections and stockings worn.
- Patients were assessed on admission and reassessed for the risk of falls every 12 to 24 hours. The electronic

nursing record included mandatory fields which prevented staff moving on until the assessment was completed and action taken and recorded to mitigate the identified risk.
- The hospital had a falls prevention programme which all staff we spoke with were aware of. This included yellow signs on patient doors to alert staff, non-slip socks for patients to wear, prominent signs near the patient to remind them to call for assistance stating 'call don't fall' and sensor mats which set off an alarm to alert staff that a patient identified as 'at risk' was moving about.

Cleanliness, infection control and hygiene

- The wards and endoscopy unit were visibly clean and dust free. Equipment was labelled after cleaning with the name of the person and the time and date. Domestic staff had access to appropriate cleaning equipment and cleaning schedules were available for every area. Standards of cleaning were monitored daily by the domestic managers. Domestic staff we spoke with were very proud to work in the hospital and of the standard of cleaning they provided.
- Hand sanitising solution dispensers were available at all entrances to the ward floors and departments, at hand wash basins and in patient rooms. Staff were observed to use the sanitiser before entering wards and patient rooms.
- Personal protective equipment was available in wall mounted dispensers which were all fully stocked. Clinical waste was appropriately managed and there was evidence of an annual audit to measure compliance with the clinical waste policy and legislation. The findings of the last audit showed systems and processes were compliant. Staff were observed to take small sharps containers into the patient rooms when administering injectable medication or taking bloods to dispose of the sharps waste. Sharps containers were signed and dated when assembled.
- Infection control policies were available to staff on the hospital intranet and were all in date, however the paper copies available on the ward were noted to be past the review date and not the same versions as those on the intranet.
- The hospital had reported no incidence of MRSA, MSSA or C.difficille between April 2013 and June 2014.
- The hospital admitted patients from abroad and had implemented additional screening questions to assess the patient's risk of infectious dieases.
- There was a programme of infection control audits carried out monthly such as hand hygiene, intravenous cannulation and urinary catheter by the link infection control practitioner for the area.
- Participation in the infection control audits was monitored and reported to the infection control committee. The data provided showed an improving compliance with the number of audits completed in each area, for example between April – June 2014 (Q2) endoscopy achieved 45% and level 5 (the medical floor) 51%, in the following quarter both areas achieved 100%.
- The hospital chief nurse was the designated Director of Infection Prevention and Control (DIPC). The lead nurse for infection prevention and control (IPCN) was supported by link practitioners in the clinical areas and had direct links with a consultant microbiologist for support and advice. The infection surveillance data base was linked to the nursing electronic record and the microbiology/pathology laboratories to ensure there was adequate oversight of infection prevention and control issues.
- Antibiotic prescribing was monitored by pharmacists who discussed directly with consultants the appropriate therapy recommended. On occasions when consultants wished to follow alternative prescribing guidance this was discussed with the microbiologist. If there were further issues these were followed up by the microbiologist with the consultant.
- As part of increasing staff awareness of infection control the IPCN in conjunction with link practitioners published a 'bug of the month' newsletter. The October 2014 newsletter featured measles and described the virus, how it spread, the symptoms, diagnosis, treatment and prevention.

Environment and equipment

- Resuscitation equipment was checked daily and documented evidence of these checks were available.
- Every patient room was equipped with a 'suitcase' of emergency equipment and drugs which was checked daily by the nursing staff and the record signed to confirm it was complete.
- All equipment seen was maintained appropriately with labels confirming it had been serviced within the last 12 months. Staff reported no concerns about the availability of equipment.

- Endoscopes were cleaned and processed in accordance with published guidance in the unit. There was one endoscope washer and all scopes were processed in it. Staff told us this was sufficient for the numbers of procedures being carried out in each session.
- A service level agreement was in place for reactive maintenance. There were tracing systems were in place to record which scope was used for the patient procedure.

Medicines

- The hospital worked to medicine management policies which were reviewed regularly and included expected prescribing standards.
- There was a hospital Medication Management Committee responsible for reviewing all medication matters including oversight of policies, MHRA drug alerts, medication incidents and findings from medication audits. The hospital medication incident information and associated recommended actions were collated into a corporate report presented to the HCA Quality Board.
- Staff told us they had completed medicines management competency based training for administering medicines. Intravenous drug administration training was provided to registered nurses and completed within six months of joining the organisation.
- Patients were risk assessed to enable them to self-administer their own medication and there was secure medication storage cabinets in patient rooms.
- We looked at five prescription charts which had patient allergies documented and patients with an allergy wore red wrist bands with the allergy written on it to alert staff.
- Medicine management audits were completed in accordance with the annual audit plan. The results of audits showed the same issues were being identified at each audit, for example signing prescriptions, nursing administration errors and inaccurate CD documentation. The pharmacy manager told us the results were challenged at the corporate pharmacy managers meeting as there was no evidence of action being taken to address the issues. We were told the hospital 'was good at completing audits but not at closing the loop'. An action plan had been developed and implemented in response to the findings. This was due to be re-audited in the coming months.

Records

- Patient medical records were created on admission to the hospital. They were stored securely and the five we looked at were completed in full. Medical staff entries were dated, timed and signed. There was evidence of a plan of care and treatment developed by the admitting consultant responsible for the patient.
- Nursing risk assessments, care plans and records of care were entered into the electronic nursing record. Staff demonstrated the system to us which included mandatory fields which prevented staff moving on through the process until all sections were fully completed. The system provided staff with condition specific care plans to choose from which then listed the actions and care required to ensure patients received appropriate care.
- The endoscopy unit completed safety checklists before and after a procedure. We tracked one patient through their procedure and observed staff completed each stage appropriately. We looked at several patient records in the unit and all contained completed safety checklists.

Safeguarding

- The chief nurse was the designated safeguarding lead for the hospital.
- Safeguarding adult and children policies and procedures were available to staff on the intranet and there was a flow chart displayed showing the reporting structure for safeguarding concerns. Staff had access to the local authority children's safeguarding guidance including safeguarding flow charts dated October 2014.
- The safeguarding children policy dated November 2012 did not refer to the latest national guidance such as Working together to Safeguard Children 2013.
- The hospital data overall showed 84% of clinical staff had attended Safeguarding Vulnerable Adults training and staff told us the training included information on the Mental Capacity Act 2005. The data also showed 88% of hospital staff had completed safeguarding children training however medical services staff attendance was not detailed separately from other areas of the hospital.
- There was no dementia training available for staff to develop an awareness of the needs of patients living with dementia. Staff gave examples of how they had

worked with other healthcare professionals to care for one patient living with dementia by implementing one to one nursing and creating pictorial signs as visual clues for the person.

Mandatory training

- There was a corporate program of mandatory training for all staff to complete and attendance was monitored by managers.
- Staff were able to see their training portfolio which was traffic light rated according to whether they had completed the training, it was due to expire or had expired.
- It was not possible to extrapolate specific training data for medical services staff. Overall the data provided by the hospital showed training rates for clinical staff of 65% (resuscitation) to 88% (Safeguarding children Level 1&2) and non-clinical staff training rates ranged between 66% (resuscitation) and 100% (Safeguarding Children Level 3&4).

Assessing and responding to patient risk

- The hospital had implemented the national early warning score (NEWS) and there was a dedicated outreach nurse from the critical care unit available between 8.00 am to 4.00 pm. Outside of those hours there was support from the critical care unit, from the sister 'in charge' providing managerial cover to the hospital and the RMO.
- The hospital used an electronic system to record patient's observations and if the score triggered a NEWS alert the RMO and outreach nurse were alerted electronically.
- The hospital had installed patient monitoring equipment which could be monitored remotely and staff in the critical care unit told us they could review a patient's status at any time if there were any concerns or if they wanted to 'keep an eye' on the patient's condition after an alert.
- Patients were referred to the urgent care unit by GP's through a dedicated phone number which was answered by the senior nurse coordinator 24 hours a day seven days a week. Beds for the urgent care unit were based on the critical care unit and patients were transferred out to the wards as appropriate after their initial assessment. The critical care unit RMO was also available if the patient required critical care on admission.
- There was a policy for unplanned acute admissions covering referrals/admissions which detailed exclusion conditions which could not be admitted. These included patients under the age of 16, patients diagnosis related to pregnancy over 16 weeks gestation, crushing chest pain, acute stroke symptoms and symptoms of a cranial bleed.
- A screening proforma was completed to include the patient's history and background. The GP also faxed a referral form. The details were then phoned through to the on call consultant who liaised directly with the GP and if the referral was accepted with the RMO to discuss the initial plan of care.
- Patients were seen by the RMO on admission and patient records showed they had been seen by the consultant within 12 hours of admission. Consultants were required to carry out two ward rounds a day for acutely unwell patients.
- There was a policy in place to transfer patients to another hospital if their condition required it.
- There were twice daily briefings to discuss bed management, unwell patients and other hospital issues with, as a minimum, the duty manager, the outreach nurse, the two RMO's and we saw other senior managers attended when available.

Nursing staffing

- The hospital reviewed staffing numbers daily and had a basic ratio of one registered nurse to four patients. Staff told us they could arrange additional staff if the patient acuity required it.
- Ward based handovers were held at the change of every shift. Staff were allocated to specific patients. They were provided with a printed patient list which included the patient's details and requirements for the day. This was followed by a bedside handover which included an introduction to the patient.
- Rotas seen showed there were sufficient staff on duty to meet the needs of patients and met the 1:4 staffing levels.
- Bank staff were used to cover short notice absence or to provide additional staff to meet increases in acuity. Agency staff usage was reported as low. There was a standard induction form which was completed when an agency nurse attended for the first time and included orientation to the ward, emergency procedures, key policies and procedures.

Medical care

- Bank staff were required to complete the corporate induction programme and attend mandatory training.

Medical staffing

- There was RMO cover to the wards twenty four hours a day, seven days a week
- The RMO's attended the twice daily bed meetings to facilitate good communication across the hospital.
- Consultants were provided with practicing privileges and we were told there was on-going work to ensure only those who met the hospital's criteria and worked regularly at the hospital had their privileges renewed.
- There was a consultant of the week and an on call consultant rota for the urgent care unit which was arranged to correspond with the days the consultant was working in the hospital for example in an outpatient clinic.
- Medical, nursing and management reported they had no problems contacting consultants and would not hesitate to call if they had a problem or needed to speak to them. The practicing privileges required consultants to live within a 45 minute travel time of the hospital.

Major incident awareness and training

- The hospital had major incident and business continuity plans in place. There was evidence the hospital had responded appropriately to an incident a few weeks prior to the inspection when the phone system had a major interruption. Staff also told us there were plans in place to deal with IT disruptions and described what actions they would take if for example the electronic monitoring system failed.

Are medical care services effective?

There was an annual programme of audits to ensure patient care was provided in accordance with the hospital policies and procedures.

Patient's direct experiences of care was audited through the patient survey. There were processes in place to ensure adequate pain control. The assessment and provision of food and nutrition was good. Patients reported the choice and quality of food was very good.

Staff were adequately supported through supervision and appraisal processes. They were provided with training opportunities to gain additional skills and knowledge. There was evidence of respectful, professional multi-disciplinary working between the various disciplines.

Consent was well managed with documentation and information available to patients to support their understanding.

Evidence-based care and treatment

- New services were developed around consultant specialities for example in endoscopy the service had been developed to provide Endoscopic retrograde cholangiopancreatography (ERPC) procedures. The service had been developed in line with best practice guidance however we were told due to the size of the unit and activity the unit could not achieve JAG accreditation.
- We looked at twelve policies and found they all referenced NICE and/ or Royal College guidelines.
- Staff showed us they could choose a symptom specific pathway of care that detailed the care and actions needed to ensure patients received appropriate care based on best practice guidance.
- There was a programme of audit to assess adherence to local policies and procedures for example medicine administration and management of controlled drugs, adherence to infection control policies, consultant documentation and nursing records including completion of malnutrition risk assessments.
- The hospital resuscitation lead carried out 'simulated events' bi-monthly to assess staff responses to emergency situations. The events were evaluated and an action plan was developed and implemented in response to identified learning. Examples seen included changing resuscitation equipment to ensure it was suitable for use in MRI.

Pain relief

- Patient's point of care records showed the level of pain was assessed regularly as part of the observation records.
- Patients told us their pain was well controlled, they could ask for analgesia when they needed it and reported it was offered if prescribed.
- Analgesia was prescribed by the medical staff if needed and we saw anticipatory pain relief was prescribed as an 'as required' medicine.

Medical care

Nutrition and hydration

- Patients were assessed for the risk of malnutrition on admission using the malnutrition universal screening tool (MUST).
- Dietetic support and input was available to patients at risk of malnutrition or who had specific dietary requirements.
- Patient menus were varied and were developed to meet special dietary and religious requirements for example halal, vegetarian or diabetic.
- All the patients we spoke with told us they were happy with the variety and availability of food and had access to food and drinks whenever they wanted them. One patient told us "the food is like a first class hotel".
- The chef would visit patients if necessary to ensure their individual needs were met and always saw those patients in hospital longer than three days to ensure there was enough variety of food on the menu for them.

Patient outcomes

- Medical services did not participate in any national audits at the time of inspection due to the low numbers of medical patients and the lack of specialist services such as acute stroke or cardiac care. The endoscopy unit were undertaking JAG audits incorporating the global rating scale. Standard operating procedures were in use to ensure the safety of patients such as use of endoscopes and decontamination, first stage recovery and the use of conscious sedation. An external company had assessed the unit to provide assurance to the hospital in the absence of JAG accreditation but we did not review this report.
- There were 46 unplanned readmissions to the hospital between April 2013 and June 2014, which was a rate of 0.33 per 100 inpatient discharges. Medical readmissions were not identified separately.

Competent staff

- All staff spoken with told us they received annual appraisals and mentoring and supervision was available to them. Appraisal rates were over 90%. Staff told us this was because pay awards were linked to satisfactory performance and completion of mandatory training. Staff confirmed training requirements were discussed and documented as part of the appraisal process.
- Managers told us they had access to a training budget to fund additional courses and training for staff if there was an identified need in the service.
- Staff recently employed by the hospital told us there was a rigorous recruitment process. They also reported there was a very structured induction and they were provided with a buddy/mentor when they commenced employment for additional support. There was a programme of competency based assessments that had to be completed before the first six months of employment.
- The hospital had a dedicated clinical nurse practice development who was identified by staff as a resource for additional training and support. For example following a recent simulated event it was identified some staff wanted additional training in the management of the deteriorating patient and a training day was organised to meet the need.
- RMO's employed by the hospital were experienced middle grade doctors undertaking research as part of their overall medical training. None of the RMO's were trainees in general medicine.

Multidisciplinary working

- There was evidence of multi-disciplinary working between medical, nursing and allied health professionals across the hospital. There were established links with joint posts between the Lister Hospital and a sister hospital based at London Bridge which promoted further interdisciplinary working.
- The ward based nursing staff reported regular communication with the RMOs and consultants in charge of a patients care. Records seen showed input from medical staff and allied health professionals including physiotherapists, occupational therapists and dieticians.
- We looked at two patient records following their admission from the urgent care unit which showed the patients were seen and assessed by the RMO on arrival and reviewed by the consultant within two to three hours and a plan of care had been decided.
- The hospital had implemented a multidisciplinary discharge plan document to record complex discharges and ensure the arrangements were available to the multi-disciplinary team. There was a flow chart for discharge planning on the form to guide staff through the process, starting on the day of admission and identified the actions and referrals needed to ensure the

patient's safe discharge for example referring to physiotherapy or occupational therapy, ensuring equipment and community nursing support was organised.
- There were procedures in place to refer patients into other services including back to NHS services if required.
- Staff told us they completed a transfer letter when a patient was transferred out of the hospital. We saw the urgent transfer policy was available and was in date and referenced the appropriate NICE 2007, IHAS 2002 and ICN 2002 guidance.

Seven-day services

- Consultants visited or spoke with patients on a daily basis or more frequently if required. There was an RMO available 24 hours a day, seven days per week and saw patients as needed. The patient medical records seen all had daily notes made by either the consultant or RMO.
- There was on call availability of imaging and physiotherapy out of hours.
- The RMO and senior nurse could access medication from pharmacy out of hours and there was an on call pharmacist available to dispense controlled drugs.
- The endoscopy service was available by appointment; we were informed that an emergency endoscopy could be arranged within a very short timescale through the on call consultant arrangements.

Access to information

- Staff reported patient records were available at the time of admission. The five records we saw contained full details of the patient's current admission and the referral and consultation details.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a hospital consent policy available to staff on the intranet which detailed the steps to be taken if a patient lacked capacity to make a decision for themselves and was referenced to the Mental Capacity Act 2005.
- Staff told us they had completed training which provided an overview of the Mental Capacity Act 2005.
- We saw two consent forms were used in endoscopy. One for oesophago- gastro–doudenoscopy / endoscopy/ gastroscopy and the other for colonoscopy procedures. The consent forms gave patients the option to choose to have the procedure with or without sedation and informed them of their right to change their mind at any time even after signing the consent form.
- Patients confirmed they were provided with sufficient information and explanations about their procedure. A patient told us 'the information I received prior to my procedure was extremely good'.
- There were explanatory 'patient information for consent' leaflets dated as issued in November 2014 available for specific conditions, those seen related to surgical procedures such as abscess incision and drainage and hysteroscopy.
- Data provided by the hospital showed 100% of consent forms were completed in full as part of the quarterly consultant documentation audit.

