Nuffield Health Taunton Hospital

Quality Report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Outstanding

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out this inspection as part of our programme of independent healthcare inspections under our new methodology. The comprehensive inspection was carried out through an announced visit on 12 and 13 July 2016. We did not carry out an unannounced inspection.

We rated this hospital as good overall. Our key findings were as follows:

Are services safe at this hospital?

- The hospital had a good track record on safety. In the year April 2015 to March 2016 there were no never events, serious injuries or deaths reported and no cases of hospital-acquired infection.
- There was a culture in which staff were encouraged to report concerns or incidents. Staff told us they were confident to raise concerns and that these would be dealt with. There was evidence of learning and improvement following incidents.
- The hospital was clean and staff observed appropriate precautions to prevent and control infection.
- Premises and equipment were mostly well maintained, fit for purpose and used correctly and safely.
- Pre-operative assessment of patients took place to ensure early recognition of co-morbidities which may present risks in relation to surgery.
- Surgical safety checklists were used in theatres and staff used early warning scores to ensure they recognised and supported deteriorating patients.
- Staff followed safe systems in respect of the management of medicines.
- Staff were appropriately trained and familiar with their responsibilities to safeguard vulnerable people.

Are services effective at this hospital?

- Patient care was delivered following recognised national guidelines, standards and best practice recommendations.
- The rate of unplanned readmissions was low compared with other providers.
- Patients' pain was assessed and managed appropriately.
- There were robust arrangements in place for granting and reviewing practising privileges.
- Staff told us they were encouraged and supported to acquire more skills and develop professionally.
- Staff, teams and services worked together to deliver coordinated care and treatment.

Are services caring at this hospital?

- Staff engaged with patients in a friendly and caring manner.
- Staff treated patients with dignity and respect.
- Privacy was maintained at all times.
- Patients were extremely positive about the care and treatment they received.
- Patient feedback was consistently positive. Friends and family scores for the period April 2015 to March 2016 were on average 95.6%.

Summary of findings

Are services responsive at this hospital?

- Services were organised so that they met people's needs.
- The hospital exceeded the national standard which requires that NHS patients should wait no longer than 18 weeks from GP referral to consultant-led treatment.
- Patients were offered a degree of choice with regard to the consultant they saw, their appointment time and payments methods (where appropriate).
- Patients attending outpatients and diagnostic imaging departments told us they were seen promptly at their appointments.
- Diagnostic imaging results were reported promptly to ensure treatment could progress without delay.
- Services took account of the individual needs of people, including those in vulnerable circumstances.
- The service had taken steps to support patients living with dementia. There were dementia link nurses who acted as a source of advice to colleagues and who had raised awareness of the needs of this patient group.
- People's concerns and complaints were listened and responded to sensitively, and learning was used to drive service improvement.

Are services well led at this hospital?

- Local managers were highly respected, visible, approachable and supportive. They worked well as a team to drive service improvement, while maintaining a culture which supported happy and motivated staff. Managers provided good role models and encouraged cooperative, supportive relationships among staff. Staff felt respected, valued and supported.
- There was a well-publicised and well understood corporate mission, supported by a set of values and behaviours. Staff were signed up to these and had been engaged in applying them to their place of work. All staff we spoke with passionately articulated shared values, focused on patient-centred care and compassion, which underpinned their work.
- There were high levels of staff satisfaction throughout the hospital Staff were proud of the organisation as a place to work. There was effective communication and engagement with staff and they were encouraged to raise concerns or make suggestions for improvement.
- There was an effective governance framework. Information was regularly reviewed to provide a holistic view of performance, which included patient safety, patient satisfaction and clinical outcomes. Risks were well understood, regularly discussed and actions were taken to mitigate them. External peer review of the hospital included a review of governance arrangements to ensure their continued effectiveness.
- The hospital encouraged, welcomed and acted on feedback from patients. There was openness and transparency when things went wrong and a constructive approach to learning from mistakes and supporting staff to improve their practice.

We saw several areas of outstanding practice, including:

- Staff had produced a video to promote hand-washing practice in a fun and innovative way.
- The hospital worked closely with a local sixth form college and had developed apprenticeships. Two healthcare assistant apprentices were employed in 2015, as well as a business office apprentice in the finance team.

Summary of findings

- Staff told us they felt well supported in terms of their ongoing education and development. Staff with a particular interest in a field were supported to develop in the area, irrespective of grade or designation within the organisation. This recognised the value of all levels of clinical and non-clinical staff. A number of 'lunch and learn' sessions had been held to share knowledge amongst all staff groups.
- There was a dementia working party established in the hospital. Staff members of this group were very proactive in improving their understanding of dementia care and had attended further self-study courses in their own time. Learning from these courses was then shared with other hospital staff.
- Staff had taken steps to support patients living with dementia. One bedroom had been adapted with appropriate signage and large face clocks to enable patients living with dementia to identify areas within their room. Patients living with dementia were identified by the use of a blue pillow case and a 'forget me not' symbol on the patient's record. This ensured that all staff involved in their care were alerted the fact that these patients may require extra support.
- There was a group of 'dementia friendly' staff who had made 'twiddle muffs'. These are knitted hand muffs with items such as ribbons and buttons attached. They are used to provide a source of visual, tactile and sensory stimulation for people living with dementia who have restless hands.
- The patients' forum had recently been re-launched and provided opportunities to capture recent patient experiences first hand. There was evidence that patient feedback and suggestions had been acted on swiftly to improve patient experience.

However, there were also areas where the provider needs to make improvements.

The provider should:

- Ensure that clinical procedures, where there is a risk of bodily fluids being spilt, should not take place in consulting rooms with carpet under foot. If unavoidable then appropriate risk assessment and IPC advice to be sought and adhered to.
- Ensure that resuscitation equipment checks are thorough and equipment is replaced when out of date or damaged.
- Ensure that mandatory training records are up-to-date and accessible for governance purposes.
- Undertake temporary remedial work in theatres, pending the theatre replacement scheduled for 2017, to make good cracked doors, which had the potential to harbour bacteria.
- Continue to take steps to improve record keeping, including the completion of risk assessments, recording of patient observations, early warning scores and clinicians' signatures and counter-signatures.
- Ensure that falls risk assessments are completed in pre-assessment clinics.
- Consider that where audit reflects a risk, such as lack of falls assessments being completed, that appropriate action is taken and monitored via the relevant governance forum.
- Review documentation used to record risk assessments of VTE and ensure that patients' records clearly show all risk factors present and the reasons for the choice of preventative treatment.
- Ensure that theatre staff sign separately for the supply, administration and disposal (if appropriate) of medicines in the controlled drugs register.
- Review the use of printed stickers on medicines administration charts so that there is sufficient space to document all medicines prescribed and administered.

Summary of findings

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Start here...
Outpatients and diagnostic imaging	Good 	Start here...

Summary of findings

Contents

Good

Nuffield Health Taunton Hospital

Services we looked at:
Surgery; Outpatients and diagnostic imaging.

Summary of this inspection

Background to Nuffield Health Taunton Hospital

Nuffield Health Taunton Hospital is an independent hospital, which is part of the Nuffield Health corporate group. It provides inpatient and outpatient services for adults. Services are provided to both NHS and privately funded patients.

Nuffield Taunton provides routine, non-urgent elective surgery for adults. Surgery is not provided for patients below the age of 18 years.

There are 25 inpatient beds which are accommodated in single rooms with en-suite facilities. In addition, there are eight day case beds, provided in single rooms.

There are three operating theatres, two of which are equipped with laminar flow (a specialised air filtration system) and a recovery area with five bays. There are two minor procedures rooms, two consultation rooms a recovery area with two bays and a laser area.

Surgical specialities provided include general surgery, including breast and colo-rectal surgery, minor orthopaedic surgery, dermatology, vascular surgery, gynaecology, ophthalmology, cosmetic and oral maxillofacial surgery. Endoscopy procedures also carried out.

The outpatients department consists of seven consulting rooms, an eye room and a treatment room. There are two pre-assessment rooms for patients attending for day case or inpatient surgery.

Diagnostic imaging services provided include plain X-ray, fluoroscopy, ultrasound, and mammography. Magnetic resonance imaging (MRI) is provided by a third party provider.

Physiotherapy services are provided to support inpatient and outpatients. Facilities include three treatment rooms and a gym.

Our inspection team

Our inspection team was led by:

Elaine Scott, Inspector, Care Quality Commission

The team included three CQC inspectors, including a pharmacist inspector and a variety of specialists: a consultant surgeon, a theatre matron and a retired senior outpatients nurse.

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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 two core services at the Nuffield Heath Taunton Hospital

• Surgery

• Outpatient and diagnostic imaging services.

Prior to the announced inspection, we reviewed a range of information we held about the service.

We carried out this comprehensive inspection as part of our in depth inspections of independent hospitals. Our inspection was carried out through an announced visit which took place on 12 and 13 July 2016. During our visit we spent time on the ward, in the outpatients department and the diagnostic imaging department, observing the treatment and care provided. We also

Summary of this inspection

spent time in the operating theatres, recovery, and the endoscopy department. We spoke with the management team of the hospital, the chair and vice chair of the medical advisory committee, a variety of staff, including nurses, healthcare assistants, doctors, therapists, radiographers, department managers and support staff. We also spoke with patients and relatives.

Information about Nuffield Health Taunton Hospital

Nuffield Health Taunton Hospital was converted from a residential home in 1974 to a small private unit serving the local community. The hospital has been extended over the years and now comprises three theatres, two wards, a minor operation suite, radiology, pathology, physiotherapy, pharmacy and 41 bedrooms. There are plans to upgrade the theatre suite, including the endoscopy department in 2017. The hospital provides outpatient and diagnostic imaging services, and surgical services (inpatient and day case), to both NHS and privately funded adult patients. The hospital ceased providing services to children and young people on 1 July 2016.

The registered manager and hospital director is Sasha Burns. She has worked at Nuffield Health for three years, following two years as hospital director for another provider. She has over 10 years' clinical experience as a radiographer in various roles in both the private sector and the NHS. She is also the designated Controlled Drugs Accountable Officer.

Nuffield Health Taunton Hospital was last inspected by CQC in January 2014, prior to the introduction of the new fundamental standards and our new inspection methodology. At our previous inspection we found all of the areas we inspected to be compliant.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	☆ Outstanding	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	☆ Outstanding	Good
Overall	Good	Good	Good	Good	☆ Outstanding	Good

Notes

The effectiveness of outpatients and diagnostic imaging services was not rated due to insufficient data being available to rate these departments' effectiveness nationally.

Good

Surgery

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Outstanding

Information about the service

Surgical services are provided for adults undergoing a variety of procedures on a day case or inpatient basis. The majority of patients attending the hospital for surgery are self-funded (insured or self-paying), with the remainder of patients being NHS-funded. Between April 2015 and March 2016, 42% of inpatient activity was NHS-funded, while 58% was privately funded.

Facilities comprise three theatres (two with a laminar flow air filtration system), and an endoscopy suite, with a shared recovery area. There are two wards, Luttrell and Kennedy, comprising 25 single bedrooms for overnight stay and eight single rooms for day case patients. All bedrooms have en-suite facilities.

The primary surgical service provided is orthopaedics, including spinal surgery, supported by physiotherapy and a 'recovery plus' service for enhanced recovery. Other surgical specialties include: ophthalmology, urology, general surgery, including bariatric and breast surgery, gynaecology, ENT, dermatology and cosmetic surgery. Between April 2015 and March 2016 there were 3683 visits to theatre.

We inspected the hospital, as part of our planned inspection programme, on 12 and 13 July 2016. During our inspection, we visited the wards, operating theatres and recovery area. We observed the care of patients on the ward, in the recovery area and during surgical procedures in theatre. We spoke with 12 patients, 62 staff, including nurses, student nurses, and medical staff, operating department practitioners, therapists, support staff, and senior managers. We reviewed comments cards which patients had completed prior to our inspection.Start here...

Summary of findings

We rated surgery as good overall because:

- Openness and transparency about safety was encouraged and staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Performance showed a good track record and steady improvements in safety.
- When something went wrong, people received an explanation, and a sincere and timely apology.
- Staffing levels and skill mix were planned and reviewed to keep people safe at all times.
- Systems, processes and standard operating procedures in infection control, medicines management, record keeping and the monitoring and maintenance of equipment were mostly reliable and appropriate to keep patients safe.
- People using the service received effective care and treatment which met their needs.
- Care and treatments were planned and delivered in line with current evidence-based guidance, standards and best practice legislation. New evidence-based techniques were used to support the delivery of high quality care and staff worked collaboratively to understand and meet the range of people's needs.
- Patients were respected as individuals and were empowered as partners in their care.

Good

Surgery

- We received consistently positive feedback from patients about the way staff treated them.
- Staff were highly motivated and inspired to offer compassionate care and promote people's dignity.
- People's emotional and social needs were highly valued by staff and were embedded in their care and treatment.
- The needs of different people were taken into account when planning and delivering services.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Complaints and concerns were taken seriously and responded to in a timely way.
- The leadership, governance and culture promoted delivery of high quality, person-centred care.
- There was a clear statement of vision and values.
- The board and other levels of governance within the organisation functioned effectively and interacted with each other appropriately.
- The service was transparent and leaders at every level prioritised high quality compassionate care.
- There was a positive staff culture where innovation was encouraged and supported, particularly in the development of dementia care.
- There was a well-publicised and well understood corporate mission, supported by a set of values and behaviours. Staff were signed up to these and had been engaged in applying them to their place of work. All staff we spoke with passionately articulated shared values, focused on patient-centred care and compassion, which underpinned their work.
- There were high levels of staff satisfaction throughout the hospital Staff were proud of the organisation as a place to work. There was effective communication and engagement with staff and they were encouraged to raise concerns or make suggestions for improvement.
- There was an effective governance framework. Information was regularly reviewed to provide a holistic view of performance, which included patient safety, patient satisfaction and clinical outcomes. Risks were well understood, regularly discussed and actions were taken to mitigate them. External peer review of the hospital included a review of governance arrangements to ensure their continued effectiveness.
- Local managers were highly respected, visible, approachable and supportive. They worked well as a team to drive service improvement, while maintaining a culture which supported happy and motivated staff. Managers provided good role models and encouraged cooperative supportive arrangements among staff. Staff felt respected, valued and supported.
- The hospital encouraged, welcomed and acted on feedback from patients. There was openness and transparency when things went wrong and a constructive approach to learning from mistakes and supporting staff to improve their practice.

However,

- We found theatre doors that were cracked and worn; these imperfections had the potential to harbour bacteria and/or to allow fragments of material to fall into sterile areas.
- Patients' records were not always complete. Risk assessments were not consistently documented, entries were not always signed or counter-signed as required and early warning scores and patient observations were not consistently recorded.
- Although risk assessments for the development of a venous thromboembolism (VTE) had been completed, the number and type of risk factors present were not recorded. Where preventative treatment (thromboprophylaxis) had been prescribed, the reason for the choice of treatment was not documented. We reported to the hospital director at the conclusion of our inspection that the risk assessment documentation in use was not fit for purpose because it did not allow clinicians to record all of the necessary information.
- We saw in theatres that staff did not always sign separately for the supply, administration and disposal (if appropriate) of the medicine in the

Good

Surgery

controlled drugs register. Pharmacy staff told us they had identified this in their quarterly hospital controlled drug audit and had discussed it with the theatre manager. The issue was raised at the hospital medicines management meeting and was to be reviewed in the next quarterly audit.