Are medical care services caring?

Medical care services were caring; patients were very satisfied with the support and care provided to them and their relatives. Patient survey feedback was generally good and when results were less than the benchmark action was taken to address the specific issue. Patients reported they were fully involved in all aspects of their care, relatives and carers were welcomed and encouraged to be involved during the person's stay in hospital.

Staff interaction with patients, relatives and between themselves was unfailingly polite, professional and respectful.

Compassionate care

- Patients were encouraged to complete patient experience forms to feedback on the standard of care and treatment they had received. The returns were collated and interpreted by an external company and the results were then compared against all hospitals and ventures across the HCA group.
- The October 2014 report showed overall 80% of all patients using services in the hospital were extremely likely to recommend it to family and friends. However the results were further broken down and showed 70% of inpatients and 84% of day patients were extremely likely to recommend the hospital.

- Action plans were developed to address low scoring questions for example discharge planning, dispensing medication at the correct time and anticipating patient needs. The plans were reviewed and evaluated monthly.
- Patients were very complementary about the staff and hospital and told us of staff 'going the extra mile' to meet their needs. Patient's comments included "the hospital is wonderful, staff are excellent and nurses very kind" and "nurses are brilliant, nice, not a mock kindness they are genuinely nice and kind".
- Comments from patient's written feedback and individual commendations were fed back to the members of staff and echoed those of patients we spoke with.
- We observed staff interactions with patients, relatives and between staff. They were unfailingly polite, professional and helpful.
- Staff told us they would have no hesitation in reporting disrespectful, discriminatory or abusive behaviour to senior managers. However the majority of staff told us the hospital was small and friendly and everyone was very supportive and friendly.
- Individual rooms provided patients with privacy and dignity and within endoscopy screens were used to separate the three trolleys.
- The hospital had established a Patient Participation Forum in 2013 to 'ensure, through monitoring and review, quality service is embedded in the hospital's culture and is meaningfully demonstrated in the day to day working of staff'. The forum included four patient representatives, the spiritual care coordinator and various members of staff from departments in the hospital. We were provided with the terms of reference of the group however no minutes were available and we were unable to meet with the patient representatives as part of the inspection process.

Understanding and involvement of patients and those close to them

- Patient allocation was determined at the start of each shift and staff introduced themselves to patients at the bedside handover. Staff reported they were allocated to same patients if possible to maintain continuity of care.
- Patients told us they were fully involved in their care and were able to discuss any concerns directly with their consultant and others involved in their care.
- We observed staff talking to relatives and answering their questions. Relatives told us they were given as much information as staff were able to give whilst protecting patient confidentiality. We were told staff had offered to contact the doctor involved in the patient's care to arrange a meeting.
- The five patients we spoke with all knew the name of the nurse looking after them on the day of inspection. They could also recall the names of other members of the ward team such as the doctor, other nurses, the physiotherapist, housekeeper and domestic staff.

Emotional support

- Patients reported staff provided them with the support they needed. Relatives were able to visit at any time and on occasions stay with the person.
- Spiritual support was available and the hospital maintained a list of religious chaplains/leaders who could be contacted to see patients on request.
- There were clinical nurse specialists which were jointly appointed between the Lister and their sister hospital who were available to support patients, for example those with diabetes.

Are medical care services responsive?

Medical care services were not always responsive to patient needs and the specific needs of patients with cognitive impairment. We did not see evidence that the hospital had tailoured medical services and considered individual needs in new developments, such as the urgent care unit.

Service planning and delivery to meet the needs of local people

- Medical services were planned and developed around the consultants with practicing privileges and their specialities.
- The urgent care unit was developed to support local GP's and was overseen and supported by experienced consultants in surgical and medical specialities.
- The development of the endoscopy unit was in response to consultants bringing patients to the hospital for therapeutic endoscopy procedures.
- We were told by senior managers that each service development was planned in detail including the numbers and types of patients expected the staffing and training requirements and equipment necessary to provide the service.
- We noted the consultant practicing privileges agreement stated that "we aim to provide hospital/

clinic facilities properly accredited to undertake the range of procedures offered to national standards". The endoscopy unit had not been JAG accredited however the hospital participated in an accreditation scheme to provide external assurance of the quality of the service.

Access and flow

- Medical care patients were admitted to the hospital following the referral to and acceptance of their care by a consultant with practicing privileges. Patients were admitted through the admissions office for planned episodes of care or via the urgent care unit for rapid access to a consultant.
- GP's were provided with a dedicated telephone number to contact the urgent care service and after an initial paper based screening process the consultant then contacted the referring GP to discuss the patient needs.
- Patient cancellations were monitored monthly and showed in total there had been 205 cancellations between January and October 2014 for a variety of reasons. It was not possible to identify the numbers of cancellations for medical care services but the highest number, 97 were noted to be rescheduling by the surgeon.
- Discharge planning was commenced on admission as part of the initial assessment of the patient, staff told us the consultant made the decision to discharge after discussion with the patient. A discharge letter was generated and sent to the patient's GP or given to the patient to take with them if they preferred.
- The hospital held periodic breakfast meetings for local GP's to provide educational updates and information on services and referral processes in the hospital.

Meeting people's individual needs

- Patient's individual needs were assessed on initial referral and on admission to the hospital.
- We were told the hospital operated a system of screening to ensure they were able to meet the needs of the person. We were told patients with a diagnosis of dementia would 'probably' not be accepted as the hospital did not have the skills to look after them. We also found there was no formal screening of patients in line with the national dementia strategy.
- Staff told us there had been occasions where a patient with early dementia had been admitted and they had implemented 1:1 nursing to ensure the patient's safety and developed pictorial signage to assist the person. The inpatient wards and rooms were not dementia friendly in that they were well appointed but had no specific identifying features such as different coloured doors for ensuite bathrooms for example.
- Translation services were available and staff were able to arrange an interpreter if needed.
- A variety of information leaflets were available in the endoscopy department in English related to gastric and colon conditions. There were no medical information leaflets available on the inpatient ward. Staff told us leaflets could be accessed in a variety of languages and large print if required.

Learning from complaints and concerns

- Patients were aware of how to raise concerns and complaints and were provided with an information leaflet as part of their information pack.
- There was a complaints policy available and staff were aware of the actions they would take in the event of a patient complaint and the timescales for responding. Formal complaints were processed and monitored centrally through the chief executive office.
- Staff reported they had received very few complaints about medical care services. All staff told us they carried out regular rounds of their patients and any concerns were addressed immediately if possible. The staff in endoscopy told us about a complaint they had received which related to the costs associated with a procedure and the response was coordinated and responded to within the published timescales.
- Complaints were recorded on the incident reporting system and were reported on at the Clinical Governance Committee as part of the on going monitoring of quality.

Are medical care services well-led?

There were clear reporting lines for staff and managers in medical care services. Although there was no formal documented vision or strategy for medical services staff were aware of the priorities for their wards and departments and shared the hospital and corporate vision.

Staff reported that the senior management team were visible and accessible; department managers were described as supportive and approachable.

Medical care

Vision and strategy for this service

- The managers and staff we spoke with were all aware of and invested in delivering the corporate vision to deliver high quality and cost effective care across all services.
- There was no specific strategy for medical care services however ward and department managers were aware of the service development priorities in their area of responsibility.
- Staff had attended hospital wide meetings regarding the future development plans for the hospital. They were aware of the service priorities for their wards and departments and these had been discussed in ward meetings.

Governance, risk management and quality measurement

- Ward and department performance indicators and quality indicators were reported monthly through a variety of meetings such as the Quality Improvement and Patient Safety (QIPS), senior nurse meetings, health and safety and risk.
- Performance data such as activity and audit results and issues arising in the meetings were escalated and reported to the Clinical Governance Committee and the Medical Advisory Committee (MAC).
- The MAC, had a representative from medicine, met quarterly and in addition to reviewing clinical quality information, recommended consultants to be offered practicing privileges after reviewing their application including evidence of their GMC registration, medical indemnity insurance and current or recent employment in the NHS.
- Managers at ward and department level showed us the electronic risk register for their area. Ward managers told us they did not routinely document potential risks with a record of the mitigation or controls put in place to reduce the level of risk.
- We saw a copy of the hospital risk register which had risks documented for most departments in the hospital. We saw risks listed for the inpatient wards related to infection control issues and staffing. There was a record of the controls put in place, the actual level of risk at the time of the entry and the target risk level to be achieved with a review date. There was an assigned person to manage the risk, usually the ward or senior manager for the area and entries were seen to be updated and closed when the level of risk was reduced.
- Executive managers told us they attended monthly meetings with the corporate managers to discuss both the quality and financial performance of the hospital and there was a corporate Clinical Council which reviewed performance indicators and outcomes.

Leadership of service

- There were identified managers for the endoscopy department and inpatient ward. The urgent care unit was nominally overseen by the critical care manager as the beds were sited on the ITU.
- The ward managers reported to the theatre manager or clinical services manager who reported to the chief nurse.
- Staff were clear about the management structure in the hospital and told us senior managers were visible in the hospital. New staff told us the chief operating officer in particular went out of their way to introduce themselves and subsequently greeted them by name. However all staff reported that managers at all levels of the organisation were seen in the clinical areas and were described as friendly, supportive and approachable.
- Staff told us they felt valued and their efforts were appreciated by managers. They said they saw their line manager regularly.

Culture within the service

- Staff told us they felt there was an open and transparent culture within the hospital. They were confident about challenging poor practice if necessary and were aware of the whistleblowing policy and procedure.
- Staff reported there was good communication across the hospital. There were regular staff forums with the senior executive managers and handovers and meetings undertaken in all departments.
- Staff reported there were good working relationships between clinical and non-clinical staff. Where there were issues, these were escalated and dealt with by managers, examples of action taken included working with clinicians to address poor performance and communication to improve multidisciplinary team working.

Public and staff engagement

- Staff were informed at ward/department meetings of the results of the patient survey for their area every month. The areas that had not reached the benchmark score were discussed and action plans developed for improvement. A standard agenda was available to

structure ward meetings and patient feedback was listed in the items for discussion. The minutes of the meetings we saw did not always include the patient feedback results.

- Patients were provided with ward and department specific feedback forms to complete and return to an external company for analysis and comparison across the hospital and HCA.
- A staff survey had been carried out in 2012; there was an overall HCA action plan with areas for improvement for 2013/14. The hospital action plan was not dated however the areas for improvement for staff included recognition and reward, communications and development. The actions to be taken were listed but there was no evidence of a formal review or who was responsible for implementing the plan.

Innovation, improvement and sustainability

- The hospital falls prevention programme incorporated innovative technology to reduce patient falls and minimise harm. This is in keeping with national patient safety initiatives.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The Lister Hospital provides day surgery and in patient treatment for patients undergoing a variety of procedures, including orthopaedic, ear, nose and throat (ENT), urological colorectal, gynaecological, ophthalmological, and bariatric surgery. The hospital also provides fertility treatment; this was not included in the inspection as the service is overseen by the Human Fertility and Embryology Authority (HFEA).

The hospital provides surgical services to private patients from the UK and overseas. The hospital does not provide inpatient surgical services to children or young people under the age of 16 years.

There are four theatres, available from 08.00 am to 9.00 pm Monday to Friday and a recovery area with five beds. Theatres can be opened in emergencies outside of these hours. There are 56 private rooms in the three designated surgical wards, 24 of which are designated for day-case procedures. There were 8,287 anaesthetic episodes between April 2013 and March 2014. Eighty-three per cent of the patients were day-case surgical patients.

The service employs nurses, operation department practitioners (ODPs), physiotherapists, occupational therapists (OTs) and radiographers to care for surgical patients. Resident medical officers (RMO's)are employed to provide medical cover. Consultant surgeons and anaesthetists have practicing privileges to hold consultations, admit and treat patients having surgical procedures at the hospital. There are around 400 surgical and anaesthetist consultants with practicing privileges but we were informed about 50 worked regularly at the hospital.

We spoke with nine surgical patients, observed care and treatment and looked at care records. We also spoke with more than 30 members of staff and visiting health professional who worked with surgical patients, including allied healthcare professionals, nurses, theatre staff, porters, ward managers, consultant surgeons and anaesthetists. During our inspection we visited the surgical wards, theatres and the recovery unit. Prior to our inspection we reviewed documents provided by the hospital.

Surgery

Summary of findings

There were processes in place to reduce the risks of surgery. Nurses monitored patients after their operation and medical staff were available if there were any concerns. Pre-operative assessment was undertaken in a variety of ways, but there was no pre-assessment policy. There had been no reported incidents of venous thromboembolism reported in the year 2013/2014. The number of falls had decreased following the introduction of a falls programme.

There were sufficient numbers of staff to care for patients and they received appropriate training for their role. The majority of patients provided positive feedback about their care and treatment.

The hospital had a limited audit programme to monitor compliance with best clinical practice and there was limited data on the outcomes for patients treated at the hospital. There were an increasing number of people requiring surgery who had complex needs. Services were being adapted to provide appropriate pre-operative assessment and multi-disciplinary input into their care and treatment. The pharmacy department and ward staff had taken action to address concerns about the effectiveness of pain relief for patients on discharge following surgery.

Senior management were approachable and responded to staff suggestions and concerns. The hospital risk register documented risks and assigned a manager to manage the risk.

Are surgery services safe?

Staff knew how to log incidents and the hospital was encouraging a more open approach to errors which focused on learning not blame. There had been no serious incidents reported in the previous year that related to surgery, however, we identified an incident that should have been reported. The provider's 2014 risk management strategy had identified that action was needed to develop and refine the process of reporting, categorising and learning from incidents.

There were sufficient numbers of staff, who received appropriate training for their role. There were processes in place to reduce the risks of surgery, such as sharing information about the planned list of procedures and undertaking appropriate checks that all safety measures were in place. Nurses monitored patients after their operation and medical staff were available if there were any concerns.

Infection control processes protected patients from the risk of infection. There were low rates of surgical site infections reported. Risks association with the environment and equipment were managed through checking processes and prompt repair or replacement when required.

Incidents

- The corporate induction training for all new staff included an overview of the incident reporting system. The hospital's local induction included risk management and reporting incidents.
- Staff we spoke with knew how to log incidents on the electronic reporting system and some were able to give examples of when they had reported incidents and what had happened as a result. For example they were informed by their manager of the action taken.
- Ward managers told us feedback was given to the individual who reported the incident and learning was shared at ward meetings every two months. There was an incident reporting forum which all nursing staff were invited to attend
- We were told by staff that there had been a change in the perception and recording of incident reporting in the last 18 months because of changes in management

who viewed an increased level of reporting as a positive step. Some of the new staff joining the hospital had worked in the NHS and were accustomed to reporting incidents, including 'near misses'.

- Staff said there was less stigma attached to reporters and there was a change in the attitude of departmental managers. However, this view was not shared by all staff and some ward staff we spoke with could not recall reporting incidents in the six months before the inspection.
- There had been an increase in incident reporting since the previous year. During January to September 2013, 170 incidents were reported; in the same period in 2014, 306 incidents were reported, of which six were categorised a high risk, 86 were moderate, 97 were low and 117 were ungraded. Surgical services incidents were not separately identified within the data.
- When staff reported an incident their manager was entered onto the system and allocated responsibility to review and take appropriate action.
- Theatre incidents were discussed at the theatre users' meetings and all incidents were reviewed at the quarterly clinical governance committee meetings. Trends were reviewed such as whether patients of specific surgeons were returning to theatre.
- We saw the report of the investigation of one of three 'near miss' incidents between 21 March to 19 June 2014 when the wrong patient was taken to surgery. The investigation examined the factors that contributed to the incident, such as a shortage of staff, the use of bank staff who did not know the checking processes, staff fatigue and distractions. Action was taken to prevent a reoccurrence, this included redrafting and implementing an approved standard operating procedure for the transfer patients from the surgical wards to theatre.
- All surgical nursing staff were informed of the new process and received a copy of the revised pathway. Staff were assessed for their competency in following the procedure.
- Improvements to the format for investigations of serious incidents were being piloted, it was now expected factors such as the interaction between staff and the working environment, would be explored as part of the investigation, so the context of human error could be better understood.
- Heads of departments attended a monthly meeting, chaired by medical director, to discuss incident reports. Managers were asked to report the action been taken in response to incidents.

Safety thermometer

- While the service did not use the NHS Safety Thermometer, which is an improvement initiative for measuring, monitoring and analysing patient harms and advocating 'harm free' care it did monitor performance against the possible harms identified in the tool. For example incidents of falls, pressure ulcers, Venous Thromboembolism (VTE), hospital acquired infections and catheter associated UTIs were monitored and used a system of safety crosses to demonstrate ward performance in the monthly audits.
- There were no cases of venous thromboembolism **(**VTE**)** between April 2013 and June 2014. Risk assessments were carried out on all surgical patients when they were admitted and appropriate measures, such as the use of surgical stockings during the procedure, were put in place. There were monthly VTE risk assessment audits, but we were told that the audit tool was not correctly capturing the data and this meant that the reported percentage of patients who had received a risk assessment (54%) was incorrect. The issue with the tool was addressed in June 2014, but we were not clear why the issue had not been resolved sooner.
- There had been no pressure ulcers above grade 2, no catheter associated urinary tract infection (UTIs) and no infections such as Methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile reported in the year to June 2014.
- The number of falls reported had decreased since the introduction of a falls assessment tool to identify patients at risk and put in prevention measures for those identified at risk. This included non-slip socks for patients to wear and signs in their room to remind them to call for assistance stating 'call don't fall'. Sensor mats triggered an alarm to alert staff when a patient was mobilising without assistance if they were identified at risk of falls

Cleanliness, infection control and hygiene

- Policies and procedures for infection prevention and control were up to date on the internet and reflected

best practice. There were audits to monitor compliance with these policies. Participation in the infection control audits was monitored and reported to the infection control committee.

- There was an accredited central decontamination unit at the hospital for the sterilisation and tracking of reusable instruments.
- The wards and theatres were visibly clean. Cleaners were allocated to each ward and nurses told us there and there was good communication with them. There were cleaning schedules on each ward and the domestic manager did daily checks to ensure these were followed. The infection prevention and control nurse inspected clinical areas weekly.
- There were wash hand basins in each patient room but no wash basins in the public area of the wards. Hand gel was available at the entrance to wards and in every patient room.
- Ward staff followed good practice in infection control principles in relation to the management of waste, including sharps items, contaminated waste and laundry.
- We observed that staff in all clinical areas dressed appropriately and were bare below the elbow. Staff had access to personal protection equipment (PPE) when needed.
- All patients were screened for MRSA on admission if they had not attended the hospital for pre-operative assessment. The results of the screening was not available immediately so infection control measures were put in place for those patients considered at risk of MRSA or for patients screened positive for MRSA. Nursing staff we spoke with, including an agency nurse in recovery, were aware of the measures taken in these circumstances.
- There had been 14 surgical site infections in the year to June 2014, these had been risk rated using a tool to predict and compare surgical site infection rates among surgeons and hospitals. Seven of which were categorised as risk index one and one as risk index two.
- There were link nurses for infection control in each clinical area, who received additional training. They were supported by the lead nurse for infection prevention and control (IPCN). There had been a decline in the number of attendees to infection control meetings in 2014. Managers were made aware of this and a decision made that attendance to meetings for link nurses would become part of managers' performance indicators.
- There was a 'bug of the month' newsletter to increase staff awareness of infection risks.

Environment and equipment

- Theatres had recently been refurbished and there were systems in place to maintain safety, including air monitoring and alarm systems.
- There were daily checks on anaesthetic machines, gas cylinders and other theatre equipment and these checks were reviewed by senior theatre staff.
- Risk assessments were carried out on new equipment in theatres before the equipment was purchased.
- All theatre equipment was checked before theatre lists began, and adherence to these checks was recorded by theatre staff before the list began.
- The resuscitation trolley in the theatre recovery area was checked daily and we saw that these checks were audited by the resuscitation officer and any discrepancies followed up with the member of staff concerned.
- Minutes of the theatre users' committee recorded discussions about equipment needs and action to be taken to address need for replacement. Theatre staff told us they reported faults immediately and we saw an example of an equipment fault noted at the debrief session at the end of the list.
- There were processes in place to address the challenges of theatre staff working with different surgeons carrying out procedures in theatre, each with specific requirements. These included theatre lists generally being planned several weeks in advance and instruments and consumables ordered in advance from the central store to ensure the surgeon's preferred equipment was available.
- Theatre staff told us they prepared instruments the day before the procedure and on the day the scrub nurse asked the surgeon to check that the prepared equipment met their requirements.
- Staff reported there were very few occasions when the right instruments were not available and on these occasions it had been possible to get the equipment from another of the provider's hospitals in a timely manner to avoid the operation being cancelled or delayed.

- There was a planned preventative management programme for the estate, with a log of all jobs that needed to be undertaken. Staff reported maintenance issues on line and these were reviewed daily by the estates team and actioned. There were estates staff on call at all times.
- Ward staff were able to access specialist equipment if needed, such as pressure relieving mattresses.
- Environmental risk assessments were undertaken quarterly, and there is an annual declaration that the site was fit for purpose.
- The pre-assessment nurse did not have a designated room in which to assess patients pre-operatively and used rooms in the outpatient department that were available.

Medicines

- There was a hospital medication management committee responsible for reviewing policies and audits of these policies. They also reviewed information on medication incidents.
- Several medication audits were undertaken by the hospital's pharmacy staff who reviewed the drug stocks in the anaesthetic room and on the wards to ensure there were sufficient stocks, to undertake reconciliation and monitor storage of medicines.
- Pharmacy staff undertook quarterly audits of medicine administration to identify omitted and delayed medicines.
- Pharmacists audited controlled drugs (CD) quarterly to check that procedures had been correctly followed.
- There was a two hour medication training provided to all new staff during their induction and updates provided to other clinical staff. There were regular competency assessments for oral and intravenous drug administration and additional training provided if required.
- We were told by ward staff that medication charts were reviewed by both nurses at handover to ensure all prescribed drugs had been administered and action taken if there had been any errors. We were given an example of staff reporting an incident when a medication administration was found to be unsigned.
- Pharmacists were allocated to each ward area to review medicines charts as well as providing patient-specific advice and support timely provision of discharge medication.
- Consultants were asked to prescribe take home medication (TTO) at the time of the patients' pre-operative assessment to prevent delays in discharging patients, in particular at weekends. Processes to check progress with ordering and dispensing TTOs by nurses were in place on surgical wards, to expedite patient discharge.
- We observed drugs being prepared in the anaesthetic room by an operation department practitioner prior to each procedure.
- There was a provider local antibiotic policy developed by a consultant microbiologist at another of the provider's hospitals. We were told there was sometimes a difference in opinion with consultants about prescribing. Pharmacists sought advice from the consultant microbiologist and felt confident in escalating to senior management if the disagreement persisted.
- Following an incident of an allergic reaction to a new medication which was unknown to pharmacy, there had been a revision to the standard operating procedure so that no new medication would be dispensed from pharmacy until pharmacy staff had received training.

Records

- The three hard copies of patient records we looked at on the surgical wards contained a nurse assessment carried out when the patient arrived on the ward. Day case records had little or no past medical history, we were told this was due to the fact that they were low risk patients having low risk surgery. We noted high risk patients had more details in their notes such as co-morbidities and current medication as well as pre-operative assessment details.
- There was evidence of preoperative assessment being completed by the anaesthetist and the surgeon and a plan of care and treatment in patients notes.
- Patient information and risk assessment details were entered on the electronic care planning system. We observed how staff were prompted to enter information by the system, and were given a specific care plan for each patient, which depended on the risk assessment and the procedure the patient was undergoing.
- Daily observations of patients were recorded to monitor assessed risk and there were prompts to remind nurses if these were not carried out as expected.

- We observed that patient records were stored appropriately and that electronic records were not left on screens for others to see. Access to the electronic record was password protected.

Safeguarding

- The chief nurse was the designated safeguarding lead for the hospital.
- Safeguarding adult and children policies and procedures were available to staff on the intranet. There was Information about how to escalate safeguarding concerns on the staff notice boards in wards and in theatres.
- Staff had access to the local authority children's safeguarding guidance dated October 2014. However, the safeguarding children policy dated November 2012 did not refer to the latest national guidance such as Working together to Safeguard Children 2013.
- There was a training programme for safeguarding children, which all staff were expected to attend. Training records showed that 88% of clinical staff had completed level 1 training or above.
- All staff were expected to complete safeguarding adults training to at least level one, which was on line training. Records showed 84% of clinical staff had completed level 1 training.
- Some staff had a limited understanding of the definitions of vulnerability and how to assess this and assumed that vulnerable adults did not use the service.

Mandatory training

- There was a corporate process for checking that mandatory training which included health and safety, and basic life support had been completed. Managers were responsible for ensuring all staff were up to date with their mandatory training. We were told by a manager that further work was underway to develop a provider level training database but no timescale was provided of when this work was expected to be completed.
- Mandatory training data showed that overall 77.3% of staff had received basic resuscitation training. The provider aimed to achieve 85% of staff trained by December 2014, the month we carried out the inspection.
- Staff were able to see their training portfolio which was traffic light rated according to whether they had completed the training, it was due to expire or had expired.
- There was a chart displaying the training that staff had completed on the day-case surgical ward, which showed that all mandatory training was up to date.

Assessing and responding to patient risk

- The consultant had primary responsibility for assessing the individual patient's risk prior to surgery. We were told the majority of patients either completed an online pre-assessment form or received a telephone call from the pre-assessment nurse. Those who required further tests were invited to attend the hospital.
- There was a preoperative checklist, completed by the nurse on the surgical wards prior to transfer to theatres, which was then re-checked by a member of theatre staff before the patient was taken to the anaesthetic room.
- We were told that patients who had general anaesthesia were observed closely in the recovery area following surgery to monitor their recovery. Following a recent incident there had been clarification on escalation to an anaesthetist or RMO when saturations levels fell below a certain point, to ensure prompt action to address any deterioration. We did not witness this while on inspection.
- The wards used the national early warning score (NEWS) to identify deteriorating patients. Observations were recorded on an electronic system, which automatically calculated an indicative level of risk which when a certain level was reached the registered medical officer (RMO) on call was automatically informed and came to review the patient and if necessary transferred them to critical care.
- Consultant surgeons were expected to review their patients if they deteriorated post operatively.There was a "buddie" system in place however assurance that the process of consultant presence in an unplanned situation post operatively was not explicit.
- Staff from the outreach team were also available to review patients who deteriorated. There was a patient monitoring system linked to the critical care unit which staff on the unit monitored to identify any significant changes.

Use of the five steps to safer surgery

- There were processes in place to reduce the risks to patients undergoing surgery. These included the use of the five steps to safe surgery: pre list briefings, the three steps of the World Health Organisation (WHO) surgical safety checklist, and post list de-briefings.

- Theatre staff told us the use of the WHO surgical safety checklist was embedded in practice and the use of briefing and debriefing before and after a theatre list was expected to occur. Staff gave examples of when the five steps had prevented errors or improved practices. Examples included taking consent and prompting the surgeon to think about VTE prophylaxis.
- Peer observational audits of the use of the WHO surgical checklist were undertaken by theatre managers from the provider's other hospitals, to assess the quality of the process and to provide feedback to staff. However, these audits were undertaken every three months and only five to seven procedures were observed at a time. The service was therefore unable to demonstrate if the five steps were embedded into practice across all theatre lists.
- We observed a pre-list briefing, which included sharing the names of the consultants and theatre team, equipment checks confirmed and any potential issues, such as those relating to the surgical procedure, staffing or equipment, were discussed and recorded.
- We observed the three steps of the WHO surgical safety checklist and noted the 'sign in' checks were completed by the operation department practitioner in the anaesthetic room. All staff present engaged with 'time out', which took place in theatre before the procedure commenced to share information about the patient and check that all steps to reduce risks had been taken. All staff were present at the 'sign out' to check that the swab and instrument count and other checks had been undertaken
- The theatre manager reviewed the post-list debriefing forms and took steps to address any issues identified, such as equipment problems. She also encouraged the recording of good practice and we saw an example of a consultant praising their theatre team.

Nursing and theatre staff

- We observed that there were sufficient numbers of nursing staff in the wards. There was a ratio of one nurse to four patients, and staffing was reviewed if there were patients who had identified risks, for example of falls. The ward manager was supernumerary and able to provide support to staff.
- Ward based handovers were held at the change of each shift. Staff were allocated to specific patients and were provided with a printed patient list which included the patient's details and requirements for the day. This was followed by a bedside handover which included an introduction to the patient.
- During the day there was a rota of supernumerary senior nurses who held the pager for the hospital; while at night this role was covered by the night senior nurses. This senior nurse was responsible for ensuring safe staffing levels.
- There were sufficient nurses in recovery area to provide one-to-one nursing for patients in the immediate post-operative period or for those patients who were intubated. Once the patient was conscious one nurse provided care to two patients.
- When lists overran or patients remained in recovery after 9.00 pm there was an on- call team of theatre and recovery staff who took over the care of patients.
- Data provided prior to our inspection indicated that there was no use of agency staff in theatres, but we concluded this was inaccurate as were told about and met agency staff in theatre. It was unclear why this data was incorrect.

Medical staffing

- There was 24 hour, seven-day resident medical officer (RMO) cover for the wards.
- The RMO attended the twice daily bed meetings and was aware of the number of patients in the hospital and any patients who may require additional medical support.
- There was an on-call rota for anaesthetic surgical consultants ensuring cover out of hours.
- We were told that patients' individual consultants would attend the hospital if a patient review was requested by the RMO or senior nurses.

Major incident awareness and training

- The hospital had major incident and business continuity plans in place. There had been an incident two weeks before our inspection when the phone system had a major interruption. There had been immediate action, with clinical staff kept informed of action and a there was a formal debrief. Following this, an improved method had been put in place to regularly update staff in the case of a major incident.

Surgery

Are surgery services effective?

The provider regularly reviewed clinical and non-clinical policies. All the policies we saw were up to date and regularly audited. Action was taken as a result of audits, but these actions were not always monitored.

The hospital had a limited audit programme in respect of clinical practice and outcomes for patients. Therapy staff were providing support to orthopaedic patients to advance recovery from surgery, but there was no monitoring of adherence to best practice such as in enhanced recovery programmes. The pharmacy department and ward staff had taken action to address concerns about the effectiveness of pain relief for patients on discharge following surgery.

Consultants provided individual pre and post-operative care guidance for the patients. However, this guidance did not always refer to best practice guidelines and was not standardisation. There was no evidence that best practice guidance for patients' fluid and food intake prior to surgery was followed. Patients assessed as at risk were monitored on the wards following surgery to make sure they were receiving adequate hydration and nutrition.

Evidence-based care and treatment

- There were arrangements in place for the review and updating of clinical and non-clinical policies. All the policies we saw were up to date.
- The service contributed to the national joint registry (NJR), which collects data on joint replacements and reports on outcomes.
- We were informed that in 2013 data on patient reported outcome measures (PROM) for hip and knee replacement was collected across all hospitals in the group but the data could not be provided specifically for the Lister. PROMs measures for other procedures were not collected due to low numbers of procedures being undertaken.
- The service contributed to the national joint registry (NJR), which collects data on joint replacements and reports on outcomes.
- The audit programme was under review at the time of our inspection and we noted that only a few audits currently undertaken related to clinical practice.
- Compliance with some policies was monitored through internal audit. We saw that regular audits of processes such as record keeping, infection control, medication management and equipment checks were undertaken.
- We were told of action taken on the findings of audits, for example additional training to theatre staff had resulted in a reduction of CD errors. The medication management committee had identified that actions taken as a result of audits were not always monitored. New processes were being put in place to ensure that action identified as a result of audits was monitored.
- Adherence to best practice in enhancing recovery from surgery was reported to be challenging. Therapy staff were putting in processes to address these challenges. These included all orthopaedic patients admitted for joint replacements being seen by a physiotherapist on the day after surgery to prompt mobilisation and recovery and referral of patients to the specialist orthopaedic clinical nurse specialist if needed. However, the facilities at the hospital for rehabilitation were limited due to the lack of space and limited contact between hospital staff and patients before surgery and after discharge.
- Patients with fractured neck of femur were admitted to the surgical wards but the nationally recognised care pathway for these patients was not followed.
- On the general surgical ward we noted that the consultant surgeon provided guidance for the care of bariatric patients, which included best-practice guidance for nursing and medical staff.
- On the day surgery ward there was a folder of protocols describing pre and postoperative care for specific procedures, which was signed by the relevant consultant, for use by the ward nurses and medical staff. However, there was no standard approach to the way this information was recorded across the surgical wards and some of the protocols were not dated or signed by the consultant.
- Care was delivered in line with individual consultants' wishes and not in line with the most recent best practice guidance. As numerous consultants had practicing privileges at the hospital this resulted in a wide variety of different approaches.
- We were told that there were plans to introduce standards in theatres, linked to good practice

guidelines, across the provider's hospitals, which would be monitored and benchmarked. However, these standards had not been introduced at the time of our inspection.

Pain relief

- Patient's records showed the level of pain was assessed regularly as part of the observation records.
- Patients were prescribed pain relief by their consultant anaesthetist for the post-operative period and were contactable by recovery and ward staff for advice. A nurse gave an example of an anaesthetist who came to the hospital in the early hours of the morning to change the prescription for a patient experiencing pain.
- Pharmacists were available to provide advice to ward staff and had access to a specialist pain team at one of the provider's other hospitals.
- Patients were provided with medication, including pain relief to take home on discharge.
- More than half the seven readmissions to hospital in quarter three of 2014 was reported to be due to inadequate pain relief. The results of the patient satisfaction survey noted that patients reported a lower satisfaction with their pain relief than for other aspects of care. Work had been undertaken by the pharmacists to address these issues and there was a new information leaflet for patients with further explanation about pain relief on discharge.
- We were informed that audits of pain relief were undertaken, but it was not clear how the findings of these audits had influenced practice and if pain relief was provided in line with best practice guidance.