- We saw one prescription and administration chart where staff had used printed stickers, instead of handwriting on the prescription chart. The doctor had not dated the prescription as required. Staff had applied two stickers to the front of the chart where doctors prescribed pre-medication and once only medicines, so there was no space for doctors to write additional prescriptions clearly. This practice could increase the risk of mistakes occurring.

Are surgery services safe?

Good

By safe, we mean that people are protected from abuse and avoidable harm.

We rated safety as good because:

- Systems, processes and standard operating procedures in infection control, medicines management, record keeping and the monitoring and maintenance of equipment were mostly reliable and appropriate to keep patients safe.
- Staffing levels and skill mix were planned and reviewed to keep patients safe at all times.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Staff were able to respond to signs of a deteriorating patient and medical emergencies.
- When things went wrong investigations were timely and learning from incidents was implemented.

However,

- We found theatre doors that were cracked and worn; these imperfections had the potential to harbour bacteria and/or to allow fragments of material to fall into sterile areas.
- Patients' records were not always complete. Risk assessments were not consistently documented, entries were not always signed or counter-signed as required and early warning scores and patient observations were not consistently recorded.
- We found, on inspection of patients' records that although it was evident that risk assessments for the development of a venous thromboembolism (VTE) had been completed, the number and type of risk factors present were not recorded. Where preventative treatment (thromboprophylaxis) had been prescribed, the reason for the choice of treatment was not documented. We reported to the hospital director at the conclusion of our inspection that the risk assessment documentation in use was not fit for purpose because it did not allow clinicians to record all of the necessary information.

- We saw in theatres that staff did not always sign separately for the supply, administration and disposal (if appropriate) of the medicine in the controlled drugs register. Pharmacy staff told us they had identified this in their quarterly hospital controlled drug audit and had discussed it with the theatre manager. The issue was raised at the hospital medicines management meeting and was to be reviewed in the next quarterly audit.
- We saw one prescription and administration chart where staff had used printed stickers, instead of handwriting on the prescription chart. The doctor had not dated the prescription as required. Staff had applied two stickers to the front of the chart where doctors prescribed pre-medication and once only medicines, so there was no space for doctors to write additional prescriptions clearly. This practice could increase the risk of mistakes occurring.

Incidents

- Staff we spoke with were aware of, and appeared knowledgeable and confident about reporting incidents. Staff had access to an online reporting system.
- Staff gave us examples of when they might report incidents, for example, when operations were cancelled at the last minute. Staff said there was a 'no blame' culture in the service and they felt empowered to report incidents without fear of reprisal.
- There were no never events in the reporting period (April 2015 to March 2016).
- No deaths or serious incidents were reported in the same period.
- Some staff told us they did not always receive individual feedback for incidents they reported; however, staff told us that when they requested feedback following an incident it was provided quickly, and in some instances, within 24 hours.
- Where learning from incidents needed to be shared, staff told us there was a good flow of information to ensure all parties were informed and up-to-date.

Duty of Candour

- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person in relation to the incident and an apology. Staff we spoke with were mostly aware of this duty. Those who seemed unclear were not familiar with the regulation but understood the principles and were able to give examples of when they may apply duty of candour. We were provided with an example, where duty of candour had been applied following a complaint from a patient. The complaint had highlighted a serious incident, which had been fully investigated. The patient had been kept informed throughout the process. The hospital shared with the patient an honest account of the event, the steps taken to prevent reccurrrence, and an apology.

Safety thermometer or equivalent (how does the service monitor safety and use results)

- The hospital used the NHS Safety Thermometer to monitor patient harms, for example, falls, pressure ulcers, venous thromboembolism (VTE), hospital acquired infections and catheter associated urinary tract infections. Pressure ulcers are damage to the skin caused by pressure from being in the same position. VTE is a blood clot, which forms in a vein, often in the leg, which can cause harm to patients.
- The service monitored safety via an electronic incident reporting system. Information gathered through this system was reported in governance meetings and monitored through a quality dashboard.
- There were quarterly audits conducted to monitor compliance with the WHO checklist. In an audit conducted in February 2016 compliance with the checklist was rated 'green' for all aspects of the checklist, except the requirement to conduct a debrief at the end of the operating session, which scored 'amber'. Nuffield Taunton Hospital was taking steps to improve this by engaging with surgeons and theatre staff.

Cleanliness, infection control and hygiene

- The hospital's patient-led assessment of the care environment (PLACE) scores for February 2015 to June 2015 were the same or higher than the England average for cleanliness.
- In the period April 2015 to March 2016 there were no reported cases of Clostridium difficile (C. diff), Methicillin-resistant Staphylococcus Aureus (MRSA) or Meticillin Sensitive Staphylococcus Aureus (MSSA) or Escherichia Coli (E-Coli).

Good

Surgery

- There were no surgical site infections for breast, gynaecology, upper gastrointestinal and colorectal, urological or vascular surgeries.
- The rates of surgical site infections from primary hip replacement and spinal surgeries were lower than the average of NHS hospitals.
- The rate of infections from primary knee replacement surgeries was the same as the NHS average.
- Patients were screened in pre-operative assessment clinics for MRSA. If this infection was identified, all staff were informed and appropriate measures were taken to ensure safe and dignified management of the patient continued.
- Pre-operative Chlorhexidine showering had been introduced as an important pre-operative measure to prevent surgical site infection. Chlorhexidine is an antibacterial agent used as an antiseptic.
- Patients were given advice on post-operative wound care to help maintain a healthy healing process.
- In May 2016 an infection prevention team ran a campaign to promote safe surgical care through improved hand hygiene. Promotional posters were displayed for both staff and patients and a patient survey was carried out to assess whether patients saw staff clean their hands. The results showed 77.5% compliance. Nursing staff and healthcare assistants were fully compliant; other staff groups scored less well. An action plan stated that the results would be shared with the medical advisory committee to encourage medical staff to ensure that they made the cleansing of their hands visual to the patient. The infection prevention team were also tasked to target some staff groups with refresher training.
- Staff had produced informative videos which were incorporated into staff training. We saw 'no more dirty talk' which highlighted the risks associated with bacteria present on mobile phones and the importance of not having them in the workplace. Staff had also recorded 'the hand washing song' which promoted the importance of correctly washing hands in the clinical environment.
- Staff were bare below the elbow to facilitate effective hand washing and reduce the risk of bacteria. We observed staff washing hands between patients.
- Protective equipment, such as gloves and aprons, were available and we saw staff using them, where appropriate. We observed staff washing their hands between patients.
- The provider regularly audited hand hygiene. In an audit of hand washing facilities in August 2015 the hospital scored 89% overall. Compliance with surgical scrub procedures was 100%. In November 2015 the score for hand decontamination was 80% overall.
- The wards and theatres were visibly clean and on closer inspection showed a high level of cleanliness.
- There were clear waste segregation practices in place and we observed these were adhered to in theatre and on the wards. This included safe storage and disposal of sharps.

Environment and equipment

- Patient-led assessments of the environment took place each year. In 2015 the hospital scored 91% for the condition, appearance and maintenance of their premises. This was better than the national average.
- There were regular audits of medical devices and compliance was monitored both locally and centrally. Audits covered accessibility, functionality, servicing and maintenance, staff competence to use equipment and governance arrangements. In March 2016 the hospital scored 86% compliance overall.
- The theatre air filtration systems for laminar flow had annual checks to ensure compliance with UK Health Technical Memorandum (HTM 2025). However, they were due for renewal and were highlighted on the hospital's risk register. An increase in infection control monitoring was in place to monitor potential bacterial risks.
- All patient equipment we looked at had been routinely checked for safety with visible portable appliance testing (PAT) stickers demonstrating when the equipment was next due for service. This included infusion pumps, blood pressure and cardiac monitors, as well as patient moving and handling equipment, such as hoists.
- A Nuffield Hospital central hub provided sterile services and supplies. Surgical instruments were readily available for use and staff reported there were no issues with supply. Instruments could be prioritised for a quick return if required.
- Surgical instruments were compliant with Medicines and Healthcare products Regulatory (MHRA) requirements.
- Overall, the theatres and clinical areas were visibly clean and well managed; however the building was listed and

looked worn in some areas. We found theatre doors that were cracked; these imperfections had the potential to harbour bacteria and/or to allow fragments of material to fall into sterile areas.

- At the time of our inspection Nuffield Taunton Hospital was not complying with the Joint Advisory Group (JAG) on gastrointestinal endoscopy requirements. JAG Accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the endoscopy global ratings standards. The hospital was working towards accreditation.
- There were plans in place to upgrade the endoscopy suite in order to comply with regulations concerning the decontamination of endoscopes. This work was to be undertaken as part of a planned theatre refurbishment project which was due to commence in 2017. Prior to the works a number of measures were being undertaken to protect patient safety, including increased frequency of high level cleaning and monitoring of air flow. The plan included replacement of all existing wall and floor coverings and repairs to floor and ceilings.
- Staff were aware of the reporting process for faulty equipment.
- The ward and theatres each had a portable resuscitation trolley. The trolleys contained medication which was to be used in the event of a cardiac arrest. We saw a daily checklist which had been completed to show that all trolleys had been checked to ensure equipment was available and in date. The resuscitation trolley located in theatres had a tamper-evident tag to alert staff to any unauthorised removal of equipment.

Medicines

- We visited the pharmacy department, theatres 1, 2 and 3, recovery, endoscopy, and the wards. We looked at the arrangements for managing medicines, including controlled drugs, and found these arrangements to be safe and effective.
- Systems in place for administration of medicines meant that nurses were able to give patients their medicines at times appropriate to the individual concerned.
- Medicines were available when needed within the hospital. The hospital pharmacy opened from 8:30 am to 4.30pm, Monday to Friday, with arrangements for access outside of these hours.
- Nursing staff and medical staff were able to access emergency packs of take home medicines for patients if these were needed when the pharmacy was closed. Staff told us they were able to access the pharmacy out of hours in an emergency but rarely needed to do this. There was also an on-call service available and information about how to access emergency medicines outside the hospital if necessary.
- The pharmacy provided a weekly topping up service to the theatre areas and the ward. Staff were able to make additional orders if needed. The pharmacy staff checked stock every three months to make sure it was suitable for use. Systems were in place to identify any medicines with a short expiry date so pharmacy staff could replace them at the appropriate time. We found one out of date medicine during the inspection, which staff immediately removed.
- Pharmacy staff visited the ward every weekday to monitor prescription charts, check the medicines patients brought in with them and discuss patients' take home medicines with them. Staff told us they thought the pharmacy system worked very well.
- Doctors prescribed people's medicines on specifically designed prescription and administration charts. We looked at eight of these records. Prescriptions met legal prescribing requirements and staff recorded patients' allergies. Staff recorded the medicines they had given or used a code to record the reason if they had not given a medicine. Records showed staff gave medicines as prescribed and recorded the reason for any omissions. The pharmacy carried out regular audits of the records to make sure they were completed correctly. The provider collected and shared this information so staff could see how they performed in relation to other services.
- Systems were in place to make sure that patients' take home medicines were available for them when they were discharged. Patients were encouraged to bring in their own medicines in their labelled containers so staff could administer these whilst they were in the hospital. Where possible, pharmacy staff labelled additional medicines dispensed ready for discharge, to reduce delays. During the inspection, we saw pharmacy staff dispensed prescriptions as soon as they were taken to the pharmacy and then delivered them to the patient.

- Emergency medicines were available. Staff checked these daily to make sure they were always safe for use. The pharmacy kept information about the expiry date of medicines so they could replace them as necessary.
- Medicines were stored securely and appropriately. Some medicines were stored in refrigerators. Staff recorded the fridge temperatures daily. Records showed these were kept at a safe temperature for storing medicines.
- Suitable arrangements were in place for storing controlled drugs such as wall-mounted strong boxes and double locked rooms. Controlled drugs are medicines which require extra checks and special storage arrangements because of their potential for misuse. We found that there were effective medicines management systems in place.
- Staff made suitable records of the use of these medicines to demonstrate they were looked after safely. However, we saw in theatres that staff did not always sign separately for the supply, administration and disposal (if appropriate) of the medicine in the controlled drugs register. Pharmacy staff told us they had identified this in their quarterly hospital controlled drug audit and had discussed it with the theatre manager. The issue was raised at the hospital medicines management meeting and was to be reviewed in the next quarterly audit.
- The service had an accountable officer responsible for the safe management of controlled drugs. Staff told us that either the accountable officer or the pharmacist attended the Controlled Drugs Local Intelligence Network meetings; they also provided quarterly information returns to the network. This helped to help promote the safe use of these medicines.
- Staff could access medicines information on the ward from a number of sources, such as the British national formulary and online. This included information about administering medicines to patients who had undergone particular procedures and may not be able to take solid medicines whole.
- Staff told us that nurses administering medicines had annual competency checks to make sure they followed safe practice.
- Systems were in place for staff to report, record and learn from medicines related incidents. The pharmacy was also part of a company-wide pharmacy network, which allowed staff to share learning from incidents that had occurred within their own and other services. This helped to prevent similar incidents recurring.
- We saw one prescription and administration chart where staff had used printed stickers, instead of handwriting on the prescription chart. The doctor had not dated the prescription as required. Staff had applied two stickers to the front of the chart where doctors prescribed pre-medication and once only medicines, so there was no space for doctors to write additional prescriptions clearly. This practice could increase the risk of mistakes occurring. Pharmacy staff told us they provided these stickers for the standard medicines used in a particular procedure performed in the hospital, to help improve the clarity of the prescriptions.

Records

- We reviewed 12 sets of patients' records. Records were paper-based. Nursing records were stored in the patient's room. Medical notes were stored in trolleys in the main ward office.
- Patients' records were multidisciplinary and we saw where nurses, doctors, and allied health professionals, including physiotherapists, had made entries that were also signed and dated.
- Integrated care records for day case surgery and long stay surgery were in use. These covered the entire patient pathway from pre-operative assessment to discharge; they included comprehensive care plans for identified care needs.
- Risks to patients, for example, from falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis, using nationally recognised risk assessment tools. However, we found incomplete documentation in several of the files we examined. We found missing signatures of clinicians, incomplete malnutrition universal screening tool (MUST) and falls risk assessments.
- Quarterly records audits were completed, reviewing a sample of 20 inpatient records. In the audit completed in the first quarter of 2016 the hospital scored 93% overall. An identified area for improvement was the countersigning by a registered nurse of entries completed by a healthcare assistant. This scored 78%.

We saw there were regular reminders issued to staff via staff meetings and noticeboard about the importance of accurate record keeping. Night sisters were tasked with auditing a sample of records when they were on duty.

Safeguarding

- Staff received safeguarding of vulnerable adults training (level 2) as part of their mandatory training.
- Staff demonstrated an awareness of potential safeguarding issues and procedures to follow for suspected or alleged abuse. All staff could tell us who the safeguarding lead was for the hospital, and knew where to seek advice how to make a referral.
- Both the hospital matron and the lead sister had completed level 3 safeguarding training.
- There was a designated adult safeguarding lead.
- There was a safeguarding and protecting vulnerable people policy and procedure, which provided guidance on safeguarding vulnerable adults.