Nutrition and hydration

- Information about patients' preoperative fasting was recorded on the pre-operative checklist. However, there was no monitoring to establish whether the national best practice standards for fluid and food intake before surgery were being met. Not all nurse we spoke with were aware of the best practice recommendation.
- The side effects of post-operative nausea and vomiting were discussed with patients by the anaesthetist at the pre-operative assessment.
- When patients experienced nausea this was recorded and we saw examples of day-case patients who had stayed overnight because they were feeling nauseous.
- A nationally recognised tool for monitoring food and fluid intake on the wards was used for patients assessed at risk of dehydration or malnutrition.
- Nursing staff had access to advice from a dietician at one of the provider's other hospitals if necessary.
- Patients commented on the excellent and wide choice of food, which met the needs of groups of patients from a variety of religious and cultural backgrounds.
- The chef visited patients if necessary to ensure they had their individual needs met and always saw those patients staying longer than three days to ensure there was enough variety for them.

Patient outcomes

- There was limited patient outcome data provided and involvement in national audits of patient outcomes was isolated to the NJR.
- There had been four deaths reported to CQC in the year to October 2014. One of these was an unexpected death. This was not consistent with the information provided to us prior to our inspection, which indicated that there had been no unexpected deaths.The provider had not update CQC post coroner's findings that this was not an unexpected death.
- In the first nine months of 2014 there were seven unplanned return to theatres. There had been 21 readmissions to hospital following surgery; the most usual cause for this was pain.
- We were informed that there was no formal process in place to review patient deaths which occurred at the hospital.

Competent staff

- There were processes in place to ensure staff employed by the hospital had access to regular appraisals and opportunities for professional development. Managers were prompted by an email when appraisals of clinical and non-clinical staff were due and of training opportunities for their staff. Information provided by the hospital indicated that 100% of staff had received their annual appraisal
- Performance development reviews included staff's achievements and there was a section for 'talent pool' nominations when staff were identified for further advancement.
- Some staff reported development opportunities such as attending courses, which enabled them to develop their skills, some of which were not directly related to their current role.
- All bank and agency staff were expected to complete and sign an induction check list when they commenced

work on the ward for the first time. We saw a folder of information for agency staff on the wards with an induction check list. An agency nurse told us she had received a thorough induction.

- The provider granted practicing privileges to consultant surgeons and anaesthetists, giving them permission to practice in the hospital. There were processes in place for the review and approval of new applicants by the medical advisory committee (MAC), these included the surgeon being on the specialist register and holding relevant registrations.
- There were processes for the provider to contribute to doctors' revalidation, or in the case of doctors working only in the sector, for the revalidation officer to lead this process. However, there was no formal process for receiving and acting on information about a consultant's' suspension by the NHS or by an investigation by the GMC.

Multidisciplinary working

- We saw examples of multi-disciplinary working between nursing, therapy and pharmacy staff, such as on the orthopaedic ward and the multi-disciplinary breast team, which included a radiologist, a clinical nurse specialist, a pathologist, consultants and nurses. We were not provided with evidence in other disciplines that it was taking place.
- Multi-disciplinary reviews and discharge plans for older patients with complex needs had been introduced, which included an assessment by a care of the elderly physician.
- Ward and theatre staff described generally good working relations with consultants. But highlighted the challenges of working with so many consultant surgeons such as the instruments they used in surgery and the medication they prescribed. To mitigate some of these risks there were some theatre teams who worked regularly with specific surgeons and anaesthetists in theatres, which enhanced multi-disciplinary working.
- Regular meetings with local GPs had been introduced and staff told us this had resulted in the hospital receiving more information about local patients' medical history. The physiotherapy teaching sessions at these meetings had reported to have promoted a joined-up approach to care for older patients whose insurance would not cover rehabilitation services and who needed access to NHS care.
- Nursing and physiotherapy staff we spoke with said they were able to telephone the consultant surgeon for advice. While recovery staff said they contacted the anaesthetist or the critical care unit if they had any concerns about a patient in the immediate post-operative period
- A discharge letter was generated and sent to the patient's GP or given to the patient to take with them if they preferred to ensure they aware of the procedure and post-operative treatment recommended

Seven-day services

- There was a 24 hour, 7 day a week rota of on-call consultant surgeons, physicians and anaesthetists, who were paid a retainer fee by the hospital.
- Consultant surgeons were expected to be available 24 hours a day, seven days a week if their patients required urgent review, or if they were not available they were expected to have arranged cover by another surgeon.
- There was 24 hourm 7 day a week on-call rota for a radiologist and an intervention radiologist.
- There was an on-call pharmacist service out of hours when the hospital pharmacy service was not available.

Access to information

- Patient information leaflets were available for those surgical procedures commonly undertaken at the hospital in a wide variety of languages by the use of an online healthcare information library. These leaflets were downloaded and printed as required.
- There was access to interpreters, 24 hours a day, seven days a week either face to face or through a telephone interpreting service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a hospital consent policy available to staff on the intranet which detailed the steps to be taken if a patient lacked capacity to make a decision for themselves and was referenced to the Mental Capacity Act 2005.
- Consent was generally obtained on the day of surgery by the patient's consultant surgeon.
- There were checks that consent had been obtained on the ward, on arrival in theatre, and before the administration of anaesthesia.
- Data provided by the hospital from the quarterly consultant documentation audit showed 100% of consent forms were completed in full.

- Training in the Mental Capacity Act 2005 was part of safeguarding training for staff. However, staff we spoke with did not demonstrate an awareness or knowledge of the requirements relating to people who might lack capacity, for example because they were living with dementia.
- There was no evidence provided to demonstrate that a preoperative risk assessment to establish patients' mental capacity to make an informed decision about consent to their procedure was undertaken.

Are surgery services caring?

Patients we spoke with provided positive feedback about their care and treatment. They said that doctors explained their treatment to them. There was high praise for the quality of nursing staff. There were a few negative comments, including a patient who said she was left alone to take a shower in spite of her believing she was at risk of falling.

Compassionate care

- Nearly all nine patients on the surgical wards we spoke with commented on the friendly hospital staff, including cleaners and porters and reception staff.
- There was high praise for the quality of nursing staff. The most common comment was how "kind and polite" they were. Other comments were, "amazing", "fabulous" and "spectacularly good". Two people commented that some nursing staff were not as good as others, and thought this might be because they were agency staff and a "bit clueless".
- One patient who had had a hip operation, said she was left alone in the shower, and felt she was at risk of a fall. Another patient said she had wanted assistance to go to the toilet and to get washed, but the nurse told her it was time for handover and she had to wait 20 minutes for assistance. Other patients, however, said there was always a prompt response when they pressed the bell for a nurse.
- We observed staff interacting with patients with respect and kindness.
- Patients were encouraged to complete patient experience forms to feedback on the standard of care and treatment they had received. The returns were collated and interpreted by an external company and the results were then compared against the provider's other hospitals.
- The October 2014 results reported that 80% of all patients using services in the hospital were extremely likely to recommend it to family and friends. The day-case surgical wards scored highest of all wards, with consistently good feedback and 84% of day patients saying they were extremely likely to recommend the hospital.

Understanding and involvement of patients and those close to them

- All the patients we spoke with had received information about their procedure and said they were fully informed and able to make an informed choice. A patient said it felt like a "joint decision". People also said the fees for their treatment were explained to them. One of the patients was very complimentary about the anaesthetist's explanation of side effects and how they were likely to feel after the operation.
- Patients who had seen the orthopaedic nurse specialist were full of praise for her support. Most people said that the nurses also explained things clearly, and always encouraged them to ask any questions they had. One patient said she had not received an explanation when she was moved from one ward to another on a different floor.
- Patients were allocated a named nurse to ensure continuity of care. The names of the nurse and the consultant were written on boards in their rooms.
- Patients were given information on discharge about aspects of their post-operative care and recovery. They were given a number to call if they had any queries.

Emotional support

- The wards had open visiting and relatives were able to visit at a time that was convenient.
- The hospital maintained a list of religious chaplains/ leaders who could be contacted to see patients on request.
- Ward staff telephoned patients on the day following discharge to answer any questions and support them in their recovery.

Are surgery services responsive?

There were an increasing number of people requiring surgery who and had complex needs Services were being

adapted to provide appropriate pre-operative assessment and multi-disciplinary input into their care and treatment. However, these processes were not embedded and there was no pre-assessment policy.

The patients we spoke with said that the admissions process had been smooth and everything had gone as planned with the procedure. There were sufficient beds for patients to transfer to the wards from theatre in a timely way, but some patients had to move wards.

Staff had access to interpreters to facilitate communication with patients whose first language was not English.

Service planning and delivery to meet the needs of local people

- Activity in surgical services had developed in response to demand, decisions relating to revenue streams and the specialties of the consultant surgeons with practicing privileges at the hospital.
- Resources, such as staffing and equipment were usually assessed in relation to service developments before developments were implemented. The pharmacy staff reported the recent service developments had resulted in increased demand on their time which had not been anticipated. Senior management now recognised that pharmacy staffing levels required reviewed.
- There was an out of hours theatre team available if patients were readmitted and required unplanned surgery or for people admitted through the urgent care services.

Access and flow

- Activity was reviewed daily at the 09.15 am senior managers and clinical staff meeting that had representation from each department. Issues from the previous day and an outline of the expected activity for the day in their clinical area was discussed. This approach facilitated the management of issues in a timely manner. For example, we were told that an issue with delays in the information about medicines for patients to take home (TTO) was highlighted as a contributing factor to delayed discharges. This was discussed and processes put in place to get the information more promptly.
- There had been 205 cancellations between January and October 2014. Nearly half of these were because procedures were rescheduled by the surgeon.
- Ward staff were aware of the expected discharge date from the initial consultant surgeon assessment of the patient. Length of stay could be extended if necessary.
- There was a conversion rate of between two and three per cent from day surgery to patients receiving overnight care in the first nine months of 2014. The most usual reasons for this were pain or nausea.
- Staff in recovery told us there was sufficient space in theatres to keep patients under observation if required before transferring them to the wards. We were not informed of any problems relating to backlogs of patients awaiting transfer from recovery to wards.
- Some patents, were transferred between wards following surgery. Eighty-nine patients had moved wards in the year to March 2014. The reasons for these moves were not documented but bed moves and occupancy were tracked using an electronic system.
- The patients we spoke with said that the admissions process had been smooth and everything had gone as planned with the procedure.
- Out of hours consultants were able to contact the nurse to arrange the readmission of a patient if this was required. However, the urgent care service and the critical care unit were managed independently from the surgical wards and there were no processes in place for patients admitted to the wards from these services.

Meeting people's individual needs

- Patient's individual needs were identified during pre-assessment undertaken by the consultant surgeon and pre-assessment nurse.
- The pre-assessment nurse, was in the process of establishing processes to ensure appropriate investigations were undertaken before patients were admitted for surgery where possible.
- The information provided by patients who completed an online pre-operative assessment form was reviewed by the pre-assessment nurse to identify if further assessment or tests were needed. However, some patients completed the online forms shortly before admission and were admitted without the nurse reviewing these forms and identifying if additional investigations were required. We were told that in some cases this resulted in surgery being cancelled or delayed.
- When the consultant surgeon identified that the patient would benefit from a telephone assessment, they or their secretary informed the pre-assessment nurse and

sent her information about the patient. The pre-assessment nurse made a record of relevant information about each patient, such as medication, medical history and factors that might affect the safety of general anaesthesia. When required, patients were asked to attend the hospital for additional investigations, and any issues relevant to the surgeons or anaesthetists were passed on to the consultants' secretary.

- Surgeons informed their anaesthetists of high risk patients so that the patient would receive a further assessment of the risk of anaesthesia by telephone or by appointment in the outpatient clinic.
- Patients from overseas generally did not have a pre assessment on the telephone or in person before admission. The pre-assessment nurse consulted the theatre lists to identify those patients who had not been assessed and visited the surgical wards on the day of their surgery to undertake a pre-operative assessment.
- If risks were identified during pre-assessment, the patient's operation could be cancelled. We saw an example of the appropriate cancellation of surgery when pre-operative investigations found the patient was unstable. The patient was referred to the relevant specialist and the surgery rescheduled.
- Some staff we spoke with, such as physiotherapists, said there was sometimes a lack of information about a person's medical history, this made it difficult to assess risks and individual needs. Steps had been taken to address this by obtaining information from the patient's GP, in addition to undertaking assessments when the patient was admitted.
- There were an increasing number of people requiring surgery who had complex needs and the process of pre-assessment and post-operative care had been adapted to address these patients' needs. However, we were not provided with evidence that training had been systematically reviewed in order to ensure clinical staff had the necessary skills to deliver care to this group of patients.
- The pre-operative assessment form noted whether there was a need for an interpreter. Interpreters were available face to face and on the telephone.
- The hospital was aware of the risks associated with all patients being in single rooms with closed doors, therefore out of the view of nurses. To address this intentional rounding had been introduced every two hours day and night on inpatient wards.

Learning from complaints and concerns

- Patients were aware of how to raise concerns and complaints and were provided with an information leaflet as part of their information pack. There was a complaint's policy available and staff were aware of the actions to take when a patient complained.
- There was an expectation that any concerns raised by patients on the wards would be immediately addressed by the manager, and if possible resolved immediately to the patients' satisfaction.
- Formal complaints were processed and monitored centrally through the chief executive office. There were systems and processes in place for managing and responding to complaints, with nearly all complaints receiving an acknowledgment within two days and a more detailed response within 20 days. If there were delays to the completion of the detailed response the patient was kept informed.
- Patients were informed of their right to a stage 2 appeal to the provider, and of the independent external adjudication process if they remained dissatisfied with the response to their complaint.
- There were 57 complaints received by the hospital in the year to March 2014, it was unclear how many of these related to surgery or theatres. The risk management strategy had identified the need to refine the process for analysing trends in complaints and integrating this into learning.
- Complaints were discussed at senior management team meetings and with relevant managers.

Are surgery services well-led?

Staff were patient focused and aimed to provide high quality care. Senior management were approachable and responded to staff suggestions and concerns. Staff had confidence in senior management and we saw examples of good leadership in surgical services. Management encouraged an open culture so that the service could learn from incidents and complaints.

Surgery

The hospital risk register documented risks and assigned a manager to manage the risk. It was not clear if there was a systematic approach to anticipating risks or to assessing the risk of changes to services.

Vision and strategy for this service

- There was no local vision or strategy for the development of surgical services that staff were aware of.
- There was an emphasis on patient satisfaction at the hospital and 'Project World Class' training had been introduced and provided to the majority of staff to increase the customer focus of staff. Staff we spoke with understood the focus on customers.

Governance, risk management and quality measurement

- There was a governance and risk management structure from provider to departmental level. There were clear reporting arrangements for committees, for example the medicines management committee and the infection control committee, reported to the hospital clinical governance committee. The committee met quarterly and reviewed data, such as unplanned readmissions and transfers to theatre, complaints and incident reports.
- The risk management strategy had identified steps to improve processes at the hospital as managers recognised that the assessment and mitigation of risk required further work. There was a need to review was the management of serious incident and refine the process of learning from incidents.
- The service's risk register documented risks such as health and safety, infection control and staffing. There was a record of the controls put in place, the current level of risk and the target level of risk to be achieved with a review date. There was an assigned person to manage the risk, and entries were updated and closed when the level of risk was reduced.
- The risk register we saw and the conversations we had with staff did not demonstrate that there was a systematic approach to anticipating risks. Potential risks were not recorded on risk registers with action to mitigate the level of risk.
- We did not see evidence that risks were adequately assessed when changes were introduced. For example, earlier in the year a new process for transferring patients to theatre from the wards was introduced. This was done following three incidents were the wrong patient could have potentially been taken to theatre. However, we were told the old process of patient transfer was reintroduced with additional safeguards, there had been no evaluation of the new process or rationale for the reintroduction of the old process.
- The theatre user group, which included the theatre manager, a consultant anaesthetist and theatre staff, met each quarterly to looked at incidents reported and any staffing or equipment issues, and discussed methods to improve processes.
- There was an emphasis on quantitative data collection within surgical services, which did not provide a context for some of the figures presented. For example, further analysis of the data, such as readmissions to hospital, was discussed at the clinical governance meetings and there was a discussion about possible action. However, we did not see evidence of a consistent approach to accessing this type of analysis, identifying action and monitoring the impact of any action taken.
- Ward and department performance indicators and quality indicators were reported monthly at meetings of the recently introduced Quality Improvement and Patient Safety (QIPS).

Leadership of service

- Theatre staff told us there had been a period of poor morale and a high turnover of staff, but there was now confidence in management at all levels. We were given examples of the positive impact of the appointment of current theatre manager, who started working in September 2014, including her visibility in theatres and in recovery.
- Porters told us the theatre manager was very supportive and if they were under pressure she would see who was available to help out or would help out herself. A member of staff described the improvement of morale and said, "Now we want to go to work."
- We saw examples of initiatives by the manager of the day-case surgical ward to enhance the quality and safety of the care on the ward and to develop a coherent approach to understanding service delivery. She had undertaken a SWOT analysis to identify strengths, weaknesses, opportunities and threats and action had been initiated to address the findings.
- The medical advisory committee (MAC), which was responsible for overseeing consultants with practicing

privileges at the hospital, reported to the clinical governance committee. When issues emerged about performance, these were taken up with individual consultants. We were not shown evidence, however, of a process for collating information about poor practice or behaviour, or assessing adherence to standards, such as those set out in the royal college of surgeons (RCS) 'Good Surgical Practice'. We were told there had been a reluctance to tackle consultants about their practice in the past, but that the new senior management was now willing to take action.

- Senior management were frequently seen in clinical areas and welcomed comments from staff. Staff told us that everyone knew each other and management were very approachable. There was an emphasis on taking responsibility for problems and seeking solutions.

Culture within the service

- Senior managers had started to place a greater importance on using information to improve services and there was work planned to integrate information from incidents, complaints and other sources to enhance learning. However, we found variation in the attitude to incident reporting among staff.
- Staff said there was a strong focus on patient safety and resources would be provided to address risks to patients. They were confident about challenging poor practice if necessary and were aware of the whistleblowing policy and procedure.
- There was a strong sense of individual responsibility for dealing with issues as they arose or discussing them with a departmental manager. For example, in theatres, when a consultant did not participate in the World Health Organisation (WHO) surgical checklist, theatre staff reported it to the theatre manager. She immediately raised this with a member of senior management, who spoke with the surgeon concerned.
- All staff leaving the hospital were invited to an exit interview to identify the reasons for staff leaving. An analysis of reasons for leaving for staff between May 2013 to December 2014 was being undertaken at the time of our inspection. Since September 2014 staff had also been invited to complete an on-line exit interview form.
- There was low staff turnover and vacancy rate on the day-case surgical ward and minimal use of bank and agency staff. The general surgery ward had a higher turnover and vacancy rate resulting in more use of bank and agency staff. The turnover of staff for inpatient departments had been 32% in 2013/2014. The use of agency staff in inpatient departments was between 8% and 17% between October 2013 and June 2014.
- There had been high turnover of theatre staff in recent years; in 2013/2014 this was 24%. Permanent replacements were being recruited at the time of our inspection. The theatre manager told us they were able to get bank and agency staff to fill gaps in the rota.
- Sickness rates for nursing staff in inpatient areas had risen to about 5% at the beginning of 2014, but had subsequently fallen. Sickness rates for theatre staff was between 0.8% and 5% in the first six months of 2014.

Public and staff engagement

- All patients were given a questionnaire in their discharge. There had been 476 questionnaires returned in the second quarter of 2014. There were high levels of patient satisfaction in many areas and action plans address areas where patient satisfaction was less high. The surgical wards had introduced a follow up telephone call for all patients the day after they had been discharged and this had increased satisfaction levels.
- A committee had recently been formed to review complaints and patient feedback from questionnaires.
- There had been a recent staff survey, in November 2014 and the response rate for the Lister Hospital was 82% a significant increase from 2012 when response rate was 42%. The analysis of the survey results was not available at the time of our inspection.
- Information sharing with staff was achieved through the intranet, newsletters and a number of forums. There were monthly managers meeting at which information was shared which was then cascaded to staff as appropriate.

Critical care

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The critical care service has six intensive care beds which provided care to level 3, multiple organ failure or advanced respiratory support and level 2 patients those with single organ failure, post-operative care or high levels of monitoring. Four of these beds are in single rooms that have a monitored negative airflow pressure.

The majority of patients admitted to the critical care unit are planned admissions following general or orthopaedic surgery and who require a higher level of care and observation post operatively, as well as some general medical patients. The critical care unit had approximately 149 admissions in the last 12 months. Very few of these patients were level 3 patients.

Between 08.00 am and 8.00 pm, the unit also hosts the urgent care service, This is a rapid access and assessment service, where local GP's can refer medical patients seven days a week, 24 hours a day. Outside these hours patients are admitted directly to one of the wards and reviewed by the senior nurse on duty and RMO. An outreach services is also provided to the wards by staff on the unit.

During the inspection we visited the critical care unit. We spoke with one physiotherapist, the critical care unit manager, two ward sisters, four staff nurses, one administer, one patient services assistant, who has a housekeeping and hostess role, two anaesthetists, a consultant intensivist, two resident medical officers and the lead intensivist. Patients on the unit didn't speak English as their first language and one patient had a tracheostomy so couldn't speak to us during our inspection, we reviewed feedback forms and complaints. We looked at records for four patients.

Summary of findings

The critical care unit followed some safety procedures, infection control practices and patient risks were assessed and acted on appropriately. Local policies and guidelines had not been reviewed to ensure that these were in line with national guidance. Formal procedures to audit compliance with national standards had not been implemented. Patient outcomes data was collected and submitted to ICNARC for critical care patients, but did not participate in any other national or local audits focussing on patient outcomes.

There were appropriate staffing levels but only 40% of staff held a critical care post registration qualification. Staff were supported by senior staff to undertake their roles but their competencies were not appropriately assessed. Staff had an understanding of the Mental Capacity Act 2005 in order to carry out their responsibilities in relation to informed consent and deprivation of liberty safeguards.

We observed caring and compassionate interactions between staff and patients, staff treated patients with dignity and respect. Patient feedback forms showed they were happy with the care they received and had been involved in decisions about their care. However this feedback did not relate specifically to their treatment on the critical care unit. There were no plans to capture information specific to critical care from patients and families at the time of our visit. Patients were admitted without delay to the unit but the number of delayed discharges were higher than the national average.

Staff were not aware of the vision and strategy to expand the service but identified with the need to

Critical care

provide excellent care. Quality and patient experience were seen as priorities and everyone's responsibility. The nursing leadership on the unit was considered by staff to be supportive but they were not supernumerary and often worked clinically to cover for staff shortages. There was limited evidence of quality monitoring processes or monitoring of the actions taken on identified risks.

Are critical care services safe?

Staff reported incidents although there was limited evidence of feedback and learning from incidents. The environment was clean and staff followed infection prevention and control practices. Equipment, including resuscitation equipment, was regularly monitored and maintained. Most staff had undertaken mandatory training.

There was regular usage of bank and agency staff which was sometimes reactive based on referrals of patients to the unit. There were a number of nursing vacancies which were due to be recruited to but there was no timescale for this. There was a specialty registrar intensivist on site and a consultant intensivist on call 24 hours a day, seven days a week.

Incidents

- In 2014 the critical care unit reported eight clinical incidents which were deemed to have caused moderate harm and 27 incidents of no and low harm. We noted that many of these incidents related to medication errors.
- Incidents were not always fully investigated. We noted three root cause analysis investigation reports had been completed for the eight incidents categorised as causing moderate harm and another investigation had been completed for an incident that had not been risk scored. The incident reports we reviewed did not always identify the root cause of the incident or actions that should be taken to prevent a similar incidents reoccurring. The investigation reports did not state learning or evidence that the findings of the investigation had been shared with the patient.
- Not all staff we spoke with were aware of how to report an incident using the hospital's electronic reporting system and could not explain the incident reporting process.
- We were told that when staff reported an incident an automatic email was sent to the person completing the submission to confirm receipt. Staff told us they were not always informed of the outcome of specific incident investigations on the unit.
- A summary of incidents and learning from all incidents reported across the hospital was provided to senior staff. Senior staff told us this information was cascaded at departmental meetings but we were not provided with evidence of this.

Critical care

- There had been no deaths in the critical care unit in the last 12 months. We were told there were no formal arrangements to review, identify action and learn from patient deaths.

Safety thermometer

- The safety thermometer, a national improvement tool for measuring, monitoring and analysing patient harms and promoting harm-free care, was not used in the unit. Hospital wide information on falls, infections, venous thromboembolism (blood clots) and pressure ulcers was monitored as part of the hospital's clinical scorecard.
- Senior staff told us that if specific issues relating to critical care were identified through the hospital wide scorecard they would be addressed, but there had been no concerns identified in the previous 12 months.

Cleanliness, infection control and hygiene

- All areas of the unit were noted to be visibly clean and tidy throughout our inspection.
- There was a dedicated cleaner for the critical care unit. The cleaning audit folder detailed the cleaning schedule required on a daily and weekly basis. Bed spaces were deep cleaned when a patient was discharged from the unit.
- Infection prevention and control policies were available to staff in the main staff room and reflected national guidance.
- There were systems and processes in place to ensure that infections were identified and treated in a timely manner this included swabbing all patients admitted to the unit, with support from a microbiologist when required.
- There had been no incidences of MRSA or clostridium difficile attributable to the unit in the preceding 12 months.
- We saw that staff observed infection control procedures for example wearing protective equipment such as gloves and aprons and disposing of them after completing patient care to reduce risks of cross contamination.
- Hand washing facilities were available throughout the unit. This included two hand washing basins by every bed side with non touch taps and hand gel was placed at the entrance and throughout the unit.
- Regular hand hygiene audits were completed and hospital wide results were displayed in the main staff room. The audit results we saw showed that the unit had continuously scored over 95% in the last 12 months of audits.
- The unit submitted evidence to the Intensive care National Audit and Research Centre (ICNARC) regarding infection prevention and control, reported no acquired infections on the unit.

Environment and equipment

- The equipment we saw was visibly clean and labelled with the last service date and a sticker identifying the date when the equipment was cleaned.
- All equipment was listed and monitored on the critical care unit's asset register. This information included frequency of required maintenance and maintenance contract agreements, which the unit manager was responsible for oversight of. The equipment we saw was found to be in working order and staff told us that repairs were undertaken in a timely fashion.
- We observed that daily checks were undertaken of the unit's resuscitation equipment and the results of these checks documented
- All bed spaces and facilities in the unit met the Department of Health building note 04-02 for Critical Care Units published in March 2013 requirements. This included having individual wash-hand basins, ceiling hoists and minimum space requirements.
- To promote staff competency as part of their induction they received equipment specific training on how to use the equipment safely.
- The unit had two negative pressure isolation rooms with double doors which promoted safely care for infected or immunosuppressed patients and prevent cross infection.

Medicines

- We found that medicines were stored securely in locked cupboards and trolleys. We saw that keys to drug areas were stored securely.
- The controlled drug registers we checked demonstrated that the management of controlled drugs met legal requirements.
- We found that the temperatures of medicine fridges were consistently checked and maintained within the required limits.

Critical care

Records

- Each bed had two electronic monitors, linked to an electronic record keeping system, which enabled staff to easily monitor patient's vital signs and ventilator data and take appropriate and timely action. The systems triggered alerts to nursing staff if readings were outside the expected ranges for individual patients. Nursing staff we spoke with told us they escalated any concerns to medical staff who would provide prompt advice.
- Staff spoke positively about the electronic medical record systems they used and told us there were no delays in accessing patient information.
- The four sets of patient notes we looked at showed that surgical and medical records were maintained in separate paper records. We were told that this sometimes meant that staff did not have access to all the information relating to patient care.

Safeguarding

- A safeguarding adult's policy which reflected national guidance was available to staff on the unit. However, the safeguarding children's policy did not include the most up to date national guidance.
- There was an annual safeguarding adults training package that all staff were expected to completed. Training records seen during our inspection showed that this training had been completed by 100% of nursing staff, but three of the four junior medical staff had not completed this training.
- Records seen during our inspection showed that safeguarding children's training for the whole hospital at level 1 had been completed by 84% of clinical staff and level 3 and 4 training had been completed by 75% of clinical staff.
- Staff we spoke with were aware of the hospital's safeguarding procedures and their responsibility to escalate signs of abuse.
- There was an established recruitment process that included the requirement for two references and a current disclosure and barring scheme (DBS) check prior to a new member of staff commencing employment and there was evidence all staff had been checked prior to commencing in their posts.

Mandatory training

- There were nine mandatory training modules all staff were required to complete annually. These included fire safety, infection prevention and control, manual handling, safeguarding adults, safeguarding children, blood transfusion, medications and resuscitation.
- All nursing staff who were in charge of shifts completed an intermediate life support course annually so that there was always a trained member of staff on shift who could attend emergencies outside the unit.
- Mandatory training was linked to pay if staff did not complete this training they did not receive their pay increments. All staff we spoke with in the critical care unit confirmed they had completed the required mandatory training.
- The training records demonstrated that attendance at training was monitored. At November 2014 84% of permanent critical care staff were up to date with all required mandatory training, which was below the hospital's target of 95%. We were not provided with equivalent figures for bank or agency staff working on the unit.

Assessing and responding to patient risk

- Risk assessments in relation to the risk of falls, pressure ulcers; venous thromboembolism (blood clots) and the use of bed rails were undertaken for all patients admitted to the unit. Where risks were identified the tools used for these assessments identified the action to be taken to reduce or manage the risk.
- An outreach service was provided by the senior nurse on duty in the critical care unit. This individual visited all patients who had been discharged from the unit within 24 hours of their discharge.
- National early warning scores (NEWS) were in use on the unit and on the wards. These were completed and patients were escalated to the outreach team when appropriate, in line with the hospital's escalation policy.
- We were told that while the outreach team members could not prescribe or administer fluids or oxygen they were able to request an urgent medical review and to admit the patient to the unit if necessary.

Nursing staffing

- The nursing establishment had been calculated using unit bed occupancy and activity data. This data showed that the unit required a complement of 18 nursing staff in the summer of 2014. Staff told us the unit had been empty for a number of months over the summer which

meant that staffing levels had to be to be reduced to 15 nursing staff by October 2014. This review had demonstrated the number of staff required but not the skill mix.

- Staffing levels on the unit ensured that all patents requiring level three care were cared for on a one to one basis, patients requiring level two or level one care were cared for on a two patient to one nurse ratio.
- At the time of our inspection only 9.6 wte of the 15 wte nursing posts had substantive nurses in post. There was one unit nurse manager, three full time senior sisters, four staff nurses and 1.6 whole time equivalent part time staff nurses. We were told recruitment for the further permanent nursing staff would take place in the near future but we were not provided with information of when this recruitment would take place. Vacant posts were covered by agency staff.
- In line with recommendations of the British Association of Critical Care Nurses for Nurse staffing in Critical Care (2009), we were told the nurse who was rostered to be in charge of the shift should have a supernumerary role to coordinate the shift and provide support to the staff team. However due to staff vacancies this did not always occur.
- The critical care unit manager reviewed staffing requirements weekly and staff told us they felt confident to raise concerns regarding staffing with their manager. Staffing was also reviewed daily and we were told that if extra staff were required because there were level three patients, bank and agency staff would be used to maintain adequate staffing levels. The evidence provided showed that bank and agency staff were used to maintain staffing levels but did not demonstrate they had the necessary skills to manage an increased acuity of patients.
- Despite requesting to see staffing rotas to confirm how often shifts had the required numbers of staff and the level of unfilled bank shifts the hospital did not provide us with this information.
- A bank nurse induction and orientation programme was in place to ensure they were familiar with the unit before commencing work and they were supervised by senior nurses. However, while this inducted them to the unit we were told not all bank nurses had critical care qualifications and therefore may not have the necessary skills to provide care to critically ill patients.
- The critical care unit was responsible for receiving patients who had been referred by their GP to access the hospital's urgent care service daily between 0800 am and 8.00pm. Outside these hours the most senior nurse on duty for the hospital undertook this role. The nursing establishment had been calculated for the critical care unit only and had not taken into account this additional service. Staff we spoke with told us that they did not consider that this extra role impacted on the care provided to critically ill patients on the unit.
- There were nursing handovers at each shift change led by the nurse in charge of the shift at which all patients and their treatment plans were handed over the nurses covering the shift.

Medical staffing

- The lead consultant for the unit was an intensivist with a special interest in critical care, whose role was to provide leadership to medical and surgical staff in caring for patients on the unit.
- Discharge planning from the unit was undertaken jointly by the intensive care consultants and the admitting surgeon
- There was a team of three dedicated consultant intensivists who covered the unit seven days a week. All had backgrounds in anaesthesia and intensive care skills and worked as full time intensivists.
- There was a specialty registrar intensivist, resident medical officer with an anaesthetic and critical care background on shift 24 hours a day, seven days a week. These arrangements met the Intensive Care Society guidelines for ensuring there was immediate access to a practitioner who had skills in advanced airway techniques.
- Staff told us that they had easy access to consultant intensivist advice 24 hours a day, seven days a week.
- Some staff said that the onsite consultant anaesthetic cover in the event of an emergency was not always appropriate and occasionally when a consultant anaesthetic could not be contacted out of hours, they had to call the consultant intensivist to provide advice and care to patients. We were told the out of hours anaesthetic cover had improved since the introduction of the urgent care service as there was now an on-call anaesthetic consultant rota which identified the name of the individual who should be contacted.
- Neither the ward based resident medical officers or the critical care resident medical officer had postgraduate training in general or acute medicine to provide appropriate care to medical patients admitted out of

hours through the urgent care service. Also there were no clear guidelines for the management of acute medical conditions to assist these doctors deliver appropriate care.