Mandatory training

- There was a comprehensive induction, and a training and development needs analysis was undertaken to ensure all staff were trained and competent to undertake their role.
- All staff who worked at Nuffield Taunton Hospital were required to attend mandatory training to ensure they had suitable training to care for patients safely.
- Mandatory training records provided showed that, hospital-wide, compliance was consistently meeting the target of 85%, with most subjects achieving 96% and upwards.
- Compliance with mandatory training was monitored centrally by the Nuffield academy and heads of departments received weekly reports. Employees received monthly reports so that they knew when refreshers were due.

Assessing and responding to patient risk

- A nurse, consultant and anaesthetist assessed patients in pre-operative assessment clinics prior to surgery. This was to ensure early recognition of co-morbidities which may present risks in relation to surgery. Any concerns or additional input required were communicated to the ward and theatre prior to the patient's admission.
- The World Health Organisation (WHO), Five Steps to Safer Surgery safety checklist was embedded in daily practice in theatre and adhered to. This is a process recommended by the National Patient Safety Agency (NPSA) for every patient undergoing a surgical procedure. The process involves a number of safety checks before, during and after surgery to avoid errors. We observed four patients' procedures and saw that the checklists were followed and completed in full.
- There were quarterly audits conducted to monitor compliance with the WHO checklist. In an audit conducted in February 2016 compliance with the checklist was rated 'green' for all aspects of the checklist, except the requirement to conduct a debrief at the end of the operating session, which scored 'amber'. To address this, theatre staff now conduct the debrief during the 'closing up stage of the procedure. to ensure that all staff have input into the debrief.
- Risks to patients, for example, from falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis, using nationally recognised risk assessment tools. However, we found incomplete documentation in several of the files we examined. We found missing signatures of clinicians, incomplete malnutrition universal screening tool (MUST) and falls risk assessments.
- Patients were assessed for the risk of developing venous thromboembolism (VTE). This is a serious, potentially fatal condition associated with a blood clot that forms in the veins of the leg or the lungs. We found, on inspection of patients' records that although it was evident that a risk assessment had been completed, the number and type of risk factors present were not recorded. Where preventative treatment (thromboprophylaxis) had been prescribed, the reason for the choice of treatment was not documented. We reported to the hospital director at the conclusion of our inspection that the risk assessment documentation in use was not fit for purpose because it did not allow clinicians to record all of the necessary information.
- Risks relating to deteriorating patients were managed using a recognised assessment tool. The Modified Early Warning System (MEWS) records certain indicators to identify deterioration in a patient's clinical status and to identify when more care and treatment is required. Within the recovery department, we observed MEWS commenced as the patient woke from their anaesthetic and multiple observations were undertaken before the patient returned to the ward.
- Clinical audits were undertaken quarterly by sampling patient records. In the first quarter of 2016 only 60% of

records (12 out of 20 records) sampled evidenced that MEWS was completed at least twice while surgical patients were in recovery and before transfer to a ward. Four out of 20 records did not evidence that MEWS scores were calculated each time patients' observations were recorded. Only 30% (6 out of 20) records evidenced that the patient's temperature was monitored every 30 minutes intra-operatively.

- There was a service level agreement in place for the transfer of acutely unwell or deteriorating patients to the local NHS acute hospital.
- On discharge, patients were given the contact details for the ward so they could call if they experienced any problems. Staff maintained a record of these calls.

Nursing staffing

- Staffing levels and skill mix were planned in advance, based on booked hospital activity and patient dependency. They were reviewed again a week in advance of surgery and re-calculated accordingly.
- All patient dependency hours and staffing hours available were calculated approximately 24 hours prior to the shift commencing. They were reviewed again on a daily basis and if unanticipated changes occurred, adjustments to staffing levels were made to maintain patient safety.
- There were no vacancies for inpatient nurses and health care assistants between April 2015 and March 2016.
- Nursing staff sickness absence was less than 5% in the reported period, April 2015 and March 2016.
- Staff turnover for theatre nurses was below the national average from April 2015 to March 2016.
- Over the same period staff turnover for operating department practitioners and health care assistants was above the national average from April 2015 to March 2016.

Surgical staffing

- There were 104 consultant surgeons and anaesthetists who worked at Nuffield Health Taunton Hospital under a practising privileges agreement. Practising privileges were granted to consultants who agreed to practice following the hospital's policies and provided evidence of appropriate skills and registration.
- Consultants were required to be available within thirty minutes, for the duration of their patient's stay or to ensure that suitable cover was provided by a colleague from the same specialty. Anaesthetists were also required to be available for the first 24 hours of a patient's stay. There was a group of anaesthetists who provided an on call service and could support medical emergencies.
- A resident medical officer (RMO) was on duty at all times. There were two RMOs who alternated a week on/ week off, 24 hours a day, seven days a week. RMOs were provided by an agency, which had a standby doctor available, in the event of short term absence.
- There was no use of bank or agency staff in theatre departments from April 2015 to March 2016.

Major incident awareness and training

- We saw the hospital's major incident plan which looked suitable and sufficient. It outlined the process for managing and coordinating the hospital's emergency response in the event of such an incident.

Are surgery services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as good because:

Patients received effective care and treatment which met their needs.

- Staff were appropriately qualified and skilled to carry out their roles effectively and in line with best practice. They were supported to maintain and further develop their professional skills and experience.
- Staff worked collaboratively to understand and meet the range of patients' needs.
- Consent to care and treatment was obtained in accordance with legislation and guidance. Patients were supported to make decisions.
- Patients had access to a variety of methods of pain relief. Patients' pain levels were assessed, monitored and responded to appropriately.
- The rate of unplanned re-admissions was low compared with other providers.

Evidence-based care and treatment

- Care and treatment took account of current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed in line with the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE) guidelines and quality standards. For example, modified early warning scores (MEWS) were used to assess and respond to any change in a patient's condition. This was in line with NICE guidance CG50.
- Patients' needs were assessed throughout their care pathway. Clinical staff followed national recommended guidance relating to falls assessment and prevention, pressure ulcers, nutrition support and recognising and responding to acute illness.
- Policies and guidelines were in date and accessible to all staff on the hospital intranet.
- The service undertook a survey of patients' experiences undergoing endoscopy procedures in order assess levels of pain and discomfort during the procedure. They then installed a database system for endoscopy to capture live comfort scores, enabling them to collate trends and take actions where appropriate.
- Nuffield Health participated in the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) audit where applicable.

Pain relief

- Patients told us that pain relief was administered on time and when required.
- We observed staff regularly reviewing and recording patients' pain in the recovery area after surgery. If a patient had pain, staff administered pain relief and checked this had the desired effect.
- The hospital used a number of different medicines for relieving pain post-operatively, dependent upon the type of surgery. Information about the medicines prescribed, including how to use them and any side effects, was given to patients.
- We saw staff administer some medicines to a patient at lunchtime using a safe and caring method. Nursing staff told us they gave medicines to the patients they were looking after. They said they did not have set medicines administration times because this depended on when the patient had surgery and when their next medicines were due. Timing of pain relief, in particular, depended on what the patient had previously received, at what time and the patient's individual needs. A pain assessment tool was available for staff to use, to help patients describe their level of pain to staff.
- A pain audit was undertaken in October 2015 following patient feedback regarding increased pain within four hours of returning to the ward, following joint replacement surgery. The remit was to identify whether there was any correlation between the different anaesthetics used. The audit was inconclusive but following subsequent discussion with the clinical team and consultants, a decision was taken to introduce local anaesthetic administration for some patients to manage their pain more effectively.
- One of the findings from the pain audit was that those patients who had fasted for longer periods before surgery experienced more pain post-operatively. (Research has suggested that dehydration and malnutrition may increase pain). Following this audit, the hospital had introduced carbohydrate drinks for patients before surgery. There were plans to re-audit this.

Nutrition and hydration

- Pre-admission information for patients provided clear instructions on how long they should go without food and drink prior to surgery. Records showed checks were made to ensure patients had adhered to fasting times before surgery went ahead.
- We saw during a pre-operative assessment check for one patient, where it was identified the patient had consumed a soft drink too close to surgery. The surgery was cancelled in the patient's best interest.
- Staff followed best practice guidance on fasting prior to surgery. For healthy patients who required a general anaesthetic this allowed them to eat up to six hours prior to surgery and to drink water up to two hours before.
- We saw patients were screened for malnutrition and the risk of malnutrition, on admission to the hospital using a Malnutrition Universal Screening Tool (MUST).
- Staff told us they could refer patients to a dietician if this was required.

Patient outcomes

- There were eight cases of unplanned transfer of an inpatient to another hospital in the period April 2015 to March 2016. This was above average compared with

other independent acute hospitals. Unplanned transfers mostly took place; these were mostly at the request of the surgeon who wanted the patient closer to their main place of work in the event of complications.

- Six cases of unplanned re-admission within 29 days of discharge were reported in the same period. This was below average when compared with other independent acute hospitals. All re-admissions were investigated as adverse incidents.
- Nuffield Taunton Hospital participated in the Patient Reported Outcome Measures (PROMs) audits for NHS-funded patients. Patients were offered the opportunity to participate in the PROMS data collection if they had received treatment for hip and knee replacement, groin hernia repair and varicose veins. PROMS measures the quality of care and health gain received from the patients' perspective. For Nuffield Taunton Hospital results for hip and knee replacements were within the range of the England average, although there were above average health gains for groin hernia surgery.

Competent staff

- Staff had the necessary skills and experience to provide effective care and treatment.
- For theatre staff there was a process for completing competency checks. This process was started on induction. For ward staff, competency files for registered nurses and a Nuffield academy project for healthcare assistant competency checks were in place.
- Staff told us they were encouraged and supported to acquire more skills and develop professionally.
- Some nurses had undertaken further training as 'link' nurses. They were encouraged and supported to develop areas of interest and act as a source of advice and training for their colleagues. There were designated link nurses, for example, in medicines management, infection control and dementia care. The nurses attended regular meetings and updated ward and theatre staff about any changes to practice that were required.
- Staff told us about a range of training sessions which had been provided by different teams within the hospital. These were periodically provided at lunchtime, with lunch included, and were known as "lunch and learn". Topics had included breast care, post tonsillectomy bleeds, bariatric care, and dementia care.
- At the time of our inspection, 100% of nursing staff and 71% of health care assistants had undergone a recent performance appraisal.
- There were appropriate processes in place to ensure that all consultants' practising privileges were granted and renewed in accordance with regulations and the organisation's practising privileges policy. Practising privileges may be granted to medical practitioners by a hospital governing board to allow them to provide patient care and treatment within that hospital, subject to them providing certain evidence of their good character, qualifications, skills and experience and compliance with the terms and conditions of the practising privileges policy.
- All new applications for practising privileges and requests by consultants to undertake new procedures were discussed and agreed by the Medical Advisory Committee (MAC) before being approved. Practising privileges were authorised for defined categories of work, known as scope of practice, such as provision of anaesthetic services or consultation and minor procedures in the outpatients department, plus admission and operative procedures on in/day patients. We saw evidence of this in minutes of MAC meetings. Once approved by the MAC, consultants were sent a formal agreement to sign to agree to work in accordance with the organisation's practising privilege policy and within the scope of practice agreed.
- Practising privileges were reviewed every two years. The review was undertaken by the hospital director, in consultation, where necessary, with the MAC specialty representative, who had to be satisfied that the practitioner continued to practise within their defined scope of practice and could provide evidence of adequate training, competence and experience. Renewals were ratified by the MAC.
- The personal assistant to the hospital director maintained a database which contained details of all consultants' practising privileges records. We saw from the database; when practising privileges were due for renewal, confirmation of consultants' registration with the General Medical Council, confirmation that they had up-to-date indemnity insurance, an up-to date check by the Disclosure and Barring service (DBS) and details of their annual appraisal. For consultants whose main employment was in the NHS the appraisal was undertaken in the NHS and shared with Nuffield Health. There was a system in place which highlighted when

any of this information was due for renewal. At the time of our inspection one medical practitioner had not supplied details of their DBS renewal, which was 13 days overdue. In accordance with the practising privileges policy, practioners were required to renew their DBS check every three years. The personal assistant to the hospital director showed us a reminder letter which had been sent by email to this practitioner two days before the DBS was overdue. They told us they had been assured by the practitioner that a renewal had taken place but they had forgotten to present their documentary evidence when they were last present in the hospital. We were told that if the necessary documentation was not presented at their next visit, practising privileges would be suspended.

- The hospital's responsible officer had a good relationship with the medical director of the local NHS trust, where the majority of the consultants who worked at Nuffield Health Taunton Hospital worked. We saw that practising privileges for one consultant had recently been suspended due to concerns about their performance. Information had been shared with the practitioner's NHS employer and the two organisations had worked together to investigate concerns and take appropriate action, including the provision of appropriate support to the practitioner.
- The resident medical officers (RMOs) were interviewed by the patient care manager and the matron on induction and a requirement of employment was the completion of all mandatory training. Six monthly appraisals were also completed by hospital staff to feed back to the external company who supplied the RMO staff. This fed into their yearly appraisal and mandatory training performed by the company.

Multidisciplinary working (in relation to this core service only)

- A multi-disciplinary team (MDT) approach was evident across all of the areas we visited and was notably inclusive of managers and team leaders.
- In theatres we observed excellent communication and teamwork between staff members.
- When patients were discharged, the hospital worked well with external care providers and services. A letter was sent the patient's GP to inform them of the treatment and care provided.

Seven-day services

- There was a comprehensive on call rota consisting of a senior clinical team member, an on-call member of the senior management team, a full theatre team, a radiographer, radiologist, maintenance personnel, housekeeping staff and pathology staff. The senior clinical team member supported the ward team out of core hours; they provided telephone advice, when required and attended the hospital as required for more practical support. When on call, these staff members were required to remain within a thirty minute drive of the hospital and to be available at all times. A pharmacist was available for telephone advice and there was an agreement in place for out of hours' provision from Taunton and Somerset NHS Trust.
- Anaesthetists were required to be available for the first twenty-four hours of a patient's stay.
- The anaesthetists participated in an on call rota to support all other medical needs, including emergency returns to theatre. The anaesthetist on call would contact the appropriate physician for additional support and advice when necessary.
- There were two resident medical officers (RMO) who alternated a week on/week off. The RMOs were on site 24-hours-a-day, seven-days-a week.

Access to information

- All staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner. This included test results, risk assessments and patients' records.
- There were paper-based records for each patient; one for medical notes and one for nursing notes. Nursing records, including observation charts, were accessible in patients' rooms. This enabled consistency and continuity of record keeping while the patient was on the ward, supporting staff to deliver effective care.
- There were computers available on the wards, which gave staff access to patient and hospital information, for example, policies and procedures.
- Staff had access to general practitioner (GP) referral letters when patients attended pre-operative assessment clinics.
- Pharmacy staff received medicines alerts so they could check them and take appropriate action. We saw a file of the alerts received and a record of actions taken.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Good

Surgery

- Information about their planned surgical procedure was given to patients at their initial visit for assessment. Following admission, on the day of the procedure, formal consent was recorded by the surgeon conducting the procedure. We saw that the consent forms had been completed correctly and detailed the risks and benefits to the procedure, which had been explained to the patient.
- During our visit staff we spoke with were clear about their roles and responsibilities regarding the Mental Capacity Act (2005) and deprivation of liberty safeguards (DoLs).