Major incident awareness and training

- Staff were aware of the business continuity plans for the unit, and were familiar with how the four single rooms with monitored negative airflow pressure would be used should for patients with infectious diseases.
- The unit manager described the systems in place to maintain fire safety and power outages. There were estates staff on call 24 hours a day seven days a week and during fire strikes there were staff resident on site to deal with a fire should it occur.

Are critical care services effective?

Local policies and guidelines had not been reviewed to ensure that these were in line with national guidance. Formal procedures to audit compliance with local and national standards were not implemented. Patients' nutrition and hydration needs were assessed and action taken to ensure their needs were met. The unit participated in very few local and national audits to demonstrate patient outcomes. In January 2014 the unit had started to submit ICNARC data.

Staff were supported by senior staff to undertake their roles but their competencies had not been reviewed. The number of staff holding post registration qualifications in critical care was not in line with national guidance. Staff had an understanding of the Mental Capacity Act 2005 in relation to informed consent and deprivation of liberty safeguards. Restraint using sedation and or bed rails were used but staff we spoke with were not aware of the hospital's restraint guidelines and staff did not consider the patient's best interests needed to be assessed in this situation.

Evidence-based care and treatment

- There were some local critical care standards, for example enhanced recovery, post-operative optimisation of the high risk patient. However, as these had not been reviewed, it was unclear if they were up to date and reflected national guidance.
- There were no protocols or patient pathways for the high risk patient or the slow wean patient, despite these being identified as two relatively common admissions. There was a lack of systems for identifying high risk surgical patient pre-operatively, for example no high risk clinic that these patients could be referred to pre-operation and no optimisation protocols or standards being applied in the perioperative period.
- There was no evidence that National Institute for Health and Care Excellence (NICE) and Intensive Care Society guidelines and standards had been implemented or were complied with.
- The ward manager told us they monitored practice on the unit through observation but there was a lack of formal audit to evidence care was being provided in line with national guidance and to the expected national standards.

Pain relief

- The patient records we reviewed showed that medication and sedation was continually monitored and documented.
- There was a pain management team that supported the service but there was no evidence provided to demonstrate that this team was available out of hours.
- We noted that the unit scored 71% on the recent patient pain management satisfaction survey. There was no evidence to show what action was planned or had been implemented to address the issues identified in this survey to improve patient experience.
- Routine delirium testing for patients on the unit was not undertaken which is not in line with the Intensive Care Society UK standards, Delirium in the critically ill patient (2006).

Nutrition and hydration

- The assessment, implementation and management of appropriate nutrition support for patients was led by the patient's consultant in collaboration with the multi-disciplinary team. Advice from dietician's advice was sought when required.
- The critical care unit manager told us that patients who were unable to eat or drink received nasogastric feeding within 24 hours of their admission to the critical care unit. We saw that daily assessment of nutrition and hydration were recorded for each patient.
- We were told that an audit of fasting times had not been undertaken or was planned to be undertaken on the unit to ensure patients were not fasted for inappropriate lengths of time.

Critical care

Patient outcomes

- In January 2014 the unit had commenced the submission of data to the Intensive Care National Audit and Research Centre (ICNARC). Data provided showed that mortality outcomes were zero, health care acquired infection rates were low and early readmissions to the unit were 1%. This data reflected the fact that very few patients on the unit were level three or two.
- Staff felt the ICNARC data was not reflective of the critical care unit's caseload as many post-operative patients were transferred to the unit for observation despite not requiring level 2 or 3 care. Decisions to admit patients were taken by the operating surgeons who felt more confident that patients would receive close observations in critical care unit than on the wards.
- Patients were admitted to the unit in a timely manner once a decision had been made that they required critical care. The time to admission data showed that all patients were admitted within the four hour national standard.
- Some quality of care indicators such as ventilator associated pneumonia and catheter-related bloodstream infection rates were measured by staff but outcomes were not used routinely to influence the quality of care.
- We were not provided with information to show how the outreach team monitored and acted on patient data to improve outcomes.
- The unit did not participate in any other national or local audits focussing on patient outcomes other than contributing to ICNARC.

Competent staff

- The average bed occupancy rate in critical care was below the England average for patients requiring level 2 or level 3 care. Therefore not all staff had the opportunity to maintain their skills and competencies to deliver level 2 and 3 care.
- We were told that some staff undertook bank shifts in other critical care units with a higher percentage of level 2 and level 3 patients, but this was neither mandatory or monitored.
- The number of critical care trained nurses working on the unit was not in line with national guidance that states all nurses should hold or be working towards a critical care qualification. Only three of the nine permanent nursing staff had an intensive care qualification. We were told that two nurses were due to commence their critical care training in January 2015.
- Most permanent staff were supported to complete local training to undertake their role which included management of arterial line, management of chest drain, ventilation, enteral feeding, pain management and inotropic management. Permanent staff we spoke with confirmed they had their competencies in these areas assessed by senior members of staff and they could approach senior staff for help and support. However, we did not see written evidence of these competencies checks.
- We were told that competency checklists had been developed for bank and agency staff by the unit manager to assess their skills when they commenced work in the unit. However, evidence to demonstrate these assessments had been completed for all temporary staff was not provided despite being requested during our inspection.
- There were a number of bank nurses that the unit could call regularly at short notice to ensure there were appropriate staffing levels. However, there was no evidence that these staff had experience or a post registration qualifications in critical care.
- The unit manager told us that all permanent staff had received or were due to receive an appraisal. But despite asking we were not provided with evidence of the number of staff who had participated in appraisal and the dates for appraisals for those who had not already receive an appraisal.

Multidisciplinary working

- The consultant intensivist led a daily ward round of all patients on the unit, which was attended by the nurse caring for the patient and the specialty registrar intensivist. During this ward round all aspects of patient care was discussed.
- There was no formal multi-disciplinary ward round. Physiotherapists reviewed patients and discussed their care with nursing staff when required.

Seven-day services

- Consultant cover was provided seven days a week and there was an identified consultant on call out of hours.

Critical care

- There were daily ward rounds and the consultant covering for the weekend attended the ward round and handover on Friday evening to ensure they were aware of any issues or potential admissions into the unit.
- There was a physiotherapy service available seven days a week.
- The pharmacy was open 8.30am to 5.30pm Mondays to Friday.
- There was an outreach service available 24 hours a day, seven days a week provided by a senior critical care nurse.
- Out-of-hours imaging was available.

Access to information

- Staff spoke positively about the electronic medical record systems they used, and told us there were no delays in accessing patient information.
- Surgical and medical records were maintained in separate paper records. We were told that this sometimes meant that staff did not have access to all the information relating to patient care.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- Whenever possible, staff told us patients were asked for their consent before receiving any care or treatment, and staff acted in accordance with their wishes.
- Staff understood their responsibilities under the Mental Capacity Act 2005 and its associated deprivation of liberty safeguards (DoLS). We were told that the unit had not made any DoLS applications in the last 12 months.
- We were told by staff that patients could be restrained using sedation medication to maintain their safety, however staff we spoke with were not aware of the hospital's restraint guidelines in place to support staff to act in the patient's best interest.

Are critical care services caring?

Throughout our inspection, we saw patients being treated with compassion, dignity and respect. Although patient feedback was collated across the hospital, there were limited formal mechanisms to capture patient and relative feedback on the care and support they received on the unit.

Compassionate care

- We observed staff speaking to patients and their relatives in a caring and compassionate manner, providing reassurance and support.
- There were no specific methods in place to capture patient feedback on the unit. Hospital wide patient feedback survey scores were shared with the unit manager, although specific comments made relating to patient's and relatives experiences of the critical care unit were not highlighted.
- We observed staff ensured patients' privacy and dignity, for example, by closing doors and blinds when providing personal care.

Understanding and involvement of patients and those close to them

- We observed staff explaining to patients and their relatives the care and treatment that was being provided, in order to reduce their anxiety.
- We saw patient information leaflets were available at the entrance to the unit.
- Translation and interpreting services were available in the hospital for Arabic speakers, and by telephone for other languages.

Emotional support

- The unit manager visited all patients and relatives on the unit daily to assess if they had any concerns with their stay in the hospital.
- We were not made aware of specific services for emotional support for patients such as counsellors and bereavement support.

Are critical care services responsive?

The critical care unit met the needs of patients. Patients were admitted to the unit in a timely manner but there was a higher than national average number of delayed discharges. There were very few transfers out of the unit to other critical care units, all external transfers were for clinical reasons. Patients received information about the service and their procedures prior to admission. One patient complaint had been received in the last 12 months, however, learning from this had not been shared with staff.

Service planning and delivery to meet the needs of local people

- The unit provided care and treatment for patient's having elective surgery and some medical patients. The

majority patients were admitted following orthopaedic or general surgery. The unit did not take emergency admissions from other hospitals or critical units, although patients were able to be escalated to the critical care unit from wards in the hospital if unexpected complications occurred following planned surgery.
- The service provided by the unit was planned on a daily and weekly basis with surgeons informing the unit of which patients would require critical care post operatively. Surgical lists were also provided to the unit in advance which assisted with planning.
- Staff on the unit told us the unit's referral criteria meant that patients under the age of 18 years were not accepted for admission and would be referred to a more appropriate setting. However the urgent care service, based on the critical care unit did accept young people over the age of 16 years.
- There had been no formal analysis of the impact that the role the urgent care service had had on the critical care service.

Meeting people's individual needs

- A significant number of patients admitted were Arabic speaking, there was an onsite interpreter available 24 hours a day, seven days a week.
- Staff were not trained in the needs of patients or relatives living with dementia and reported that they had not had to care for patients who were living with dementia or who had a learning disability in recent years.
- There was written information available on the unit for patients and their relatives, this included general information about the unit and condition specific leaflets. We noted that some Arabic information guides and menus were also available.
- Staff showed us that information in other languages was available on the provider's website and was easily accessible.
- Each patient's bed had an individual entertainment system console and screen to access the internet, television and radio.
- Relatives were encouraged to visit. Visiting hours were allocated between 1.30-3.00pm and 4.30pm to 8.00pm to allow patients time to rest. Flexible visiting time was at the discretion of the nurse in charge for new admissions.

Access and flow

- The average bed occupancy rate in the critical care unit January to November 2014 was significantly below the national average of 85%. For patients requiring level 3 care this was less than 5% and for patients requiring level 2 care the average occupancy rate was 43%.
- The average length of stay on the unit was less than two days and patients were only occasionally ventilated overnight. This was below the national average.
- There were 12 unplanned re-admissions to the critical care unit between April and November 2014. This was noted to be an increase and had been escalated in October 2014 to the hospital's governance committee as the reasons for the readmissions and possible trends had not been identified. No outcomes or actions had been identified or reported by the committee.
- There were no out-of-hours discharges and patients were not discharged from the unit after 10.00pm.
- There were arrangements in place to admit patients to the unit from the wards in an emergency. The decision to transfer the patient to critical care was made by the medical staff on the wards, the specialty registrar intensivist and the nurse in charge of the unit. Staff told us a number of patients who required closer monitoring, or level 1 care, were admitted to the critical care unit in 2014 to support ward staff, as they did not have the skills to provide this care. We were not told what action was being taken to address this lack of skills.
- There were no non-clinical transfers out of the unit in the last 12 months. Between April and September 2014, there had been three transfers, 0.1% of the total number of discharges, from the critical care unit to other hospital, all these were reported to be for clinical reasons.
- Data submitted to ICNARC showed that 20% of discharges from the unit were delayed which was worse than the national average.
- We were told there had been no mixed-sex breaches on the unit in the last 12 months.

Learning from complaints and concerns

- Staff we spoke with told us they would try to resolve any concerns informally by escalating to the unit manager to avoid families making formal complaints.
- Complaints were not always responded to in a timely manner. The critical care unit had received one complaint in the last 12 months, relating to care

received from nursing staff. The complaint response was sent 45 days after the initial complaint was acknowledged, which was not in accordance with the hospital's complaint's policy.
- The unit manager told us the learning from any complaints was discussed at the relevant weekly staff meeting, there was no evidence, such as minutes of these meetings, provided to demonstrate that this had happened.

Are critical care services well-led?

There was no local vision or strategy to develop the service. Staff were not aware of the hospital's strategic objectives and the impact they would on the expansion of the service. They did identify with the hospital's values and the need to provide excellent care. The local leadership of the unit was considered to be supportive, but leadership of the governance of the unit had not been given sufficient priority and there was limited evidence of quality monitoring processes or monitoring of actions taken on identified risks. Patient and staff feedback to improve the service was not formally undertaken on the unit.

Vision and strategy for this service

- The hospital's strategic objectives for 2014 were to increase elective activity and to expand services to care for patients with higher acuity needs. Not all staff we spoke with were aware of this and the impact it would have on the unit.
- The hospital vision was to increase bed occupancy and acuity of patients on the critical care unit. However, it was not clear how this would be achieved.
- Staff were not aware of a local vision or strategy for the unit and saw their role and purpose on the unit as providing excellent and compassionate care to patients.

Governance, risk management and quality measurement

- There was limited evidence to demonstrate the quality of care delivered on the critical care unit met local or national standards. The unit gained reassurance about the quality of the service mainly through personal observation by the manager, the positive feedback from medical staff using the unit and the thank you cards from patients. This approach was subjective and did not evidence the quality of service being provided.
- The unit manager met regularly with the wider hospital team and was updated on information during attendance at the hospital's clinical governance meetings. This included information on complaints, incidents, and audit. The manager told us this information was shared with staff during unit team meetings but despite requesting this we were not provided with evidence of this.
- We were told the service had a risk register. Despite requesting to see the unit's risk register, which we were told the unit manager maintained this, we were not provided with this and therefore could not confirm what risks have been identified and what mitigation or actions have been taken.
- The lead consultant intensivist had taken an advisory role for governance and risk management across the hospital at the beginning of December 2014. We were told that due to clinical commitments he had very limited time to undertake this role and there was a lack of clarity of the expectations by the senior managers about this role.
- The hospital used a corporate clinical quality metric to monitor performance, which included infection rates, compliance with reporting and recording of incidents and complaints, the incidence of venous thromboembolism (blood clots) and pressures sores These were not specific to the critical care unit and did not report the unit's performance separately from other parts of the hospital.
- Staff were aware of the hospital's clinical dashboard. There were no issues identified on the dashboard for escalation in the critical care unit.
- We requested information on the monitoring of intensivists to ensure they all had current medical indemnity insurance, appraisals and professional registration. This information was not shared with us during our visit but received post inspection.
- The critical care unit had started to contribute to the ICNARC survey in January 2014, but did not undertake local audits.
- The critical care unit was not part of a critical care network and did not work with other critical care units to share learning, address staff skills and competencies.
- The lead intensivist was keen to expand the use of the electronic patient record so that more formal patient

pathways could be implemented, as well as to demonstrate compliance with national guidelines and collect data on care quality indicators. It was not clear if and when this would be implemented.

Leadership of service

- The lead intensivist had oversight of the clinical management of the critical care unit and represented their speciality on the hospital's medical advisory committee (MAC).
- Staff spoke highly of the support the unit manager provided to themselves and to patients. All staff said they were supported to report concerns to the manager who would act on their concerns and kept them up to date.
- Staff told us the chief operating officer was visible and that they felt listened to.

Culture within the service

- Staff on the unit spoke positively about the service they provided for patients. They said they worked well together as a team.
- Staff were focused on the delivery of high a quality care in the critical care unit and told us senior staff led by example.
- We asked for specific data on staff sickness rates on the unit but were not provided with this information. We were unable to assess if sickness levels were similar to other departments in the hospital

Public and staff engagement

- Staff said they felt engaged with their services and their managers. Staff told us that the use of staff meetings and handover sessions meant they felt fully informed and involved in the running of the critical care unit.
- Staff surveys were undertaken periodically across the hospital and the survey undertaken in August 2012, results were not broken down by staff group or clinical area. We were not provided with evidence to show what actions had been taken in response to addressing the issues highlighted in the last survey that specifically related to the critical care unit. Another survey had been undertaken in 2014 and the results were being analysed at the time of pour inspection.
- Patient and staff feedback to improve the service was not undertaken within the unit.
- There were patient forum meetings took place in the hospital but there was no critical care representative on the patient forum.

Innovation, improvement and sustainability

- The introduction of the electronic remote monitoring system for sick patients on wards using online telemetry linked to the monitor on the ITU nurses station was highlighted as innovative practice by the outreach nurse. This system assisted in identifying deteriorating patients.

Outpatients and diagnostic imaging

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The outpatients service located in The Lister Hospital covers a range of specialities such as general surgery, gynaecology, orthopaedic, ophthalmology and ear, nose and throat (ENT). The service see adults, children and young people, the data provided for the number of outpatient attendances was not specifically for the Lister hospital but also included visits to other satellite outpatient clinics provided by the hospital. Patients are referred from general practitioners, consultants private practice or as self referrals; clinics are held on a as required basis when requested by individual consultants to meet the request of patients. The recently refurbished outpatient department (OPD) has four treatment suites with 17 consulting rooms in total. The imaging department carries out routine X-ray as well as more complex diagnostic tests such as MRI and CT scans.