Are surgery services caring?

Good

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

We rated caring as good because:

- Patients were respected as individuals and empowered in their care. They told us that they, and those close to them, were given information about what to expect and were kept well informed.
- Feedback from patients was positive about the way staff treated them. We heard of an example of staff 'going the extra mile' to help reassure an anxious patient with learning disabilities.
- Staff were highly motivated and offered compassionate care. We received many positive comments from patients. They commented on friendly porters and chatty and funny anaesthetists, who took their minds off their surgery. Nursing staff were described as attentive, responding quickly to calls for help. One patient said "they have been absolutely brilliant". Another patient told us "nothing is too much trouble". Patients told us that consultants visited them every day and inspired confidence.
- Staff took steps to ensure patients' dignity was maintained. We saw during the Five Steps to Safer Surgery safety checklist process, that staff treated patients with dignity in the operating theatre.

Compassionate care

- Without exception, patients told us staff were polite, friendly and approachable, always caring and respectful. Some patients welcomed the relaxed atmosphere, others praised the way staff treated them with dignity, and how nothing was too much trouble.
- We observed staff knocking at patients' doors before entering.
- We observed patients remained covered in the anaesthetic room, operating theatre, recovery areas and during transfers between ward and theatre in order to protect their dignity.
- The hospital had a chaperone policy in place. A chaperone is a person who accompanies a patient during an examination, for example, a female patient would be accompanied by a female member of staff when being examined by a male member of staff. Staff we spoke with told us every time a chaperone was required they were asked to assist.
- Staff treated patients as individuals and spoke to them in a kind and sensitive manner.
- We were given a positive example of staff going out of their way to protect the dignity and privacy needs of a patient with a learning disability. The hospital had recognised the patient needed to be supported in a sensitive way, and arranged for additional staff to care for this patient.
- The hospital used the friends and family test to capture patient feedback. Friends and family test results (hospital-wide) April 2015 to March 2016 showed that between 93% and 97% of patients indicated they would recommend the service to friends and family, with an average score of 95.6%.
- Patients who attended a patients' forum meeting in March 2016 were very positive about theatre staff. They said "the theatre staff and the anaesthetists were all lovely and the atmosphere was calming, which helps you when you are nervous". Recovery staff were described as "very attentive".

Understanding and involvement of patients and those close to them

- Patients and relatives told us they felt involved in their care. They told us they received full explanations of all procedures and the care they would need following their operation. We observed staff explaining to patients exactly what would happen after their operation.

Good

Surgery

- Patient records we looked at included pre-admission and pre-operative assessments; these took into account individual patient preferences.

Emotional support

- We saw staff providing reassurance for patients who were anxious. This included a nurse spending time with a patient, explaining what the patient should experience and how staff would help.
- Patients' anxiety was assessed as part of the admission process and continued to be monitored and recorded in their records.

Are surgery services responsive?

Good

By responsive, we mean that services are organised so that they meet people's needs. We rated responsiveness as good because:

- Waiting times, delays and cancellations were minimal and were managed appropriately.
- It was easy for people to raise a concern. Complaints and concerns were listened to, taken seriously and responded to in a timely way. Processes were in place to ensure that lessons were learned and used to improve the quality of care.
- Services were planned and delivered in a way, which met the needs of the individuals. The importance of flexibility, choice and continuity of care was reflected in the services.
- Access to care was managed to take account of people's needs, including those with urgent needs.
- A dementia working party had been set up in the hospital. Staff members of this group were very proactive in improving their understanding of dementia care and had attended further self-study courses in their own time. Learning from these courses was then shared with other hospital staff.

However,

- Family members or other members of staff were, at times, asked to assist with interpreting. The use of family or staff members is not considered best practice because staff could not be assured that the patient had given consent for information to be shared.

Service planning and delivery to meet the needs of local people

- Surgical lists were routinely planned between Monday and Friday. Occasionally, additional operating lists ran on a Saturday to meet demand. Patients were offered a choice of dates to best suit their needs.
- Limited parking was a common issue raised by staff and patients, and more so, when the mobile MRI scanner was parked across the front of the hospital every two weeks.
- There was good access to the hospital, including wheelchair access.
- Pharmacy staff told us that a recent patient survey had highlighted that patients felt they did not always have enough information about their medicines on discharge. In response to this, pharmacy staff told us they had looked at how they gave patients their take home medicines and made some changes to improve this. This included changes to the timing of providing information to patients. The next patient survey had shown an improvement in this area.
- Pharmacy staff told us they had made some staff changes recently. This had allowed them to look at how to work most efficiently and provide a more effective service to both the hospital staff and the patients. One member of staff was undertaking medicines reconciliation training, so they could contribute to this further. Medicines reconciliation ensures that medicines prescribed when patients are admitted to hospital correspond to those taken before admission.
- Pharmacy staff audited their service against standards in the Royal Pharmaceutical Society Hospital Audit. This had highlighted a possible area for improvement relating to patients pre-admission assessment. As a result, of this staff said they were considering how they could input into this to improve safety for patients, in relation to their medicines.

Access and flow

- People could access care in a timely manner. None of the patients we spoke with had any concerns or worries in relation to their admission, waiting times or discharge arrangements
- Between April 2015 and March 2016 compliance with the NHS target, which aims to ensure that patients receive consultant-led treatment within 18 weeks of referral, ranged between 83 and 97%.

- When patients' operations had to be cancelled, they were re-booked in a timely manner, within 28 days, and a suitable time agreed. In the last twelve months ten appointments were cancelled and this was due to an equipment failure.

Meeting people's individual needs

- The service took into account the needs of different people, including those in vulnerable circumstances.
- There was a dementia working party established in the hospital. Staff members of this group were very proactive in improving their understanding of dementia care and had attended further self-study courses in their own time. Learning from these courses was then shared with other hospital staff.
- Pre-operative assessment identified patients with complex needs, such as those living with dementia or patients with a learning disability. This allowed the staff to decide whether they could accommodate these patients or whether they should be referred to another healthcare provider who would be better able to meet their particular needs. Staff told us a carer would normally accompany patients living with dementia or those with a learning disability to their appointments and remain with them.
- We saw a dementia resource folder on the ward, which included information and resources to support staff care for patients living with dementia.
- Staff told us about adjustments they made to meet the needs of patients living with dementia. One bedroom had been adapted with appropriate signage and large face clocks to enable patients living with dementia to identify areas within their room. Patients living with dementia were identified by the use of a blue pillow case and a 'forget me not' symbol on the patient's record. This ensured that all staff involved in their care were alerted the fact that these patients may require extra support.
- There was a group of 'dementia friendly' staff who had made 'twiddle muffs'. These are knitted hand muffs with items such as ribbons and buttons attached. They are used to provide a source of visual, tactile and sensory stimulation for people living with dementia who have restless hands.
- Patients told us they had received sufficient information prior to their planned surgery. They were provided with both verbal and written information to ensure they understood the planned procedure and had clear expectations about their admission to hospital. They told us risks were explained to them.
- For patients whose first language was not English telephone translation facilities were available. However, during our conversations with staff it became apparent that family members or other members of staff were, at times, asked to assist with interpreting. The use of family or staff members is not considered best practice because staff could not be assured that the patient had given consent for information to be shared.
- On discharge, information was provided to patients about post-operative care and how to contact the service if they had any concerns.
- Patients were able to choose what they had to eat and drink and their dietary needs and preferences were catered for. Most of the patients we spoke with commented positively on the choice of food available.
- Menus were changed daily and there was a wide choice of hot and food available. There were separate menus for those with vegetarian or gluten free diets and other dietary preferences and requirements could be met as required. There were three set meal times but staff told us that patients could choose to have their meals at times to suit them. There were provisions kept on the ward and staff had access to the kitchen out of hours. The kitchen had sufficient food stocks to enable staff to supply sandwiches, soup, toast and cereals if patients were hungry at any time.
- Staff assisted people to eat and drink as required. Plastic beakers and adapted cutlery were available for those patients who were unable to use traditional crockery and cutlery. Finger foods were provided for patients whose coordination skills made it difficult to use cutlery.
- Patients were asked for their feedback about catering services. In May 2016 the hospital scored 95.2% in relation to menu choice, 96.4% in relation to quality of food and refreshment, and 95.3% in relation to how well dietary requirements were met.

Learning from complaints and concerns

- People's concerns and complaints were listened to and responded to and used to improve the quality of care.

Good

Surgery

- The hospital received relatively few formal complaints. Their approach was to pre-empt complaints by ensuring that patients had the opportunity to discuss concerns with a senior member of staff.
- A complaints register was maintained which showed that complaints were fully investigated and responded to in a timely fashion.
- We saw that complaints had been discussed with the staff involved, where they were identified, and systems and processes had been changed where appropriate.
- The hospital director took overall responsibility for the management of complaints in line with Nuffield Health corporate policy. If a complaint involved aspects of the clinical care of the patient, the matron was involved in the investigation, as well as the relevant head of department. This ensured that any learning form the complaint could be shared as appropriate.
- Complaints were regularly discussed by the hospital board at meetings of the clinical effectiveness committee, medical advisory committee, health and safety committee and heads of department meetings.
- We reviewed one complaint, which had been the subject of a root cause analysis. A root cause analysis is a detailed investigation to identify how and why a patient safety incident occurred. A patient had developed blistering, causing pain and discomfort following surgery. The investigation was thorough and identified a number of contributing factors. Records of the investigation showed that a number of remedial actions were taken in response to this complaint and the findings were shared with staff. Actions included a change in the substance used in pre-operative skin preparation, and a review of theatre equipment used post-operatively. The findings of the investigation were shared with the patient, demonstrating openness and transparency.

Are surgery services well-led?

Outstanding ☆

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We have rated this domain as outstanding because:

- Local managers were highly respected, visible, approachable and supportive. They worked well as a team to drive service improvement, while maintaining a culture which supported happy and motivated staff. Managers provided good role models and encouraged cooperative supportive arrangements among staff. Staff felt respected, valued and supported.
- There was a well-publicised and well understood corporate mission, supported by a set of values and behaviours. Staff were signed up to these and had been engaged in applying them to their place of work. All staff we spoke with passionately articulated shared values, focused on patient-centred care and compassion, which underpinned their work.
- There were high levels of staff satisfaction throughout the hospital. Staff were proud of the organisation as a place to work. There was effective communication and engagement with staff and they were encouraged to raise concerns or make suggestions for improvement.
- There was an effective governance framework. Information was regularly reviewed to provide a holistic view of performance, which included patient safety, patient satisfaction and clinical outcomes. Risks were well understood, regularly discussed and actions were taken to mitigate them. External peer review of the hospital included a review of governance arrangements to ensure their continued effectiveness.
- The hospital encouraged, welcomed and acted on feedback from patients. There was openness and transparency when things went wrong and a constructive approach to learning from mistakes and supporting staff to do better.
- Working arrangements with third parties were well managed. The hospital director met with the manager of the third party catering provider each month to discuss patient feedback in relation to choice and quality of food.

Vision and strategy for this this core service

- Nuffield Health's mission was "to support, enable and encourage people to improve their health and wellbeing in order to help them get the most out of life". A corporate strapline encapsulated the mission in the phrase "for the love of life". The mission was underpinned by a set or core values: enterprising, passionate, independent and caring and a set of behaviours, which were shortened using the acronym 'EPIC'. Although not all staff were not able to articulate

the Nuffield behaviours and values precisely, they spoke about compassion, honesty and openness, and never putting financial gain in front of patient care. Some quoted the strapline" "For the love of life". Staff told us they had attended an away day in 2015 where they discussed the values and behaviours and how they applied them in their roles. They felt that the values and behaviours were things they could relate to and which they applied in their working lives as a matter of course. "They are obvious, they come naturally".

- A business plan set out the hospital's strategy, which was aligned to its mission and values. Strategic objectives were measurable and quantifiable and the risks, challenges and strategies to address these were clearly set out. For example, there was management focus on staff succession planning in theatres where the age profile meant a number of retirements were anticipated. Preceptorships and apprenticeship schemes had been developed to address this risk.

Governance, risk management and quality measurement for this core service

- There was an effective governance framework. Information was regularly monitored and reported under CQC's five domains (safe, effective, caring, responsive, and well-led) to provide a holistic understanding of performance.
- Governance arrangements were set out in Nuffield Health Quality Governance Policy, supported by a suite of standing operating procedures and manuals. The policy set out the organisation's structure, the roles and responsibilities of the board and other committees to ensure that the organisation's quality service objectives were met.
- There was a clear committee structure within the hospital which ensured effective communication from ward to board and management oversight of all activity. A range of committees, including a health and safety committee, clinical effectiveness committee, infection prevention expert advisory group, and medical advisory committee, had clear reporting lines to the hospital board, as well as corporate committees and Nuffield Health board. Standardised agendas ensured that all key performance measures were regularly monitored and action trackers were used to monitor progress.
- There was good engagement with the consultant body via the medical advisory committee (MAC). The MAC represented the medical practitioners who practised at the hospital via specialty representative elected to the committee. This was a key forum for two way communication between the consultant body and the hospital management. The MAC chair met regularly with the hospital director and the matron (who also attended MAC meetings). MAC meetings were held quarterly and minutes were sent to all consultants, also summarised in one page flyer. An annual consultant survey was undertaken. Comments from the last survey include "I am universally happy with the level of support and equipment"; "well organised and efficient"; as a group of anaesthetists we have a good working relationship with the hospital director. She is approachable, trustworthy and responds to our concerns".
- The MAC had also elected a deputy chair, who undertook an advisory role of clinical governance lead. The MAC chair, deputy chair and matron met quarterly to discuss clinical incidents, including complaints, and to review relevant patient records. If any concerns in relation to consultant performance were identified, the clinical governance lead wrote to the clinician concerned. We saw some examples of this correspondence, which was supportive in tone. A quarterly report was then presented to the MAC.
- A monthly quality governance dashboard was produced and signed off by the senior management team. This reported compliance under CQC's five domains: safe, effective, caring responsive and well led. A clinical action log was maintained, which all clinical leads had access to and which was regularly discussed at departmental meetings, head of depart meetings, the clinical effectiveness committee and the board.
- A risk register was maintained. Low level risks were managed locally and we saw evidence that these were regularly reviewed and control measures discussed. There was a clear process by which moderate and high level risks were escalated and scrutinised by corporate governance committees and, ultimately, the board.
- A clinical action log was maintained, which all clinical leads had access to and which was regularly discussed at the clinical effectiveness committee and the board.

Good

Surgery

- There were regular provider management reviews (at least annual) to ensure that the quality governance framework was functioning effectively. These were undertaken by peer reviewers from within the Nuffield group. The last one had taken place in March 2016. Reviews covered: customer feedback (both patient satisfaction results and complaints) audit results, process performance and incidents, status of preventative and corrective actions review, approving improvements to products and services, approving improvements to the quality management systems and processes, approving resources required to meet improvement plans. The hospital had been rated 'green' in all domains. A number of improvement actions had arisen from the review and some of these had been completed. These included improving medical records storage on the ward and improving security in theatres. There was an ongoing action plan to improve nursing documentation, in particular, the recording of early warning scores.
- Working arrangements with third parties were well managed. For example, the hospital director met with the manager of the third party catering provider each month to discuss patient feedback in relation to choice and quality of food.

Leadership / culture of service related to this core service

- The senior management team comprised the hospital director, matron, finance manager.
- Staff told us that the matron and hospital director were visible and accessible. They said they were able to approach them without question for guidance and support when necessary. One member of staff told us "they are brilliant; you can go and see them anytime if you are concerned about anything". A number of staff told us about the support they had received from hospital managers and the human resources department when they had experienced difficult times, perhaps during illness, or following bereavement. One staff member told us "the support I received when I was off sick was incredible".
- Staff described their immediate managers and members of the senior team as having an 'open door' policy and providing 'excellent support'. The patient care manager (responsible for managing the ward and outpatients) regularly worked clinical shifts on the ward.
- Staff told us they enjoyed working at Nuffield Taunton Hospital and were proud to work there. Team work was cited by many as being the best thing about working there. Peer support and camaraderie within teams and between teams were common themes. One staff member told us "we are like a big family". They talked about a friendly atmosphere "where everybody smiles". One staff member said "I look forward to coming to work" another staff member told us "I love my job- you would be mad to work anywhere else." Students and newly qualified staff told us about the supportive transition and the welcome they had received when they started work.
- There was a culture of mutual respect and recognition. Staff felt valued and respected. They told us that mangers were on first name terms with all of the staff and always greeted them when they saw them. One staff member said "little things mean a lot - just knowing my name". Many staff told us about gestures of thanks from the management team. They had enjoyed strawberries and cream during Wimbledon week and Easter eggs at Easter. The hospital director had arranged one day for an ice cream van to park on site and staff had free ice creams.
- One staff member told us that good performance was acknowledged by consultants in feedback to heads of departments. Another staff member told us a consultant had funded their attendance at an external course and they were now able to cascade their knowledge to colleagues.
- Staff turnover in clinical areas was low and staff satisfaction was high. The service used the net promoter score, otherwise known as the leadership MOT to assess staff satisfaction. Scores overall had increased steadily year on year. The latest survey results (November 2015) were the 5th highest out of 33 hospitals in the Nuffield hospitals group, and overall, consistently higher than the average for the group. Some issues scored less well for theatre staff, in particular, in relation to work/life

balance. An action plan had been developed and steps were being taken to improve this through recruitment and rostering. Short term sickness levels were consistently below the Nuffield target of 3%.

- There was a culture of openness, honesty and transparency. Staff told us they felt empowered to raise concerns. When mistakes occurred there followed reflection, learning and support.

Public engagement

- There was a patients' forum held quarterly. This was facilitated by the sales and services manager and attended by the matron, patient care manager and the finance manager. The format the meetings had been amended so that patient representatives had recent experience of care and treatment at the hospital, rather than having an established membership. Two meetings had been held in this format and it was thought that they had been successful. Patients were taken through the patient journey from initial contact with the hospital, through outpatient appointments, diagnostics, admission, ward, theatre, recovery. They were asked to comment on visiting health professionals, such as physiotherapist and pharmacists and asked about the hospital environment, cleanliness and food. Patients then had lunch with the senior management team to discuss the matters raised. In some cases the management team were able to respond to issues raised immediately, in other cases they committed to take these issues away and discuss further.
- We saw in the minutes of the patients' forum meeting held in March 2016 that issues were raised about car parking and the mobile MRI scanner. The hospital director was able to share plans to optimise parking on the site and plans to install a permanent MRI scanner. An issue raised concerning draughty corridors was taken away for consideration, as was the limited choice of magazines in the waiting room. Minutes of the meetings were circulated with actions identified. The hospital director told us that one patient who had attended a patients' forum had raised a concern that, following a surgical procedure, they experienced some incontinence, which they had not been prepared for, and which had caused them some inconvenience on a long journey home. In response to this feedback the hospital reviewed the patient information leaflet for this procedure and supplied patients with incontinence pads.

Staff engagement

- The hospital was commended in its latest provider management review for its effective staff engagement.
- Staff told us that communication was effective in their workplace. There were regular staff meetings and team briefs. They were also able to attend other meetings within the hospital if they chose, for example governance meetings.
- Staff told us they felt their views were important to the management team and they were encouraged to provide feedback and make suggestions to drive improvement.
- Staff engagement forums were held from time to time. Open sessions had taken place in February and in June 2016. The hospital director presented key themes and important messages and this was followed by a feedback session. Records showed that a number of staff suggestions were actioned. For example, staff had been authorised to buy better fitting and more comfortable clogs for use in theatre and claim the cost back.

Innovation, improvement and sustainability

- The hospital had plans to replace operating theatres, commencing in 2017, and incorporating improvements to the endoscopy suite, which would enable JAG accreditation standards to be met.
- The hospital worked closely with a local sixth for college and had developed apprenticeships for healthcare assistants, who undertook a level three diploma in healthcare. A healthcare assistant apprentice was employed in theatres in 2015.
- A newly qualified theatre nurse commenced the Nuffield Health preceptorship course in 2015.
- The pre-assessment process was reviewed in 2015 and was now supported by an anaesthetist who reviewed all patients to ensure early recognition of co-morbidities which may present risks in relation to surgery.
- The hospital had introduced a ward staffing and productivity model to ensure 'right people, right place and right time, doing the right thing in the right way.'

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Outstanding

Information about the service

The outpatient and diagnostic imaging services at Nuffield Health Taunton Hospital are provided in a two storey listed building, and in the newer main building. The service consists of seven consulting rooms, including an eye room and a treatment room. There are two pre-assessment rooms where patients booked to undergo surgery have pre-operative checks completed. Outpatient consultations are also provided in two consulting rooms in the Healthstyle Suite, which had two minor operation/clinical procedure rooms and a laser therapy room, which doubled as a recovery room. Consultants from a range of specialties provided consultation and treatment via practising privileges. This means they were granted permission to practice in the hospital, subject to them providing evidence of their good character, qualifications, skills and experience.

A Patient Care Manager (senior nurse) manages the outpatients department and is responsible for managing the inpatient ward. The outpatients department is staffed by registered nurses and healthcare assistants.

There were 21,106 outpatient attendances between April 2015 and March 2016, of which 8,851 were first attendances and 12,255 were follow-up appointments. The majority of outpatient activity was self-funded or funded by private health insurance (82%), and the other 18% was NHS-funded. The hospital ceased providing services for children at the end of June 2016. The main specialities are orthopaedic, ophthalmic and bariatric surgery. There is a specialist bariatric team located in premises nearby.

Diagnostic imaging services include plain X-ray, fluoroscopy, ultrasound, and mammography. A third party provides magnetic resonance imaging (MRI) in a mobile unit, which attends the hospital twice a week. A radiology team leader manages the department.

Physiotherapy services are provided to support inpatients and outpatients. Facilities include three treatment rooms and a gym. The physiotherapy manager leads this service. The team of three physiotherapists provide treatment for outpatients and inpatients daily, 7.30am to 7pm, including weekends on a rota system, and out of hours on call for inpatients. Services provided include post-operative therapy for patients following orthopaedic surgery, mastectomy and gynaecological procedures. The physiotherapy team also provide acupuncture treatment and accepts self-referrals and GP referrals.

Pathology services were provided via a 'hub and spoke' arrangement, with the hub laboratory located off site.

During the inspection, we visited the Healthstyle suite, outpatients clinic, diagnostic imaging, pathology, and physiotherapy departments. We spoke with 21 staff members, including doctors, nurses, radiographers, laboratory staff, physiotherapists, receptionist and secretarial staff and managers. We met five patients and we observed care and patient interactions in all departments. We reviewed seven patient records.

The previous inspection in 2014 did not highlight any serious concerns.

Good

Outpatients and diagnostic imaging

Summary of findings

We rated the Nuffield Health Taunton Hospital outpatients and diagnostic imaging services overall as good because:

- The hospital director demonstrated exceptional leadership and was supported by a committed and competent senior management team.
- There was a high level of staff satisfaction; staff told us they were proud of their departments. Staff showed commitment to patients, their responsibilities and to one another.
- There were effective governance arrangements and performance, quality and safety were regularly monitored.
- There were reliable systems, processes and practices in place to protect patients from avoidable harm and abuse.
- Patient areas were visibly clean and tidy and staff complied with infection prevention practices.
- Service planning and delivery was patient focussed. Patients could access care and treatment in a timely way.
- The hospital managed the complaints process with efficiency and promptly resolved issues to the satisfaction of all parties.
- There was good governance and compliance with radiation legislation.
- Staff had the skills and competence appropriate for their role and they were supported to obtain new skills and share best practice.
- Staff engaged with patients in a friendly and caring manner and treated them with dignity and respect.
- Patients were extremely positive about the care and treatment they received.

However:

- Floor coverings in some treatment rooms were not appropriate.
- Pre-admission falls risk assessments were not routinely recorded. The incident reporting system recorded eight patient falls in the period January to April 2016. A recent audit highlighted the lack of falls assessment completion and there were no action plans to resolve this.
- Staff used family members to interpret when English was not understood. This is not considered best practice. A plan was in place to address this.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good because:

- There were robust systems in place for reporting and investigating incidents. Staff were encouraged to report incidents and were confident to do so. There was evidence of learning and changes made as a result of incidents.
- Outpatients and diagnostic imaging departments were fully staffed with suitably trained staff and there was evidence of continuous learning.
- The hospital scored well in cleanliness audits. Patient areas we inspected were clean and records showed that cleaning took place consistently.
- Patient records were appropriately stored in several locations on and off site.
- Equipment was appropriately tested and maintained. The required radiation protection checks to ensure equipment safety, quality checks and ionising radiation procedures were carried out in accordance with national guidance and local procedures.

However,

- The provider was unable to provide us with accurate and up-to-date information in respect of staff compliance with mandatory training. We could not therefore be assured that staff had the required knowledge of safety systems, processes and practices.
- Staff told us that clinical procedures took place in carpeted clinic rooms. The Department of Health (DoH) does not recommend carpet for use in rooms used for clinical procedures such as gynaecological examinations and tests. We saw no evidence that a risk assessment had been carried out with advice from the infection prevention control team or a clearly defined preventative maintenance and cleaning programme put in place, as recommended by the Department of Health.
- Pre-admission falls risk assessments were not routinely completed. The incident reporting system recorded eight patient falls in the period January to April 2016. A recent audit had also highlighted this area of risk but there was no documented action plan.

Incidents

- There were no never events, serious incidents or deaths reported in outpatients and diagnostics for the period April 2015 to March 2016. Never events are serious incidents that are wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at national level, and should have been implemented by all healthcare providers.
- During the same period, 11 clinical incidents were reported in outpatients and nine in diagnostic imaging. This is below average when compared with the seven other independent acute hospitals we hold this type of data for. The incidents did not demonstrate any clear themes.
- In the outpatients and diagnostic imaging departments staff were aware of their responsibility to report incidents. Staff were encouraged to, and were confident in reporting concerns. They confirmed the types of incidents they would report and these ranged from 'near-miss' events, such as wrong patient information recorded on documents, to incidents involving patient harm.
- Staff reported incidents on an electronic reporting system. Staff we spoke with told us that they were updated with the outcome of incidents. Feedback and lessons learnt from incidents were discussed with individual staff members concerned. Wider learning was cascaded to staff in team meetings, and staff bulletins and 'lunch and learn sessions'.
- During our inspection, we saw minutes of team meetings where incidents had been discussed and changes in practice made as a result. An example of this was when pathology samples were sometimes left in a black transit box in the department overnight instead of being stored in the pathology fridge. This rendered the samples unusable. New clear boxes were introduced which ensured that samples could be seen and this has prevented this happening any further.
- The senior nursing staff described an incident where blood samples had been wrongly labelled. Following the incident, a group learning opportunity was arranged to update all staff responsible for blood sampling.
- The hospital had a process in place to ensure radiation incidents were reported as required under the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). The diagnostic imaging manager acted as the

Radiation Protection Supervisor (RPS). This role is to oversee diagnostic imaging work, make sure local rules are followed, and the conditions imposed by the environment agencies via environmental permits and certificates of registration and authorisation are met.

- Staff in radiology confirmed results of critical, urgent or unexpected significant radiological findings, immediately to the referrer in accordance with Royal College of Radiologists (RCR) and national patient safety agency (NPSA) standards. This process was undertaken in person or by telephone and followed up in writing to ensure the information was passed as quickly and efficiently as possible.
- There were no safeguarding concerns raised by or recorded against the hospital and there were no expected or unexpected deaths in 2015. Mortality and morbidity cases were discussed at integrated governance meetings as required.

Duty of Candour

- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person in relation to the incident and offer an apology.
- Staff were able to give examples of what DoC meant and what their roles and responsibilities were.
- There had been one incident of unnecessary radiation exposure. Staff reported the incident appropriately to their radiation protection advisor (RPA), and informed the patient in accordance with the duty of candour (DoC) regulation 2015.

Cleanliness, infection control and hygiene

- All outpatients and diagnostic imaging waiting areas and clinical rooms were visibly clean and tidy. Staff had cleaning schedules for all clinic areas and records were consistently completed to show that areas had been cleaned.
- Separate hand washing basins, hand wash and hand gel dispensers were available in the departments and patient areas.
- Hand sanitizer points were available to encourage good hand hygiene practice.
- The hospital had appropriate arrangements for the safe handling and disposal of clinical waste and sharps.
- Staff adhered to the 'bare below the elbow' guidance, which enabled thorough hand washing to prevent the spread of infection between staff and patients.
- Staff cleaned examination couches and laid fresh paper sheeting between patients.
- There was an infection control link nurse in the outpatients department. They had attended an infection prevention and control training course in 2015 and produced a video with other members of staff to promote hand-washing practice in a fun and innovative way.
- Staff in the outpatients department were familiar with the infection prevention strategy and policy. Staff knew who to contact for infection prevention and control (IPC) advice and who the IPC link person was within their department.
- Personal protective equipment (PPE), such as gloves and aprons, were readily available for staff in all clinical areas, to ensure their safety when performing procedures. We saw staff used them appropriately.
- There were no cases of Clostridium difficile, methicillin-resistant Staphylococcus aureus, methicillin susceptible Staphylococcus aureus reported between April 2015 and March 2016.
- The outpatients department scored 93% in a hand washing and IPC audit for the period April to June 2016.
- The hospital participated in the hospital hand hygiene awareness day in May 2016 to promote best IPC practice. There was an audit which measured how often patients witnessed staff clean their hands. The hospital scored 77.5%. As a result of this, two actions were identified; the IPC links for each area were to target specific staff groups for refresher training and the matron was to raise this at the medical advisory committee (MAC) meeting in order to remind consultants of the importance of cleaning their hands in front of patients.
- The hospital scored 99% for cleanliness in the annually 'patient-led assessment of the care environment' (PLACE) audit (February 2015 to June 2015). These self-assessments are undertaken by teams of NHS and private/independent health care providers, and include at least 50%members of the public (known as patient assessors). They focus on the environment in which care is provided, as well as supporting non-clinical services such as cleanliness, food, hydration, and the extent to which the provision of care with privacy and dignity is supported.