We inspected the OPD, physiotherapy and imaging departments. During our inspection we spoke with 18 patients and 35 staff, this included medical practitioners, nurses and allied health professionals. We observed care and treatment and looked at care records. Patients privacy and dignity was maintained and people were positive about the care they received. The environment was clean and there were systems in place to manage infection prevention and control and the risks to patients. The outpatients department had not reported any serious incidents or never events. There were policies and procedures in place to investigate incidents and staff were aware of the reporting policies and procedures.

Summary of findings

The outpatient, physiotherapy and diagnostic imaging departments followed procedures to ensure that patient care was safe and effective. There was managerial leadership within all the OPD departments at a local level; staff reported that the senior management team were visible and accessible. Staff participated in appropriate mandatory training and were aware of how to report and deal with incidents and complaints. All incidents and complaints were investigated and where necessary clinical and administrative practice was changed to prevent recurrence. Radiology staff followed national guidance and equipment was appropriately maintained and tested. Imaging regulations were followed and staff received the necessary training and competency assessment to ensure patient safety.

Patients were able to access the service easily and the outpatient services opened Monday to Friday 08.00-20.00 and 08.00-13.00 Saturday. Patients were positive about their experiences and reported staff were caring and treated them with dignity and respect. Information leaflets and an interpreting service was available. Although leaflets were available these were only in English. Patients and relatives told us they felt involved in the decisions about their treatment and that staff communication and the information provided was good.

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Incidents were reported and investigated in accordance with the hospital policies and procedures. Staff received feedback and changes were implemented following learning from incidents. Governance arrangements were in place with a reporting and escalation process for managers to identify risks. Staff told us that there was an open and transparent culture within the OPD service as well as throughout the hospital and senior managers were visible and accessible.

All the departments included in the outpatient services were clean and clutter free, the OPD and imaging departments had been recently refurbished. Staff adhered to infection prevention and control policies and procedures. There were facilities available in all areas for staff to maintain appropriate hand hygiene practices. Equipment was cleaned and serviced as required. All staff participated in mandatory training and annual appraisals. Arrangements and equipment were in place to deal with emergencies and medicines were stored securely.

Records were available prior to consultation and all other records were held securely prior to being scanned into the computer; there were systems to ensure that confidential information was checked prior to being destroyed appropriately.

Patients were positive about their experiences and reported staff were caring and treated them with dignity and respect. Staff adhered to 'knock and wait' prior to entering the consulting rooms and patients were able to access a chaperone if required. Safeguarding training was provided at the appropriate level for all staff, although the safeguarding children policy did not reflect up to date national guidance.

Incidents

- The hospital used an electronic incident reporting system and all staff we spoke with were familiar with how to report any incidents using the hospital electronic reporting system and gave examples of reporting incidents. The incidents documented were related to diagnostic imaging.
- The diagnostic imaging department had reported five radiation incidents via the electronic reporting system; these were also reported to the radiation protection advisor (RPA) between January 2014 and November 2014 and no further action was advised by the RPA. These were recorded in the radiation incident log for November 2014.
- The manager of the imaging and diagnostic department said all incidents were investigated using a root cause analysis tool. Contributory factors which may have affected individuals such as stress, language barriers and staff training were also considered during the investigation. This was assessed using an additional specific tool developed by an NHS trust.
- The two incident reports we looked at showed the incidents had been reported electronically, investigated and the identified learning had been documented. Investigation findings were cascaded to all staff at team meetings. We saw evidence that actions and changes to practice had been implemented to prevent a recurrence. For example the actions included staff received further training and the checking process was changed from one to two members of staff with use of implementation of the World Health Organisation (WHO) check list to ensure the correct protocols for specialist scans were used. The report showed that no further incidents had occurred.
- Staff told us that they received an automatically generated acknowledgement for any incidents they reported and they were routinely given feedback on the investigation of any incident that had reported.
- The managers we spoke with confirmed information relating to reported incidents was collated and discussed by the management team at the providers monthly Quality Improvement and Patient Safety Group (QIPS) and the Radiation Protection Meeting, minutes we saw confirmed this.

Cleanliness, infection control and hygiene

- All areas and equipment in the outpatient and imaging departments were visibly clean. There were cleaning schedules and checking process in place to ensure that standards of cleanliness were maintained throughout the department. We were told and staff meeting minutes confirmed that there was an established cleaning programme for the children's toys. The minutes confirmed that this was the responsibility of the paediatric nurse staffing the children's OPD clinics.

Outpatients and diagnostic imaging

- There were policies and procedures to reduce the risk of cross-infection. Staff confirmed that they could access the infection, protection and control (IPC) policy dated March 2014, either on line or refer to a hard copy.
- Staff were aware of the trust's aseptic non-touch technique guidance which aimed to reduce the risk of infection.
- There were hand washing facilities and hand disinfectant gel available in in every consultation room. We observed staff washing their hands and using hand gel between treating patients. 'Bare below the elbow' policies were adhered to by staff in the clinical areas where examinations were taking place.
- The majority equipment such as minor treatment instruments were decontaminated on site in the Central Sterile Services Department. All instrument sets seen during our inspection were traceable and logged appropriately in the patient notes.
- Staff told us that the majority of equipment in the outpatient department such as blood pressure cuffs were single use only.
- Sharps bins were labelled, signed and dated correctly and none were seen to be over full which reduced the risk of needle-stick injury.
- Personal Protective equipment (PPE) such as disposable aprons and gloves were available and easily accessible to staff.
- Infection prevention and control (IPC) training was mandatory for all clinical and non-clinical staff. Training records confirmed that 85% of staff were currently up to date with IPC training, this was lower than the hospital's target of 95%.
- The OPD had an IPC link nurse who attended the internal link practitioner's group meeting and participated in the IPC audit programme for the area. These audits included hand hygiene and the environment and showed 100% compliance.
- Hand hygiene audits were undertaken quarterly and were recorded as 100% compliant up to and including quarter three and therefore there were no outstanding actions for OPD or the imaging department.
- The IPC link nurse for outpatient and the imaging department told us all infection control and prevention policies were reviewed and ratified by the chief executive officer (CEO) and the chief nurse officer (CNO) and that any changes were discussed at the outpatient department monthly meetings. Minutes we saw confirmed changes to policies had been discussed to ensure all staff were aware of the updates.
- All staff had access to the hospital wide information newsletter, 'Bug of the Month'. The newsletter provided staff with information on a variety of viruses and infections their cause, diagnosis and treatment. Staff told us that they found this information sharing very useful.
- Patients were screened for Methicillin Resistant Staphylococci Aureus (MRSA) prior to admission.
- The OPD manager provided us with confirmation that risk assessments had been completed on the use of scalpels, injectable drugs, venepuncture (the taking of blood) and suturing (the stitching of wounds). These items had been assessed as moderate risk and an action plan was in place to reduce the risk by for example by using manually retractable needles for venepuncture. The actions were all due to be completed by 31 January 2015. We were told that following that date a further risk assessment would be carried out.

Environment and equipment

- There was an asset register in place which included a record of all the equipment within the OPD and imaging department to ensure that equipment was serviced and maintained annually. This was held, collated and maintained by the biomedical staff for the hospital.
- All equipment we saw was visibly clean and serviced as required to ensure it was fit for purpose. We noted equipment was labelled with the last service and portable appliance test date, all of which had been undertaken in the last 12 months. .
- All equipment faults were reported electronically. Staff we spoke with were aware of who to contact if a piece of equipment was faulty and we were told that the majority of faults were rectified the same day.
- Resuscitation equipment was available throughout all the OPD, imaging and physiotherapy department.
- All resuscitation equipment was in line with national resuscitation councils recommendations and was ready to use. Documentation seen confirmed that daily checks of all resuscitation equipment had been completed appropriately.
- The imaging department manager told us that all x-ray equipment such as computerised tomography (CT)

were compliant with national standards for example IR(ME)R and that there were radiation supervision local rules in place to ensure safety standards were maintained.
- Radiation audits and risk assessments were undertaken to ensure appropriate doses were not exceeded. Two of the three audits carried out between September–November 2014 we saw had resulted in action plans to address issues identified.
- There were emergency call bells in the consultation rooms that were in working order.
- In the majority of consulting and treatment rooms throughout the physiotherapy, outpatient and imaging departments additional screening was available around examination couches to ensure patients dignity was maintained.

Medicines

- Some medication such as local anaesthetic and hydrocortisone were available in the OPD these were stored in a locked cupboards in the minor treatment rooms and not in the consulting rooms.
- All medicines seen were stored securely in a locked cupboard and were in date.
- A record was maintained of all medication administered to patients during minor procedures in the minor treatment rooms. This included the name of the patient, their consultant, the medication used. All entries were noted to be fully completed.
- There were anaphylaxis drug kits available in the minor treatment rooms in case of an emergency, which were in date and had been checked daily.
- The OPD did not stock take home medication, patients prescribed medication as part of their consultation were provided with a prescription, which was dispensed by the hospital pharmacy. The pharmacy department closed one hour before the last outpatient appointment. Staff told us that if the prescription was urgent and pharmacy was closed they could call the on call pharmacist who would dispense the medication or the patient could take the prescription to a local pharmacist.
- A CT scanning audit carried out in September 2014, which looked at the completion of patient information and examined the radiographers compliance in the completion of iodine contrast information found that 95% of entries in the CT log book included a record of the expiry date of the contrast. We noted that an action plan had been developed to address the issues identified in the audit and this included a planned re-audit in December 2014.

Records

- Staff told us that outpatient records written by the consultants when they saw patients in the OPD were not retained by the hospital but were kept by the individual consultants who took responsibility for the notes and their secretaries ensured they were available if further consultations or appointments were required.
- We were told by staff that patient records were always available in clinics and in the last 12 months and there were no reported incidents of records not being available in OPD and patients having to be seen using temporary records or rescheduled as their records were not available.
- There had not been any reports concerns or incident to date where notes had not been available when required.
- All nursing and diagnostic imaging records were electronic and these were stored on the hospital's IT system, which was accessible by clinical staff using individual passwords.
- Copies of all diagnostic reports for procedures undertaken in the hospital were available on the hospital's computer system. Staff told us patients were also given copies of their scans which they retained for their personal records.
- Inpatient medical records were stored securely in the hospital. Staff told us that all paper patient records such as hand written notes or test results were scanned onto the computer system and checked to ensure that the scanned information was legible prior to the paper record being disposed of confidentially.
- The information governance team were responsible for auditing and maintaining the medical records system.

Safeguarding

- Staff had access to the safeguarding adults and children policies and procedures electronically or were able to refer to a hard copy which was held within the OPD. However, the safeguarding children policy dated November 2012, did not refer to the latest national guidance such as Working together to Safeguard Children 2013.

Outpatients and diagnostic imaging

- In the 'staff only' corridor there was a safeguarding flow chart which provided staff with details of how to report concerns and the contact details of social services. Staff also had access to the local authority children's safeguarding guidance including safeguarding flow charts dated October 2014.
- Records reviewed prior to our inspection and staff told us that there had not been any reported safeguarding issues in the department.
- There was a chaperone policy and we saw there were posters throughout the department advising patient how to access a chaperone should they wish to do so. Staff showed us the records that were maintained in the in the OPD, which included details of all examinations where a chaperone had been requested or had been provided.
- We were told that safeguarding training was mandatory for all staff and the level of this training depended on their role. As training records and numbers of staff completing safeguarding training were present for the hospital and not broken down for the outpatients we were unable to confirm how many staff had completed safeguarding adults or children's training.

Mandatory training

- There was a training policy in place which outlined the mandatory training staff were expected to complete. This included fire, health and safety, basic life support (BLS) or intermediate life support (ILS) and manual moving and handling.
- Training was delivered either via e-learning modules or face to face sessions. Staff told us that they were provided with time during their shift to complete the required training modules, which was recorded on the rota. However, on review of the duty rotas for September to December 2014, a period when staff stated they had completed training, we could not see specific allocated 'training time', therefore were unable to confirm that this approach was taken.
- The manager told us that all staff had completed the provider's mandatory training programme and this was linked to the appraisal system. The training matrix for the OPD provided showed that most staff had completed their mandatory training.
- Staff had all received corporate training called 'World Class' which they reported as beneficial in developing patient and working relationships.

Assessing and responding to patient risk

- Staff said that the majority of patients that attended the OPD, imaging and physiotherapy departments were considered to be 'low risk' as they were attending either pre or post operatively for planned procedures such as orthopaedic and cosmetic surgery. The imaging department manager reported that scenario training for staff to deal with emergency situation was carried out and essential as the radiographers given contrast mediums and there was a risk of patients reacting.
- Venous thromboembolism risk assessments were carried out as part of the pre-assessment procedure, prior to admission.
- Staff we spoke with said that all patients attending for cardiology tests such as ambulatory electrocardiogram (ECG) and stress echocardiograms were risk assessed on arrival using a assessment tool prior to starting the tests. We were told if staff had any concerns they would contact the RMO in full first time for advice and the RMO would make a decision on whether it was safe to proceed with the test.
- We were given an example of a tool used to risk assess patients prior to and during specialist cardiac test such as trans oesophageal echocardiogram, a test to take pictures of the heart and blood vessels.

Nursing, physiotherapy and imaging staffing

- There was an on-going recruitment programmes in the department, for example the OPD manager was appointed in September 2014 and five new staff nurses had recently been recruited, three who were in post at the time of our inspection and two were due to start in January 2015.
- The department always had a nurse in charge on duty who had responsibility for resolving any patient or staffing issues that occurred or what were management arrangements
- Staff said there were adequate staffing levels to enable the clinics to run effectively. Staff told us that the department did not use agency staff and any shortfalls in staffing due to sickness were covered by the provider's bank staff.
- To cover the regular children's clinics a children's nurse had been recruited and was due to start in January 2015. However, we were informed by the Chief Nursing Officer (CNO) that the hospital did not intend to develop services for children in the OPD.

Outpatients and diagnostic imaging

- Staff told us that the workforce was stable with the majority of physiotherapists and radiographers being employed for a number of years.
- Staff said that there was good cross cover of staffing between the Lister Hospital and a sister hospital for cardio-physiologist. This ensured that safe staffing levels could be maintained and unavoidable staff sickness could be covered.

Medical staffing

- We were told that over 521 consultants had practicing privileges at the hospital and could therefore see patients in the OPD. We were not provided with information to demonstrate how many of these doctors regularly saw patients in the OPD.
- There was a process in place for granting and reviewing practicing privileges, this was via the medical advisory committee. We were told that the majority of doctors granted practicing privileges also worked in local NHS hospitals. Staff told us that the majority of doctors usually attended promptly for their clinics and could be easily contacted if they needed advice.
- There was a resident medical officer (RMO) present in the hospital 24 hours a day, seven days a week to provide medical support across the hospital.

Major incident awareness and training

- Staff we spoke with were aware of the hospital's major incident plan and understood what actions to take in the event of an incident such as a fire.
- The hospital had a business continuity plan in place and staff reported that in the week prior to the inspection, the business continuity and major incident plan was invoked due to the telephone cables being cut by an external contractor. This incident had affected the imaging department as MRI/CT scans could not be downloaded and viewed in the usual way. The manager told us that to avoid disruptions to treatment or delays in reporting results backup systems such as putting scans on discs using reporting facilities at a nearby local hospital were used. Staff also said that while the systems were not functioning paper records were maintained until electronic recording had been restored.
- The manager told us that a debriefing session had been carried out post the incident and learning had been identified, including maintaining a paper record of staff contact details, routinely stored electronically.

Are outpatients and diagnostic imaging services effective?

The outpatient, physiotherapy and imaging department worked collaboratively within a multidisciplinary team across the hospital. We found that some policies did not reflect up to date national guidance. Patient feedback was positive and they were able to access the service for medical consultations, physiotherapy and diagnostic imaging easily.

Patients were provided with pain relief via a prescription if required. Staff were competent and qualified to carry out their roles and professional registration and pre and post employment checks were carried out.

There was a draft provider audit plan in place for 2014 and some audits relating to the diagnostic imaging department had been completed. The imaging department adhered to national guidelines and had effective systems in place for monitoring radiation levels administered for diagnostic treatments, interventions and patient outcomes.

Evidence-based care and treatment

- There was a provider draft audit plan in place for 2014, that identified the monthly and quarterly audits to be undertaken within each area to assess compliance with local and national standards such as IR(ME)R that were relevant to the imaging department.
- The imaging department manager told us that the department local audits were undertaken to monitor the effectiveness of care and action was taken if improvements were required. Monitoring was undertaken to ensure staff had received updated radiation training and IR(ME)R X-ray standards were discussed at the team meeting. Minutes of these meetings and staff we spoke with confirmed these discussions had taken place.
- The audits undertaken monitoring of local practices including CT scanning IR(ME)R and x-ray form completion against best practice guidelines. The results of the audits undertaken in the last three months showed that some improvements were required such as ensuring that the date of female patients last menstrual cycle was recorded. We noted that action plans to improve practice had been developed were necessary.