- An upstairs consulting room had carpet floor covering and there was inconsistent information provided as to its use for clinical examinations. Staff in outpatients told us this room was used for gynaecological examinations such as pessary insertion, smears and high vaginal swabs, where spillage of body fluids may occur. We informed the hospital director of our concerns. They told us that clinical procedures should not have been taking place in these clinic rooms and that staff had been instructed accordingly. The Department of Health guidance (Health Building Note 00-10: Part A – Flooring, paragraph 3.115) states that carpets should not be used in clinical areas. This includes all areas where frequent spillage is anticipated. If carpets are to be considered for non-clinical areas (for example interview rooms, counselling suites, consulting rooms), it is essential that a documented local risk assessment is carried out with the involvement of the infection prevention control team and a clearly defined pre-planned preventative maintenance and cleaning programme is put in place. We did not see any evidence of this risk assessment.
- There was chandelier type lighting in the same room that was not easily accessible and we were unable to speak to the housekeeper to confirm how and when this was cleaned.

Environment and equipment

Diagnostic Imaging

- There were suitable safety arrangements in place in the diagnostics area to restrict access where x-ray and imaging equipment was in use. These included warning signs and red lights for 'in use rooms' for patients and staff, and specialist personal protective equipment for staff available in all rooms.
- The diagnostic imaging areas had lead lined tunics for use during imaging procedures and these were regularly checked for damage.
- Staff acknowledged some imaging equipment (plain film imaging) was ageing however, the machines were capable of carrying out safe and efficient diagnostic imaging and there were plans to update to digital x-ray equipment.
- A new mini-c arm x-ray machine had been purchased for use in the operating theatres but had not been used yet. Diagnostic imaging staff and clinicians had been trained and had plans to audit use.
- A radiation protection advisor (RPA) from an external organisation undertook equipment and paperwork audits and quality control checks were performed six weekly by Nuffield Health.
- A list of all equipment including model, make, age and serial numbers, was available in the department.
- Maintenance contracts and service level agreements were in place with external providers to service, maintain and repair equipment. Equipment maintenance contracts were checked and records showed all schedules were up-to-date. The performance of all equipment was satisfactory.
- The department had all required mandatory policies and procedures in place in relation to the radiation protection principles and regulations covered by IR(ME)R and the Ionising Radiations Regulations 1999 (IRR99).

Outpatients clinics

- The hospital scored 91% for the condition, appearance and maintenance of premises in the PLACE audit (February 2015 to June 2015). This was higher than the England average score of 90%.
- In the 2015 consultant survey: 67% of respondents indicated that the outpatients department facilities were of a good standard, 76% indicated that the consulting rooms were suitably equipped for their specialty, 72% indicated that the hospital was sufficiently flexible to accommodate their preferred consulting times. An action plan was in place to respond to identified areas of concern. Actions included a review of the age and suitability of all outpatients department equipment. A business case was submitted to convert first floor administration areas to additional consulting rooms but there was some concern that this would require better access for those with poor mobility and the hospital was investigating the installation of a chair lift.
- All equipment we checked met local and national safety regulations. There was evidence of electrical equipment testing and equipment was labelled accordingly.
- The laser protection advisor (LPA) had recently reviewed the service documentation about the laser therapy equipment, and we were informed during the inspection that all criteria had been met.
- The hospital had appropriate arrangements for the safe handling and disposal of clinical waste and sharps.

- Resuscitation equipment was stored in a treatment room in the outpatients department in a 'grab bag'. This allowed it to be carried outside if required, such as when the magnetic resonance imaging (MRI) unit was visiting. We saw a daily checklist had been completed consistently to show that the bag and its contents had been checked to ensure equipment was available and in date. On inspecting we saw that the bag-valve-mask, (a hand-held device commonly used to provide positive pressure ventilation to patients who are not breathing or not breathing adequately), was very creased and out of date. We informed the nurse responsible who organised for a replacement.

Medicines

- Medicines were available as needed within the hospital. The hospital had a pharmacy open from 8:30 am to 4:30 pm Monday to Friday, with arrangements for access outside of these hours.
- Patients were given prescriptions for medicines if needed. Patients could take these to the hospital pharmacy or a community pharmacy if this was more convenient, or the hospital pharmacy was closed.
- The pharmacy provided a weekly 'topping up' service for stock medicines. Staff were able to make additional orders if needed. The pharmacy staff checked stock every three months to make sure it was suitable for use. Systems were in place to identify any medicines with a short expiry date and pharmacy staff replaced them at the appropriate time. This meant the correct medicines were available for staff to use.
- Medicines in the outpatients department and Healthstyle suite were kept safely in locked cupboards and fridges. We checked a range of medicines and all seen were in date. The nursing staff checked expiry dates weekly.
- There were no controlled medicines stored in outpatients or diagnostic imaging.
- Staff recorded medicine fridge high and low temperatures daily to ensure medicines were stored at the correct temperature. We saw records of this which had been recorded consistently.
- The pharmacy issued prescription pads to each consulting room and staff kept them in locked cupboards. If a prescription was required, the consultant asked the nurse to unlock the cupboard and one prescription was issued at a time. The pharmacy tracked and monitored prescriptions and carbon copies of prescriptions on pads were returned to the pharmacy. However, we saw that patient details were only attached to the top copy. The patient took this copy, so the carbon copies did not show to whom the prescription had been given if any check were needed in future. Staff told us that the doctor recorded any prescriptions given to a patient in the patient's notes.
- The consultant radiologist prescribed contrast medium (a radiopaque substance injected into a part of the body, to provide a contrasting background for the tissues in an x-ray or fluoroscopic examination) in the diagnostic imaging department. Administration and dosage was signed by the radiologist and radiographer and uploaded to the computerised radiology information system (CRIS).
- Contrast medium was stored in a locked cupboard within the department.

Records

- Nuffield Health medical records remained in the hospital for a minimum of twelve months post procedure, with a tracking system in place to identify the location of medical records in other departments within the hospital. There was a service level agreement (SLA) with a medical records storage facility for older medical records to be stored and retrieved (usually within a few hours).
- Consultants' own medical records were stored at the hospital for the duration of their patients' treatment. Consultants who had medical secretaries based outside the hospital took notes off site in order for them to be updated. Records were returned, usually the next day, to be stored on site in accordance with the Nuffield Health Information Risk Framework. Consultants and their secretaries were required to register as data controllers with the Information Commissioner's Office.
- Nuffield Health medical records were allowed off-site, unless being transferred to a storage facility.
- Records were stored in several locations throughout the hospital, dependent on whether they were NHS, Nuffield or consultant's private notes. We questioned whether this made it difficult to locate notes if they were needed at short notice but we were assured that this was not a problem.
- Medical records required for clinics were prepared the day prior to appointment. The incidence of patients being seen in outpatients without notes in the period January to March 2016 was less than 1%.

Good

Outpatients and diagnostic imaging

- Letters detailing the outcome of patient consultations were sent to patients' GPs.
- Diagnostic imaging referrals and requests were made on paper forms. Staff transferred this information onto the electronic CRIS record. Reports were produced electronically and paper copies were also sent to the referring clinician.
- We checked a sample of electronic and paper patient records within the diagnostic imaging department. They were completed correctly and fully. Records included imaging request forms, risk assessments, last menstrual period (LMP) checks and a modified World Health Organisation (WHO) checklist, (a proforma used to minimise risk related to patients undergoing procedures), in line with local policy and recognised national guidance.
- Radiology information was available to clinicians who needed it. All radiology images were stored on a picture archiving communication system (PACS) for easy access throughout the hospital. The staff were also able to access images from other hospitals via the Image Exchange Portal (IEP) system, thereby reducing the risk of repeated and unnecessary radiation exposure.

Safeguarding

- The hospital reported no safeguarding concerns between April 2015 and March 2016.
- The hospital matron and the patient care manager had undertaken safeguarding training at level three (advanced). The matron was the hospital's adult safeguarding lead.
- Staff training records showed that 93% of outpatients staff and 100% of diagnostic imaging and pathology staff had completed safeguarding vulnerable adults (level one) training.
- Staff were aware of their roles and responsibilities in relation to safeguarding and could describe what types of concerns they would report and the process they would follow. They knew how and where to access safeguarding policies and procedures. An example given of this was when a health care assistant (HCA) had noted that a patient from a nursing home had attended the outpatient department looking unkempt. This was escalated to the safeguarding lead, who contacted the patient's GP, the care home and a relative. All actions were in line with the Nuffield Health Safeguarding Adults Statement of Purpose which classified this incident as no harm and required informal action only.

Mandatory training

- The hospital delivered mandatory training using a combination of electronic learning packages and face-to-face learning. Staff completed their training during their work time. Mandatory training included basic life support, infection prevention and control, manual handling, fire safety and information governance.
- There was delayed recording of mandatory training. Data submitted by the hospital prior to the inspection indicated that their mandatory training was 97% compliant overall. The Nuffield target was 85% completion. Training compliance was recorded on an electronic tracker. Outpatients and diagnostic imaging mandatory training was mostly up to date, however basic life support (BLS) was shown as; outpatients 71%, reception 20% and diagnostic imaging 25%. Infection prevention practical; outpatient 79%, reception 20%, diagnostic imaging 50% and pathology 50%.
- Information provided by the hospital confirmed that the tracker was not up to date and that overall, clinical staff basic life support was 90%, with 15 members of staff out of 55 not up-to-date. There was no breakdown to confirm who the staff members were, so we were not assured that all outpatients and diagnostic imaging staff were fully compliant with mandatory training.
- Medical staff completed mandatory training at their employing NHS trust. There were assurance systems in place to ensure that they were up-to-date. Managers advised that any failure to meet mandatory training requirements would potentially lead to a suspension in practising privileges.

Assessing and responding to patient risk

- Staff in each department were clear about how to respond to patients who became unwell and how to obtain additional help from colleagues in caring for a deteriorating patient. The hospital had no emergency facilities and when patients became unwell or deteriorated during a consultation or minor procedure, an ambulance was called to take them to the nearest hospital with facilities.
- Signage for the radiology department was clear with radiation warning lights and yellow warning symbols evident.

Good

Outpatients and diagnostic imaging

- Staff followed a radiology 'six-point' checklist before using any radiological equipment. This confirmed the correct: name, address, date of birth, site, type of investigation, and previous imaging.
- Specific patient risks associated with diagnostic imaging procedures were considered in line with national guidance and statutory requirements, such as checking renal function for high risk patients undergoing investigations requiring intravenous contrast material.
- Staff followed Royal College of Radiologists guidelines for administration of contrast media and we saw that guidelines were available.
- The diagnostic imaging lead performed the radiation protection supervisor (RPS) role to ensure that equipment safety, quality checks and ionising radiation procedures were carried out in accordance with national guidance and local procedures. Evidence was seen that these checks and procedures were being completed correctly.
- The diagnostic imaging department manager had developed a strong and effective working relationship with their external radiation protection adviser (RPA). The adviser was accessible at all times during normal working hours, with an on-call service at all other times.
- All radiologist reports were checked prior to signing. Dictated reports were signed and verified by the radiologist and the administration team checked against the request form and also checked that the radiologist had not voice dictated something that did not make sense. This provided another level of safety by minimising risk of error.
- Staff used a modified World Health Organisation (WHO) checklist for patients undergoing minor procedures in the clinical procedures rooms. It was specific to minor operations and was in use for all appointments where outpatient surgical procedures were undertaken.
- The hospital provided an on-site blood audit release system (BARS), to securely manage and store blood required for transfusion. The system allowed the urgent release of blood units in emergencies.
- The outpatient pre-admission clinic staff carried out assessments for patients who were booked to undergo surgical procedures who required admission to hospital. This assessment would identify any risks from surgery to the patient, based on their medical history. We noted that falls risk assessments were not completed at this time. An audit of patient records performed by the hospital for the period April to June 2016 also identified this. There was no evidence of an action plan to rectify this.

Nursing staffing

- The outpatients department was fully staffed during the period April 2015 to March 2016. As at April 2016 there were 5.2 whole time equivalent (WTE) registered nurses (RNs) and 4.76 WTE health care assistants (HCAs) employed in outpatients. The Healthstyle suite had two full time and two part time RNs and one HCA.
- In the outpatients department the nurse manager worked within a weekly maximum hour allocation to cover the clinics. This meant that there was flexibility to have more staff on duty on the busier days, and less on the quiet days, rather than everyday fixed shifts.
- In the 2015 consultant survey 65% of respondents indicated that there was an appropriate level of nursing support for outpatient consulting. The action plan arising from this indicated that the outpatients department manager met with consultants to understand where support was not being given, and nursing rotas were changed to address this.
- Staff in the outpatients department told us there were sufficient staff on duty to provide safe and effective care to patients. This view was supported by consultants and patients. Staff told us clinics had never been delayed or cancelled due to staff shortages.
- Sickness levels were slightly below average when compared with the 13 independent acute hospitals we hold this type of data for. There were no unfilled shifts in outpatients from October to December 2015. We looked at duty rotas for the period January 2016 to May 2016, which showed how staff were utilised to manage the busier clinic days. The outpatient manager confirmed staff rostering was very fluid to meet the needs and demands of the consultants and clinic times.
- There was no use of bank or agency staff in the outpatient department from April 2015 to March 2016.
- The skill mix appeared appropriate for the outpatient clinics and we noted that staff had some choice in the clinics they preferred to work in.

Diagnostic imaging staffing

Good

Outpatients and diagnostic imaging

- There were two permanent radiographers, one radiology assistant and two administrative assistants employed in the diagnostic imaging department. Two bank mammographers were employed to support the breast clinics.
- The diagnostic imaging department also used bank radiographers during busy periods to cover annual leave and weekends. The bank radiographers were previously employed permanent members of staff and were familiar with processes and procedures.
- The department operated between 8am and 8pm generally, but the diagnostic imaging department mirrored outpatient clinic times. Staff were flexible to meet particular requests outside their core hours.
- Radiography staff operated a scheduled on call rota outside of normal working hours and were no more than 30 minutes travelling time away.
- Specialist radiologists attended to cover breast, vascular, renal, gastrointestinal, musculoskeletal, and neurological imaging reporting.

Medical staffing

- There were 105 medical staff with practising privileges at the time of the inspection.
- The hospital completed relevant checks against the Disclosure and Barring Service (DBS). The registered manager and Medical Advisory Committee (MAC) chair liaised appropriately with the General medical Council (GMC) and local NHS trusts to check for any concerns and restrictions on practice for individual consultants.
- Consultants agreed clinic dates and times directly with the hospital outpatient and administration teams. Within the outpatient department, consultants covered all specialties for all clinics. There were no concerns raised about the availability of consultants to cover their clinics.
- If required, the resident medical officer (RMO) or other consultant medical staff would be available in emergencies.
- Nursing and radiography staff called on the RMO when required and said they were very responsive.
- If required the resident medical officer or other consultant medical staff would be available in emergencies.

Major incident awareness and training

- The hospital had a business continuity and a major disaster plan. This detailed roles and responsibilities along with escalation procedures covering a number of potential internal incidents such as: fire and flood, bomb blast and generator failure.
- Staff we spoke with were aware of the policy and could describe the types of incidents, which would trigger a major incident escalation procedure.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate the effective domain.

- Patient care was delivered following recognised national guidelines, standards and best practice recommendations.
- Consent to care and treatment was obtained in accordance with legislation and guidance.
- There was evidence of good multi-disciplinary team working.
- Staff skills and competence were appropriate for their role and staff were supported to obtain new skills and share best practice.

Evidence-based care and treatment

- Staff provided care and treatment in line with evidence-based practice. Policies and procedures, assessment tools and care pathways followed national standards, met statutory requirements and aligned to approved guidelines such as the National Institute for Health and Care Excellence (NICE), Royal College standards and best practice recommendations.
- The matron reviewed published guidelines and a log was kept of action taken and who they were disseminated to.
- The pharmacy staff received medicines alerts so they could check and take appropriate action. We saw a file of the alerts received and a record of any action taken.
- In the diagnostic imaging department, there was good evidence that compliance with national guidelines was audited. The lead radiographer completed an Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) audit proforma, as part of clinical self-audit against procedures on an annual basis.

Good

Outpatients and diagnostic imaging

- The diagnostic imaging department used diagnostic reference levels (DRLs) to optimise medical radiation exposure. These levels were used to help staff make sure the right amount of radiation was used to image each part of the body. Staff were able to locate and explain how they used DRLs.
- DRLs were audited annually and we saw evidence of this during the inspection.
- IR(ME)R audits were undertaken in line with regulatory responsibility. We saw copies of these audits, outcomes, actions and results during our inspection.

Pain relief

- Staff gave patients pre-operative information, including information about pain relief and managing their pain. Staff considered pain may be a consequence of various treatment options and surgical procedures and this was discussed at consultation.
- Staff recognised when a patient was exhibiting signs and symptoms associated with pain, and demonstrated a good understanding of simple comfort scale methods available to them for the assessment of patient's pain.
- Patients were offered local anaesthetic for minor procedures undertaken in the minor operations rooms.
- Patients received pain relief medication following their procedure. Pain relieving medication was prescribed to patients upon discharge if required.
- In the diagnostic imaging department radiologists performed ultrasound guided injections to administer pain relief for certain medical conditions.
- Physiotherapists used visual analogue scores to assess pain and response to treatment.

Patient outcomes

- As many patients were transient through the outpatients and the diagnostic imaging departments, patient outcomes were not formally collated.
- Staff informally monitored patient progress at follow-up appointments in the outpatients department.
- Patients were offered the opportunity to take part in the Patient Reported Outcome Measures (PROMS) data collection if they received treatment for hip and knee replacement and inguinal hernia repair or varicose vein surgery. (PROMS measures the quality of care and health gain received from the patients perspective).
- Consultants monitored the results of procedures and treatment for their patients, and were required to provide a copy of their annual appraisal, which included practise information regarding patient outcomes data.
- There was limited evidence that clinical audits were being undertaken in outpatients, including recording of patient reported outcomes.
- The hospital did not take part in any national outcome measures such as the Imaging Services Accreditation Scheme (ISAS). A patient-focussed assessment and accreditation programme designed to help diagnostic imaging services ensure that their patients consistently receive high quality services, delivered by competent staff working in safe environments, or the Improving Quality in Physiological Services programme (IQIPS). A professionally-led accreditation programme encompassing a quality improvement pathway, followed by accreditation.

Competent staff

- All medical staff with practising privileges had an annual review by the senior management team (SMT) which comprised a face-to-face review of practice, including a review of their appraisal and clinical variances. Practising privileges is a system by which medical practitioners may be granted the right to practise in a hospital, subject to them providing evidence of their good character, qualifications, skills and experience. Practising privileges were granted or rejected by the hospital's medical advisory committee (MAC). In order to assess a consultant's suitability to practise at the hospital, the provider undertook checks on qualifications, reviewed references and checks undertaken by the Disclosure and Barring Service (DBS). All medical staff had been granted practising privileges and relevant checks had been performed.
- Outpatients and diagnostic imaging staff were appropriately qualified and registered and had the skills they needed to carry out their roles effectively and in line with best practice. The manager supported staff to maintain and further develop their professional skills and experience.
- All nurses were familiar with the revalidation process and felt well supported by their manager in obtaining this status. Revalidation is the new self-reflective and peer review process that all nurses and midwives in the

United Kingdom need to follow to maintain their registration with the Nursing and Midwifery Council. It demonstrates that they practise safely and effectively throughout their career.

- Staff learning and development was identified through the appraisal process and through one to one meetings. Performance and continuous improvement was also assessed through discussions about essential training, clinical skills and competencies. Processes were embedded for performance management enabling early intervention and support.
- The patient care manager kept training folders, detailing training completed and competencies in a variety of topics such as medical device training, clinical procedures and life support.
- Registered nurses in the outpatients department had all received appraisal within the previous 12 months, however only 71% of health care assistants had been appraised. In the diagnostic imaging department, all staff had been appraised.
- Staff said they were supported to develop their learning and progress in their careers. For example, the hospital had provided funding for healthcare assistants to participate in apprenticeship schemes. Nurses told us how much they valued participating in a preceptorship scheme. Nursing and radiography staff were encouraged to take on more responsibility, for example, by enrolment onto management style courses, and they were able to access learning provided by Nuffield Health, and from external sources.
- Staff with a particular interest in a field were supported to develop in the area, irrespective of grade or designation within the organisation. This recognised the value of all levels of clinical and non-clinical staff.
- There was a register of signatures of authorised laser operators and their training in place with certificates. Annual reports and audits were also available.

Multidisciplinary working (related to this core service)

- A range of clinical and non-clinical staff worked as a team in outpatients and diagnostic imaging departments.
- The hospital employed a breast care specialist nurse who liaised with diagnostic imaging, the ward, outpatients and clinicians providing a 'one stop clinic'.
- The physiotherapy team worked closely with the outpatient clinicians and the ward staff to provide a seamless service.
- The diagnostic imaging staff liaised with other service providers when a patient had undergone imaging elsewhere in order to avoid a repeat or unnecessary exposure and to compare any changes between images.
- Departments worked closely to ensure patients did not have to make unnecessary visits. For example, radiographers offered patients x-rays on the same day as their clinic appointment, if needed and results were available electronically for consultants to view in the clinic.
- Pre-operative multidisciplinary appointments were made for inpatient operations. This enabled patients to have diagnostic tests such as blood tests and x-rays and talk to physiotherapists at the same appointment as their pre admission assessments.

Seven-day services

- Outpatient and diagnostic imaging services were routinely available from Monday to Friday 8 am to 9 pm, with occasional Saturday clinics in outpatients when required. Diagnostic imaging was available outside these hours via an on call rota.
- Physiotherapy services were provided seven days a week from 8 am to 8 pm. Out of hours cover was available via on call rota also.
- The resident medical officer was available seven days a week, 24 hours a day and performed on a two-week rota working two weeks on and two weeks off. Cover for annual leave and sickness was provided by the same external company who supplied the RMO.
- Pathology services were provided from 8 am to 5 pm, Monday to Friday. The facility held Clinical Pathology Accreditation (CPA) and was Medicines and Healthcare Products Regulatory Agency (MHRA) compliant for Base Quality Score Recalibration (BQSR) 2005.
- Out of hours, urgent simple tests were managed by the RMO who had been trained to use the equipment required or were provided by a neighbouring NHS trust with whom there was a service level agreement.

Access to information

- Patients' clinical notes were available to ensure continuity of care. Hospital notes were kept on site and hospital secretaries made the consultants' own notes available.
- Patients were able to contact consultant's secretaries for queries.

Good

Outpatients and diagnostic imaging

- Staff told us diagnostic imaging and blood test results were available electronically, which made them readily available to staff in the outpatient clinics. Radiology formal reports were completed within 48 hours.
- All staff had access to the hospital's intranet to gain information relating to policies, procedures, clinical guidelines and e-learning modules.
- The physiotherapy team kept their own electronic notes and confirmed that there was always someone available who could access them if required.
- Consultant to general practitioner letters were usually sent out within two days of appointment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff confirmed the importance of patients being fully informed when they were asked to give consent for care and treatment. This included ensuring that they were given the opportunity to ask questions and agree with proposed treatment options. Where this was not possible due to a lack of understanding, staff confirmed they would always act in the best interests of the patient.
- Staff told us patients who may lack capacity to make an informed decision about surgery were very rare. This would be identified at the pre-admission assessment and if any consideration was needed this would be undertaken at this stage.
- Staff completed Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training during induction and as part of their mandatory updates. They had a good understanding of the principles underpinning MCA and DoLS guidance and were aware of the hospital policy.
- Patients gave verbal consent for minor x-ray procedures, outpatient procedures and physiotherapy treatments.
- Consent for procedures was always undertaken by the consultant.
- Consultants we spoke with confirmed they would not consent a patient to a surgical procedure using a family member to translate for non-English speakers and would access a translation service if necessary, although they commented that this would rarely be required.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good because:

- Staff engaged with patients in a friendly and caring manner.
- Patients were extremely positive about the care and treatment they received.
- Staff treated patients with dignity and respect.
- Privacy was maintained at all times.

Compassionate care

- We spoke with five patients and they all made very positive remarks regarding their care.
- They commented that staff were always very friendly. One patient said staff had been "very nice and kind". Another commented they "could not have had better treatment anywhere".
- Staff were friendly and courteous in their interactions with patients. We heard them introduce themselves to patients.
- We observed that staff treated patients with dignity and respect at all times. They waited for slower moving patients when transferring from the waiting area to consulting rooms and asked them if they needed any assistance.
- There were private changing areas for patients available within the departments.
- Consultations with medical and nursing staff took place in rooms with closed doors and could not be overheard.
- There were signs to indicate consulting rooms were in use in the wellbeing suite, and staff knocked on doors before entering in the outpatients department.
- The outpatients reception desk was located next to the waiting room and near the nurse's station and conversations could be heard by staff and passing patients but not by patients in the waiting room, as doors were kept closed. We saw reception staff greeting patients in a friendly and welcoming manner and explaining details regarding appointments and payments in a quiet professional way.
- Chaperones were used for all intimate examinations and were available for other consultations on request. There was a chaperone poster in the waiting room.

Understanding and involvement of patients and those close to them

Good

Outpatients and diagnostic imaging

- Patients we spoke with told us they understood why they were attending the hospital and were involved in discussions about their treatment. They confirmed they had been given enough information, both verbal and written, to make an informed decision about their care and treatment.
- One patient who had attended pre-assessment, said they were "very impressed with the information given and all questions were answered". Another patient said that they "had all the information that they required and felt well prepared for surgery". A bariatric patient saw the anaesthetist at pre-assessment and felt well prepared.
- They told us that during their consultation they had been given sufficient time to discuss any concerns they had and that staff made sure they understood the treatment options available to them.
- One patient commented that the consultant "was not condescending" and "very thorough explaining in a language which can be understood".

Emotional support

- Reception staff described that in situations where there was a need for privacy or if a patient appeared distressed, there were areas that they could use for greater privacy.
- During our conversations with staff, it was clear they were passionate about caring for patients and clearly put the patient's needs first. They demonstrated empathy and compassion in their interactions and one nurse described how some patients just needed a little more time spent with them.
- Staff and patients told us they were encouraged to bring a relative or friend to consultations for support.
- A breast care clinical nurse specialist accompanied patients from investigation to clinical appointment and was a source of information and support.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good because:

- Patients had a degree of choice for a preferred consultant, appointment time and payment methods.
- Outpatient appointments were arranged in tandem with other investigations to reduce multiple attendances.
- The percentage of NHS patients seen within 18 weeks was higher than the national standard of 92%.
- The hospital process for handling, investigating and responding to patient complaints was sensitive, and organised to resolve matters promptly to the satisfaction of all parties.
- Turnaround times for reporting investigation results in diagnostic imaging were good. Patients received results promptly in order for care to be progressed without undue delay.

However,

- Difficulties with car parking were an on-going concern. There were plans to improve this.
- There were no lifts to first floor consulting rooms in the listed part of the building, although staff were accommodating and moved downstairs if necessary to see patients who were unable to use the stairs.

Service planning and delivery to meet the needs of local people

- The hospital management had forged strong links with the independent sector and insurers. The hospital engaged with local NHS trusts and local clinical commissioning groups (CCG) to plan and deliver contracted services based on local requirements.
- There was a range of outpatient clinics offered in over 20 specialities including a variety of surgical specialties, dermatology, gynaecology, neurology and rheumatology.
- Signage throughout the hospital was clear and easy to follow.
- Outpatient clinics were located in the old listed part of the building, accessible separately from the rest of the hospital. There were steps to the front door and a ramp for disabled access. There was a small outpatient reception area, which was staffed during clinic opening times for patient registration. There was a large waiting room with sufficient chairs and hot and cold drinks were available.
- Clinic rooms were spacious and conversations could not be heard outside clinic rooms.
- The Healthstyle suite had its own small waiting area where there was very limited seating. Other patients waited in seating areas in the main corridor.

Good

Outpatients and diagnostic imaging

- The diagnostic imaging department was located in the main building and comprised of an ultrasound room, x-ray, room, viewing room, changing room and two offices. Space was at a premium, with limited seating within the department, so waiting was usually in the corridor but the facilities were suitable for purpose.
- The hospital provided independent healthcare for self-funded and NHS referred patients. Patients were offered a degree of empowerment in choosing a preferred consultant, an appointment time to suit and for self-funding patients, options on payments methods.
- The hospital operated an enhanced recovery programme, which aimed to help patients get better quicker. This started at pre-operative assessment. The aim was for patients to spend less time in hospital after their operation. Patients received early physiotherapy and free use of the associated gym for a short period following certain surgeries.
- Car parking on site was free but there were limited spaces and this was further reduced when the mobile MRI scanner was on site. We saw a plan had been made to improve the number of spaces by removing some trees and was awaiting local council approval.

Access and flow

- The majority of outpatient activity was self-funded or funded by private health insurance (82%). There were 21,106 outpatient attendances between April 2015 and March 2016, of which 8,851 were first attendances and 12,255 were follow up appointments.
- The hospital did not formally audit 'did not attend' (DNA) or clinic cancellation rates because they felt these were such rare occurrences. However, we were assured that processes were in place to follow up patients who DNA and to offer alternative appointments when a clinic was cancelled. During the inspection, there were no DNA and no clinic cancellations.
- Diagnostic image reporting was usually completed within two days, which allowed patients to be informed of results promptly so that care could be progressed without undue delay.
- Waiting times in clinic were not formally displayed or audited however, staff informed patients of any potential delay upon registering. Patients we spoke to indicated that they rarely waited longer than a couple of minutes past their appointment time. During the inspection, we observed no delays in any of the clinics or waiting times for diagnostic imaging procedures.
- The hospital allocated appointments based on clinical need and not ability to pay. All patients received their consultation and access to treatment options in a timely manner. Staff confirmed there was no cap on appointment numbers and no minimum number of patients required for a clinic to run. This allowed patients to access clinic in a timely manner and avoided cancellations.
- There were 'one stop shop' clinics for breast care and some gynaecology and dermatology conditions, where diagnostic tests and/or treatment was provided on the same day as consultion, raher than the patient returning for another appointment.