- A Radiation Protection (RP) and IR(ME)R external audit carried out on 07 November 2014 showed that the department had systems in place to ensure safety and best practice guidelines were adhered to. The report confirmed that between December 2013 and November 2014 there had not been any adverse dose reports and that the department was meeting national requirements. The report identified concerns as Diagnostic Reference Levels (DRL's) guides were not present. The manager told us and we saw that these were now present in all x-ray rooms.
- The Radiation Protection meeting minutes dated 11 November 2014 showed the RP and IR(ME)R audits were discussed alongside the RPA annual report for 2014. An action plan following the external audit covering the recommendations made was due to be completed by 24 January 2015 by named individuals to ensure that national guidelines were complied with. We were unable to confirm that this action plan had been completed at the time of our inspection.
- Staff we spoke with in the imaging department were aware of the national guidance relating to agreed radiation doses for X-rays.
- National policies, such as NICE guidelines were not always used to inform local policies and procedures. For example only five of the 17 generic policies we reviewed referred to the most recent national guidance. While the resuscitation policy and the management of possible pregnancy for imaging referred to the most recent national guidance, the safeguarding children policy dated November 2012, did not refer to the latest guidance. The policy referred to a safeguarding publication dated 2006 and not the updated version 'Working together to Safeguard Children' 2013.

Pain relief

- Staff said that pain was assessed on an individual basis but no specific pain assessment tool was used, Patients undergoing minor surgical procedures were provided with a prescription to obtain analgesia if required.
- There was no specific paediatric pain assessment tool and the guidance for staff on paediatric pain relief, available in the OPD guidance was undated.

Competent staff

- Medical, nursing and allied health professionals such as physiotherapists and radiographers were required to submit evidence annually of evidence that they held a registration with the appropriate professional body. Medical staff were also requested to provide details of their insurance indemnity.
- There was a process in place for ensuring that all medical practitioners received appraisal and revalidation. The provider had a revalidation officer (RO) who was responsible for over seeing this process and completing the Designated Body Statement of Compliance as required by NHS England Medical Revalidation Programme.
- The department managers told us that the information relating to staff's registration with their professional body was collated by the human resources department and they were informed of any issues or lapses. We were told that staff who did not have active registrations were not allowed to work.
- The OPD manager told us that some medical staff were accompanied in clinic by their own nursing staff, who assisted them in clinics. The same requirements regarding registration, training and Disclosure and Barring (DBS) applied and these checks were carried out by the consultants. However, this information was given informally to the managers, there was no formal process in place for the managers to receive written confirmation that all the checks had been completed.
- Three recently employed members of staff told us that their pre-employment checks had included submitting an application, interview, references, DBS checks and professional qualification checks had all been carried out prior to the staff starting work at the hospital.
- All staff participated in annual appraisals which included their individual learning needs being identified and a review that they had completed the required mandatory training. The appraisal rate was reported to be 100% by the OPD manager, staff confirmed this verbally and evidence was not requested.
- We were told all radiographers had a competency assessments completed and continuous professional development (CPD) in the past year. The manager told us that all staff were required to be up to date in order to meet safety requirements. Two staff shared the supervisor radiation protection role and had received updates.
- The OPD manager told us one to one supervision for the staff had recently been introduced and would be offered on a monthly basis.

- The physiotherapy and imaging department managers told us the arrangements for supervision for their staff were informal due to the low numbers of staff.
- Staff told us that they had received a provider and local induction to familiarise them with their role. A recently appointed nurse told us they had a copy of their induction programme which contained information on policies and procedures as well as details relating to mandatory training requirements.

Multidisciplinary working

- Staff told us that they felt there was effective multidisciplinary team working across all specialities. The physiotherapist gave an example of a change in practice and the development of a discharge care pathway that had been developed and shared with the ward areas.
- We observed the majority of staff working as a team and providing support to ensure that care, treated and the patient journey was well managed.
- The staff from the cardiac OPD told us that they were supported by staff from a sister hospital and provided cross site cover to cover unavoidable sickness to ensure the service for patients was not disrupted as patients getting care was " top of their list".

Seven-day services

- The outpatients service did not provide a seven-day service. All outpatient clinics were provided Monday to Friday 08.00 am-20.00pm and 08.00 am-13.00pm Saturday service.
- The pharmacy department was opened Monday - Friday: 08.30am – 19.00pm, Saturday: 09.00am – 12.30pm
- There were 24 hour seven day a week on-call arrangements for pharmacy and imaging. The manager of the pharmacy department said that there was always cover and that although they were not often called out of hours by OPD staff if a prescription was urgent they would be called into the hospital.
- The manager of the imaging department told us that there was 24 hour seven day a week cover provided for urgent scans

Access to information

- Patient information was available in the clinics and imaging department. This was given to patients prior to consultation or treatment being carried out. This included information about diagnostic tests and advice leaflets for patients following procedures that included the injection of contrast mediums. We noted this information was only available in English.
- The department displayed posters outlining the importance of informing staff if patient's thought they could be pregnant.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us that they received Mental Capacity Act (2005) and Deprivation of Liberty Safeguards training as part of the mandatory safeguarding training. It was not possible to extrapolate specific training data for outpatient staff. Overall the data provided by the training records seen during our inspection showed that 78% of staff had attended safeguarding adults and 88% had attended safeguarding children at level one and two.

Are outpatients and diagnostic imaging services caring?

All patients attending the outpatients, physiotherapy and imaging departments we spoke with felt that the care and services provided met their needs. Staff were caring, compassionate and supportive. Patients and relatives told us they felt involved in the decisions about their treatment and were positive about staff communication and the information provided.

Compassionate care

- Patients told us they were treated with dignity and respect and that felt that their privacy was maintained at all times. Consultants and nursing staff ensured all patient consultations took place in private rooms and we noted that sensitive information was never discussed in public areas.
- Patients said staff were professional at all times. We observed staff knocking and waiting prior to entering consulting rooms.
- Patients told us they were happy with the care they received in all departments involved in their care, which included physiotherapy and diagnostic imaging. One patient said the staff were "fantastic". Another patient said the nursing staff were "very good and the doctor was perfect".

Outpatients and diagnostic imaging

- We observed positive interactions between staff and patients in the outpatient, physiotherapy and imaging departments. However, during our inspection we hear a consultant speak very loudly and disrespectfully to a member of staff. The situation was promptly managed by senior nursing staff to ensure patients were not alarmed and the member of staff was supported.

Understanding and involvement of patients and those close to them

- Patients told us they felt involved in all aspects of their care and treatment and staff provided support and advice. One patient told us that they had been supported in their decision regarding reconstructive surgery and been given information leaflets.
- Staff told us that the consultants answered most patient queries regarding treatment and they would ensure the patients understood their treatment before they left the department.
- The OPD, imaging and physiotherapy department carried out monthly patient satisfaction surveys and the OPD manger said the response rate was not high. However, despite requesting the response rate and findings of these surveys, this information was not received.
- We were told that patient satisfaction outcomes were discussed regularly at the management team meeting to identify any specific issues.

Emotional support

- Staff told us that a high percentage of patients attending the hospital were Arabic and to assist with communicating with these patients the physiotherapy department had put together some phrases in Arabic to promote the patients understanding of key elements of their treatment.
- Staff told us they provided support for patients and we observed staff in the gait clinic providing positive encouragement to a patient attending for treatment.

Are outpatients and diagnostic imaging services responsive?

The OPD, physiotherapy and diagnostic imaging service met the majority of the needs of patients. The service provided outpatient clinics at times requested by medical staff.

There was a variety of written information but this was only available in English, however staff were able to access interpreter services when required. Complaints were investigated and changes to practice implemented to prevent recurrence of similar issues.

Service planning and delivery to meet the needs of local people

- The outpatient, imaging and physiotherapy departments had recently been refurbished to improve facilities for patients. Improvements included redecoration and new furniture**.**
- The out patient and imaging departments had separate waiting areas with comfortable seating areas. Although we noted in one outpatient clinic which was busy, there was insufficient seating for the number of patients and their relatives attending. While staff had obtained additional seating this resulted in the area being cramped and making it difficult for some patients to move easily.
- There was not a dedicated children outpatient area, toys were available in clinic waiting areas and a children's trained nurse was present in children's clinics to meet their individual needs.
- The outpatient clinics were arranged at the request of individual consultants and provided a flexible, as required service. Consultants with practicing privileges liaised with the OPD managers to arrange the use of the consulting rooms as and when required, in the majority of cases these requests were met. Staff told us that if necessary they were usually able to arrange clinics at short notice to meet the needs of patients.
- The imaging department manager told that us that a business case had been submitted to purchase a new CT machine which would improve the quality of the scans undertaken. At the time of our inspection this business case had not been approved and therefore we were unable to confirm these improvements were due to be implemented.
- The physiotherapy manager had identified the need for specialist services and staff with specific skills. For example the need for a daily a gait clinic.

Access and flow

- Most patients who attended the outpatients department were self referred or referred by their general practitioner.

Outpatients and diagnostic imaging

- Patients reported that they had not experienced any delays and staff said that the majority of the clinics ran to time. If delays did occur nursing and reception staff kept patients informed about the length of the delay and the reasons.
- One patient told us that they had been sent to the hospital by her general practitioner for a MRI scan and had been waiting 20 minutes. We were told that staff had verbally apologised and explained that there would be a wait for the procedure to be carried out as the appointment had not been per-arranged.
- The OPD manager told us that the clinics usually ran to time and the clinics did not have a high cancellation rate, although we were not provided with information about the numbers of patients who failed to attend their appointments.

Meeting people's individual needs

- The hospital entrance included a ramp to facilitate easy access for people using wheelchairs or those with mobility problems. All clinics and department were accessible via a lift and additional support was provided by the potering staff.
- Translation services could be accessed via language line for people whose first language was not English.
- A variety of information leaflets were available in all the outpatient departments but only in English. Staff told us leaflets could be accessed in other languages, large print or Braille if required. However, there were none on display and we did not see any notices indicating that people could access information in other languages.
- There were no facilities for easy read information leaflets for people with learning difficulties.
- All clinics had been fitted with induction loops to support people with hearing needs.

Learning from complaints and concerns

- Information on how to make a complaint was easily available in the outpatients waiting areas.
- The hospital's complaints process included ensuring all written complaints were acknowledged within two days and responded to within 20 days following the completion of an investigation into the complaint.
- Staff told us they were aware of the complaints procedure and how to report and escalate any concerns raised by patients or their relatives.
- The OPD manager told us that all complaints were logged and investigated. There had been two complaints received by the department between September and December 2014, both related to the cost of treatment.
- We were told that all complaints were reviewed hospital wide by the senior management team to identify trends. Complaints management was also discussed on a quarterly basis at the quality governance and safety meeting attended by representatives from across the hospital. Discussions included the progress on investigating complaints and the resolution reached.
- The physiotherapy manager told us that they received very few complaints and that where possible they endeavoured to resolve any concerns that were raised verbally preventing the need for patients to make a formal complaint.
- The physiotherapy manager provided evidence of learning from complaints using a recent complaint that involved the physiotherapy department and the inpatient services. The complaint related to a complex discharge plan that had not been implemented appropriately. Changes that had been made as a result of learning from this complaint included a revised discharge care plan being developed and the contact details of local social services teams being obtained and made available to staff. Training sessions on the management of complex discharges had also been organised and feedback provided to staff at team meetings across the OPD and ward services.

Are outpatients and diagnostic imaging services well-led?

The outpatient, physiotherapy and diagnostic imaging departments had identified leadership and reporting lines for staff and mangers. There was no formal documented vision or strategy for the outpatient department staff were aware and shared the hospital and corporate vision.

The senior management team were visible and accessible; department managers were said to be supportive and approachable.

Vision and strategy for this service

- The outpatient, imaging and the physiotherapy managers were all aware of the corporate vision to

deliver high quality and cost effective care across all services. However, we were told that there was not a locally agreed strategy or vision for the outpatient and imaging department.

- All staff we spoke with were clear about the hospital's vision and values and the majority of staff had attended hospital wide meetings regarding the development plans for the hospital's services
- The individual managers we spoke with all had their own vision for their department but this had not been shared with staff, documented or approved as the way forward for the development of services and not included in the corporate vision.

Governance, risk management and quality measurement

- The performance information provided relating to all outpatient clinics provided by the provider, which were not part of this inspection and were not specifically related to services provided at the Lister Hospital. Therefore it was not possible to extrapolated the data that related to the outpatient services provided at the Lister hospital.
- Staff told us that discussions about complaints, incidents and risks were a part of their regular team meetings.
- There were a range of monthly meetings attended by departmental managers at which quality was discussed, these included the Quality Improvement and Patient Safety meeting, and risk management meetings. Issues identified at these meetings were escalated to the quarterly Quality Governance meetings and the senior management team.
- The OPD, imaging and physiotherapy service managers were aware of the key risks for their service and the risks that were currently on their departmental risk registers. For example the imaging manager told us an audit carried out between March and September 2014, identified a error rate of 10% for voice recognition in the dictation of results. This had been added to the risk register and mitigating actions identified and were being implemented to reduce this risk.

Leadership of service

- The majority of the managers in the department had been in post for a number of years and provided a stable leadership team. The OPD manager had started in September 2014 and had completed her induction programme.
- There were identified reporting arrangements for all managers, for example the OPD manager reported to the CNO and the physiotherapy and diagnostic imaging managers reported to the chief operating officer.
- Staff told us that senior managers were accessible and visible within the hospital and were positive about the hospital management team.
- Staff reported that the OPD, imaging and physiotherapy managers were approachable and supportive. Some staff stated that regular formal one to one meetings were provided and that this was helpful, whilst other staff told us that they met their managers on a daily basis and were able to have informal supervision meeting when needed.
- Team meeting were held regularly and staff told us they could access their managers and discuss any concerns on a daily or as when required basis.

Culture within the service

- Staff told us that they felt there was an open and transparent culture within the hospital. They felt confident in challenging poor practice if necessary and were aware of the whistleblowing policy and procedure.
- Staff said that there was generally good communication within teams and regular verbal daily handovers were undertaken in all departments.
- The majority of staff reported that there was a good working relationship between clinical and non-clinical staff and that they felt valued by their managers..

Public engagement

- Staff told us that they received regular feedback from monthly departmental patient surveys that were carried to seek the views of patients about the care they received.
- Patients attending outpatients clinics were given a questionnaire which sought their feedback on the service they had received. This feedback had not been analysed at the time of our inspection and therefore we were unable to assess if it had resulted in changes to services.

Innovation, improvement and sustainability

Outpatients and diagnostic imaging

- There was a proposal to introduce a speech and language therapist (SALT). Minutes of the May 2014 management team meeting submitted confirmed discussions had taken place about the introduction of this post, although this service was not in place at the time of our inspection.

Outstanding practice and areas for improvement

Outstanding practice

- Staff were caring and compassionate and focused on meeting individual patient needs.
- The infection surveillance data base was linked to the nursing electronic record and the microbiology / pathology laboratories to ensure there was adequate oversight of infection prevention and control issues.
- The hospital used an electronic system to record patient's observations and if the score triggered a NEWS alert the RMO and outreach nurse were alerted electronically.
- The hospital falls prevention programme incorporated innovative technology to reduce patient falls and minimise harm. This is in keeping with national patient safety initiatives.
- The patient menu had been planned with the input of a dietician, this provided an extensive range of high quality food that met all patients needs.

Areas for improvement

Action the hospital MUST take to improve

- Ensure that all staff in the critical care unit have the appropriate skills, knowledge and competencies and that these are in line with national guidance.
- Implementation effective systems to monitor, review all patient death and disseminate the learning from these reviews.
- Implement formal systems and process to maintain a record to demonstrate all nurses accompanying medical staff hold an appropriate registration and have completed a Disclosure and Barring (DBS) check.

Action the hospital SHOULD take to improve

- Ensure that practices and policies reflect up to date national guidance and best practice.
- Ensure that the process in place which ensures a consultant can be reached in unplanned situations should be explicit.
- Review its provision of care to patients with cognitive impairment such as dementia, to ensure staff have an understanding of how to assess and meet the needs of this group of patients.
- That all services such as the endoscopy unit are accredited with the appropriate body or have a plan in place to demonstrate how the unit is working towards accreditation.
- Review national audits and identify those that they are eligible to participate in.
- Take action to ensure all incidents are appropriately investigated and the outcomes shared with staff.
- Consider extending peer observational audits of the use of the WHO surgical checklist to include larger sample sizes and across all theatre lists.
- Continue to review the practicing privileges granted to consultants to ensure there is an accurate record of those consultants who regularly work at the hospital and that they meet the hospital's criteria for being granted these privileges.
- Ensure that there is evidence that MDT meetings take place across all specialities.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers There were no effective systems in place to monitor and review all patient death and disseminate the learning from these reviews.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing There were insufficient numbers of suitably qualified, skilled and experienced nurses working in the critical care unit and the numbers did not reflect national guidance for this clinical area.