Meeting people's individual needs

- Staff recognised certain patients might require additional support in advance of attending the hospital and during the appointment, such as those with disabilities. They described how they would expedite an appointment so that it would be less distressing for patients with learning disabilities and find them a quiet place to wait.
- For patients with hearing loss the hospital provided a hearing loop system in the main outpatients.
- There was a ramp for disabled access to the outpatients department, which led to a side door with a bell to alert staff, as the door could only be opened from inside. There were no lifts to access the first floor consulting rooms but consultants would come downstairs to see patients who were unable to manage the stairs.
- Staff demonstrated good awareness of the needs of people living with dementia and described a valuable 'lunch and learn session' provided by the dementia link nurse. There were 'forget me not' stickers to be affixed to patient notes and 'this is me' forms available, although staff confirmed that it would be rare to use them. The 'forget me not' stickers help ensure those with the condition are easily identified by staff and their care is planned accordingly. The 'this is me' tool is intended to provide professionals with information about the person with dementia as an individual, to enhance the care and support given while the person is in an unfamiliar environment.
- Appointment time spent with the consultant varied, dependent on clinical need, for example, new

appointments were allocated a longer time slot. Staff confirmed that if they were aware that if a patient had concerns and needed a longer slot they would try to accommodate this.
- Information leaflets were available to patients regarding their treatment. Staff either sent the leaflets in appointment letters or gave them to patients to take away.
- Staff in radiology aimed to accommodate patient attendance on the same day to avoid the potential inconvenience caused by a repeat visit.
- The hospital worked with a specialist bariatric team. Bariatric appointments were arranged so the specialist staff were all available for the appropriate support. Bariatrics is the branch of medicine that deals with the causes, prevention, and treatment of obesity.
- Staff described how they referred patients to colleagues during appointments if an opinion was required. This reduced the need for patients to return for other appointments.
- Staff told us that they usually relied on a family member to interpret. The use of family or staff members to translate is not considered best practice, as staff could not be assured that the patient had given consent for information to be shared or that the correct information was being translated. There was no documented agreement for translation services. The bookings team had information to contact a translation service if required but this was used infrequently. We saw evidence in a recent governance meeting minutes that this had been identified and there were plans to address this. Staff did confirm that consent for surgery would not be sought via a relative translating to a patient.
- Written patient information was available in English but could be made available languages other than English on request.

Learning from complaints and concerns

- The hospital director was responsible for the management of complaints, supported by the matron and relevant clinical heads of department when concerns were of a clinical nature. Complaints relating to individual consultants with practising privileges were reviewed by the medical advisory committee.
- Staff described how they always endeavoured to resolve patient concerns informally in the first instance if they felt confident to do so, but would escalate to senior staff if necessary. Staff were aware of the hospital's complaints procedure.
- Staff recorded complaints on the hospital electronic reporting system. The hospital had a procedure in place for investigating complaints, responding to the complainant and learning from complaints.
- Complaints leaflets were available in the main reception and outpatients waiting rooms.
- There were 16 complaints for the period April 2015 to March 2016. This was higher than the previous year when 10 complaints were recorded, but was still below average based on the other hospitals we hold this type of data for.
- Five complaints were recorded for the period January to April 2016. One related to a discrepancy about procedure cost and another to staff attitude in reception. Both complainants received a 'stage one' letter indicating that the complaint was resolved at a local level.

Are outpatients and diagnostic imaging services well-led?

Outstanding ☆

We rated well led as outstanding because:

- The hospital director leader demonstrated exceptional leadership and was supported by a committed and competent senior management team.
- The senior management team were highly respected and were visible, accessible and supportive.
- There was a well-publicised and well understood corporate mission, supported by a set of values and behaviours. Staff were signed up to these and had been engaged in applying them to their place of work. All staff we spoke with passionately articulated shared values, focused on patient- centred care and compassion, which underpinned their work.
- There was a great sense of teamwork, with staff at all levels demonstrating shared values and commitment to providing the best patient-centred care and treatment.

Good

Outpatients and diagnostic imaging

- All staff were treated with respect and their views and opinions were heard and valued by the senior management team.
- There was a high level of staff satisfaction; staff told us they were proud of the departments they worked in. They showed commitment to their patients, their responsibilities and to one another.
- There were effective governance arrangements, which ensured that performance, quality and safety were monitored.
- The senior management team engaged well with staff and patients, actively seeking their opinions within staff forums and a quarterly patient forum, and acting on suggestions.

Vision and strategy for this this core service

- Nuffield Health had a clear corporate vision to 'support, enable and encourage people to improve their health and wellbeing in order to help them get the most out of life' and this was shared with staff throughout the organisation.
- Departmental managers adopted the organisational values and beliefs and senior staff talked about being "EPIC" (enterprising, passionate, independent and caring).
- Staff had a good understanding of the core values of the service and were committed to providing patient-centred care, although the term EPIC was not familiar to all. They did repeat the "not for profit" phrase and 'never putting financial gain in front of patient care' comments.
- The phrase 'for the love of life' had been developed by Nuffield Health as a strapline and was known by most staff.
- Staff told us the hospital shared their vision on future plans and proposals for the development of the departments through regular updates at meetings.
- The business plan set out long term strategy and this included plans to extend the number of consulting rooms in outpatients. The management team were investigating the challenges of installing lift access for the upstairs consulting rooms in the listed part of the building. The diagnostic imaging manager had long-term plans for replacement of plain film x-ray equipment with digital x-ray and the installation of a permanent MRI scanner.

Governance, risk management and quality measurement for this core service

- There were effective governance arrangements, which ensured responsibilities were clear and that quality, performance and risks were understood and managed.
- Senior and junior staff were aware of the hospital risk register and could describe the risks that applied to their departments. A shortage of reception staff due to sickness, vacancies and competence of temporary staff was shown as a moderate risk on the register and there was evidence of the plans to manage this and regular monitoring.
- Managers and clinicians discussed risks at clinical governance and medical advisory committee meetings.
- There was a range of regular, well attended committee meetings including: quarterly health and safety meetings, clinical effectiveness, infection prevention, medical advisory committee (MAC), and heads of department meetings chaired by the hospital director. Departmental meetings took place quarterly and there was good evidence of communications from junior to board staff and the other way around. Standardised agendas ensured that all key performance measures were regularly monitored and action trackers were used to monitor progress.
- There was a hospital-wide governance log with action plans, which were disseminated via the clinical effectiveness committee, hospital board meetings, heads of department meetings and departmental meetings.
- The matron prepared a quarterly clinical quality report, which detailed incidents and complaints in the reporting period and was shared with staff across all departments.
- There was an annual quality assurance review undertaken by peer reviewers from within the Nuffield group. The last review took place in March 2016. Assessments took place under domains which were aligned with the Care Quality Commission's inspection framework and compliance was assessed as red, amber or green, with recommendations for improvement being made where appropriate.
- The pharmacy department undertook regular audits of the services they provided to check the quality, for example, a medicines security audit. We saw the results

of a recent quarterly review of pharmacy and medicines management by the provider's Pharmacy Quality Manager. This found there were no areas of concern and only a few points for improvement.

- In the diagnostic imaging department, there was good evidence that compliance with national guidelines was audited; Nuffield Health had an IR(ME)R audit proforma in place, which the lead radiographer completed as part of clinical self-audit against procedures on an annual basis. They shared the outcomes with staff and any non-compliance was addressed with an action plan.
- The hospital manager, through the MAC, and with support from human resources, ensured any consultant seeking practising privileges had appropriate and valid professional indemnity insurance in accordance with the Indemnity Arrangements Order 2014.
- Consultants with practising privileges engaged with the senior management team via the MAC who acted as their representative body. A MAC representative met regularly with the hospital director and matron and she, in return, attended their quarterly meetings. Results from the annual survey showed great satisfaction with the management of the hospital. This was confirmed by consultants that we spoke to who commented on the organised and efficient way the hospital was run and the leadership of the hospital director.
- The roles and responsibilities of the MAC were well defined and there was good engagement in governance oversight, particularly around reviewing practising privileges and advising on consultant performance.

Leadership / culture of service

- Staff expressed a great deal of respect for one another and commented very positively about the support and commitment of their managers.
- The hospital reported low staff turnover and high levels of staff satisfaction hospital-wide. There was no staff turnover for registered nurses in the outpatients department during the period April 2015 to March 2016. Over the same period, staff turnover for healthcare assistants was above the average of the 12 independent acute hospitals that we hold this type of data for. The senior management team confirmed that new staff had been employed within the last few months.
- The terms 'feeling like we belong' and 'being part of a big family' were also expressed on more than one occasion.
- Staff told us that the senior management team were very good at saying "well done" and "thank you" and that meant a lot to them.
- Staff were very complimentary about gestures of thanks from the management team, such as an ice cream van attending on a hot summer day and the provision of ice creams for all the staff, and strawberries and cream during Wimbledon tennis fortnight. They also enjoyed Easter eggs at Easter.
- Staff told us they were very proud to work at the hospital and some members of staff had been there for many years. Other staff told us they had left to travel and do other things but always ended up coming back to the hospital, as it was such a great place to work.
- The hospital previously had a staff award scheme but this was discontinued, and staff at a forum meeting spoke of how they felt embarrassed being singled out for praise as they felt that good work was largely a team effort.
- Several members of staff commented that the teamwork made it such a good place to work and that everyone was included in the team.
- Staff told us they felt valued and respected. This was noted to have become more apparent over the last two to three years since senior management changes.
- There was a positive culture of mutual respect, recognition and support. There was an open door policy for the senior management team and staff were on first name terms with the managers.
- One member of staff was particularly grateful for the support they received when a family member was in hospital and said that the senior nursing staff "bent over backwards" to accommodate hospital visits in their work time.
- Staff turnover in clinical areas was low and staff satisfaction was high. The service used the net promoter score, otherwise known as the leadership MOT to assess staff satisfaction. Scores overall had increased steadily year on year. The latest survey results (November 2015) were the 5th highest out of 33 hospitals in the Nuffield hospitals group, and overall, consistently higher than the average for the group. Some issues scored less well for outpatients staff, in particular, in relation to work/life balance, which scored 7.3 out of 10. An action plan had been developed in response to this and all scores under 7.5 and we saw that steps were being taken to address these areas. Short term sickness levels were consistently below the Nuffield target of 3%.

Good

Outpatients and diagnostic imaging

- A new staff member in diagnostic imaging commented that working in the hospital "was like a breath of fresh air", and that the leadership team were "open and progressive".
- Staff sickness was below 3% in outpatients, which is lower than the average for hospitals of this type that we hold data for.
- The senior nursing team had recently attended a leadership course where their own leadership styles were identified. They felt that this helped them to recognise better ways of working.

Public engagement

- The hospital actively encouraged patients to complete a satisfaction survey during or after their visits. Feedback from such surveys was considered at national, local and departmental level.
- There was a quarterly patients' forum. The forum was comprised of patients who had received treatments or procedures or attended the outpatients department. This had changed within the last year to be representative of recent experiences, rather than the same group of people attending every quarter. Patients were invited to feed back on their experiences across a variety of topics such as environment, food, care and staff competence.
- The forum was attended by the patient care manager, matron, and the finance manager. The senior management team were then invited to discuss any issues raised.
- The minutes of the patients' forum meeting held in March 2016 indicated concerns regarding parking when the mobile MRI scanner was on site, the draughty waiting area near the main reception and the limited choice of magazines in the outpatients waiting area. Plans for parking optimization and the possibility of a permanent MRI scanner installation were shared with the group by the hospital director. We saw the magazine choice in the outpatient waiting area had been addressed on inspection.
- Patients' feedback forms were collected as part of our inspection process. Of the 26 forms collected, all had positive comments, with seven also making some minor negative comments. The negative comments were related to parking, the age and appearance of the outpatient building, communication, room temperature and "would have liked more opiate pain relief".

Staff engagement

- The hospital was commended for good staff engagement during a recent Nuffield Quality Assurance Review (March 2016).
- In the leadership MOT in November 2015, the outpatients department scored 6.8 out of 10 in relation to staff feeling their concerns views and ideas were listened to all the time.
- Staff were able to attend governance meetings and there was encouragement to contribute to ideas to improve facilities and services.
- Staff feedback forms were collected as part of the inspection process. Six staff members submitted forms. All were positive, with three minor negative comments relating to parking, accessing training and a poor functioning door.

Innovation, improvement and sustainability

- A staff member in outpatients produced a video with other staff to highlight good hand washing practice. The video included members of the team demonstrating hand washing and singing at the same time to a popular 'carwash song' which made it memorable and fun. The video was to be sent to the Nuffield corporate team at head office.
- The senior nursing team provided learning in an innovative way with 'lunch and learn' sessions. The hospital provided free lunch and staff were able to engage with specific learning opportunities at the same time. Staff felt these were very useful and a good way to access knowledge.
- The hospital was pro–active with staff development and funded external apprenticeship schemes for healthcare assistants. One of these worked in outpatients and was working towards their level three diploma.

Outstanding practice and areas for improvement

Outstanding practice

- Staff had produced a video to promote hand-washing practice in a fun and innovative way.
- The hospital worked closely with a local sixth form college and had developed apprenticeships. Two healthcare assistant apprentices were employed in 2015, as well as a business office apprentice in the finance team.
- Staff told us they felt well supported in terms of their ongoing education and development. Staff with a particular interest in a field were supported to develop in the area, irrespective of grade or designation within the organisation. This recognised the value of all levels of clinical and non-clinical staff. A number of 'lunch and learn' sessions had been held to share knowledge among all staff groups.
- There was a dementia working party established in the hospital. Staff members of this group were very proactive in improving their understanding of dementia care and had attended further self-study courses in their own time. Learning from these courses was then shared with other hospital staff.
- Staff had taken steps to support patients living with dementia. One bedroom had been adapted with appropriate signage and large face clocks to enable patients living with dementia to identify areas within their room. Patients living with dementia were identified by the use of a blue pillow case and a 'forget me not' symbol on the patient's record. This ensured that all staff involved in their care were alerted the fact that these patients may require extra support.
- There was a group of 'dementia friendly' staff who had made 'twiddle muffs'. These are knitted hand muffs with items such as ribbons and buttons attached. They are used to provide a source of visual, tactile and sensory stimulation for people living with dementia who have restless hands.
- The patients' forum had recently been re-launched and provided opportunities to capture recent patient experiences first hand. There was evidence that patient feedback and suggestions had been acted on swiftly to improve patient experience.

Areas for improvement

Action the provider SHOULD take to improve

- Undertake temporary remedial work in theatres, pending the theatre replacement scheduled for 2017, to make good cracked doors, which had the potential to harbour bacteria.
- Continue to take steps to improve record keeping, including the completion of risk assessments, recording of patient observations, early warning scores and clinicians' signatures and counter-signatures.
- Ensure that falls risk assessments are completed in pre-assessment clinics.
- Consider that where audit reflects a risk, such as lack of falls assessments being completed, that appropriate action is taken and monitored via the relevant governance forum.
- Ensure that resuscitation equipment checks are thorough and that equipment is replaced when out of date or damaged.
- Review documentation used to record risk assessments of VTE and ensure that patients' records clearly show all risk factors present and the reasons for the choice of preventative treatment.
- Ensure that theatre staff sign separately for the supply, administration and disposal (if appropriate) of medicines in the controlled drugs register.
- Review the use of printed stickers on medicines administration charts so that there is sufficient space to document all medicines prescribed and administered.

Outstanding practice and areas for improvement

- Put in place a process for ensuring that notes are accessible for sharing with NHS or other providers following procedures.
- Ensure that mandatory training records are up-to-date and accessible for governance purposes.