

KIMS Hospital

Quality Report

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Weaving,
Maidstone, Kent
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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?		Good	

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

KIMS Hospital is operated by KIMS Hospital Ltd. The hospital has 99 beds, 72 of which are currently in use. Facilities include five operating theatres, three of which were laminar flow, an endoscopy suite, an interventional lab/suite, and X-ray, outpatient and diagnostic facilities.

The hospital provides surgery, medical care, and outpatients and diagnostic imaging (including services for children and young people). We inspected surgery, medical care, outpatients, and diagnostic imaging.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 10 and 11 January 2018.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

The main service provided by this hospital was surgery. Where our findings on surgery – for example, major incident planning – also apply to other services, we do not repeat the information but cross-refer to the surgery core service.

Services we rate

We rated this hospital as good overall.

We found good practice in relation to medical care:

- Patients were supported, treated with dignity and respect, and were involved as partners in their care.
- Patient records were written and managed to keep people safe. They were clear, legible and risk assessments were completed in all of the records we reviewed. Notes were organised and stored in a lockable trolley.
- Staffing levels were planned and reviewed to keep patients safe and staff were flexible and happy to adjust their shifts to suit patient need.

- The hospital used a quality dashboard and routinely collected and monitored information about patient outcomes. The hospital took part in national audits and staff created action plans to improve patient outcomes.

We found good practice in relation to surgery:

- The hospital had a clear incident reporting process and staff had good knowledge of this. Staff were encouraged to report incidents and felt they could report incidents openly. They provided examples of learning and where changes had taken place.
- The service had introduced strong processes to ensure consultants only operated within their scope of practice. Staff had evidence of up-to-date appraisal to provide assurances around their skills and competencies.
- The service actively involved patients and their relatives in their treatment, such as by providing an educational pre-operative “joint school”.
- Governance and performance management arrangements were proactively reviewed and reflected best practice.

We found good practice in relation to outpatients and diagnostic imaging:

- The hospital had safeguarding leads, a named doctor and a named nurse for adults at risk and children and young people. Staff could name the key people and had knowledge of what to do if they had to raise a safeguarding concern.
- Staff managed medicine safely and followed hospital policy and national guidance. Medicines were stored securely and were within their expiry dates.
- There was effective multi-disciplinary team working with teams of all services throughout the hospital.

We found an area of outstanding practice in medical care:

- The cardiac catheterisation laboratory carried out comprehensive risk assessments for all patients. We saw a pre-assessment and discharge checklist and

Summary of findings

specific pathways for each procedure. Based on risk assessments, staff had included additional checks to the World Health Organisation 'five steps to safer surgery' checklist.

We found areas of outstanding practice in the hospital as a whole:

- The hospital had volunteers known as 'KIMS' angels' who spent time in departments talking to patients. This was introduced to enhance patient care and support patients so that they felt listened to.
- The hospital's strong commitment to staff engagement included direct links to the board through 'KIMS Voice' so they could directly communicate their views, ideas and concerns

We found areas of practice that require improvement in surgery:

- The exclusion and acceptance criteria for surgery did not give specific guidance to consultants, which meant the service could not be assured that consultants were consistent in determining a patient's suitability for surgery at the hospital.

- Carpeted flooring in clinical areas should be replaced in line with the hospital's replacement programme.

We found areas of practice that require improvement in outpatients:

- The safety gate installed at the doorway to the children's waiting room was covered with hazard tape. This could lead to potential trips and/or falls.
- Not all treatment areas had flooring fit for purpose.

Following this inspection, we told the provider that it should make some improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Amanda Stanford

Deputy Chief Inspector of Hospitals (area of responsibility)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good 	Medical care services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe, effective, responsive to people's needs, caring and well-led.
Surgery	Good 	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as good because it was safe, effective, responsive to people's needs, caring and well-led.
Outpatients and diagnostic imaging	Good 	We have included children and young people's services within outpatients and diagnostic imaging as they represented only 3% of this activity and were not seen elsewhere in the hospital. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe, responsive to people's needs, caring and well-led.

Summary of findings

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Good 

KIMS Hospital

Services we looked at

Medical care; Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to KIMS Hospital

KIMS Hospital is operated by KIMS Hospital Ltd. The hospital opened in 2014. It is a private hospital in Maidstone, Kent. The hospital primarily serves the communities of Kent. It also accepts patient referrals from outside this area. The hospital has 99 beds, 72 of which were in use at the time of the inspection, five purpose built theatres, including three laminar flow, an endoscopy suite, an interventional suite and outpatient and diagnostic facilities. Since the hospital opened in 2014, it has brought back in house several services which had previously been contracted out to third parties, including pathology, physical therapy and catering.

The registered manager has been in post since 2016 and is also the controlled drugs accountable officer.

The hospital has been inspected once previously in September 2015. This found that the hospital was not meeting all standards of quality and safety it was inspected against and requirement notices were issued against the breaches of regulation which were identified. Since then, the hospital had provided evidence that they had addressed these breaches.

Our inspection team

The team that inspected the service comprised a CQC inspection manager, four CQC inspectors, and two

specialist advisors with expertise in surgery and diagnostic radiography. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Information about KIMS Hospital

The hospital has four wards and is registered to provide the following regulated activities:

- Surgical procedures
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury
- Family planning services

During the inspection, we visited all outpatient and diagnostic imaging areas, all areas providing medical care including the wards, the endoscopy theatre and the endoscopy cleaning room, and the theatres. We held a staff forum and spoke with 25 clinical staff who attended. We also spoke with 37 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, allied health professionals, a voluntary worker and senior managers. We spoke with 12 patients and three relatives. We also received 73 'tell us about your care' comment cards which patients had completed prior to our inspection.

During our inspection, we reviewed 22 sets of adult patient records, 11 prescription charts and three children's patient records, including consent forms for both groups where required. We reviewed data provided by the hospital prior to, during and after our visit, including 26 policies and 20 audits. We also took account of the feedback from discussion and written communication from stakeholders.

Outpatient services at KIMS Hospital offer appointments for a wide range of specialities where assessment, treatment, monitoring and follow up were required. The specialities offered include orthopaedics, general surgery, gynaecology, interventional cardiology, rheumatology, urology, ear, nose and throat, neurology, ophthalmology, psychotherapy and pain management. Orthopaedics was the most attended clinics and accounted for 41% of all outpatients' appointments within the reporting period

Summary of this inspection

November 2016 to October 2017. The outpatient department has 14 consulting rooms and three treatment rooms. It is open Monday to Friday from 8am to 8pm and Saturdays as required.

The diagnostic and imaging department carried out routine x-rays, Magnetic-Resonance Imaging (MRI), Computerised Tomography (CT), Nuclear Medicine (NM), mammography and ultrasound scans. It is open Monday to Friday from 8am to 8pm including Saturday and Sunday as required.

The outpatient physiotherapy and dermatology units are open Monday to Friday from 8am to 8pm and Saturdays as required.

The hospital has an on-site pharmacy. The hospital pharmacist team provides a daily service Monday to Friday between 8.30am and 5pm, and out of hours, staff were able to access the resident medical officer or senior nurse for pharmacy support and advice.

The medical services at KIMS Hospital are made up of the endoscopy suite, the one-stop breast clinic, the cardiac catheterisation laboratory and the medical assessment unit.

The endoscopy suite operated 8am to 8pm Monday to Friday as required. The suite provided services to patients over 18 years of age and completed 15 to 20 procedures a week. The suite employed three members of staff.

The one-stop breast clinic operated on a Tuesday and Wednesday from 6pm to 8pm. There were 107 attendances during the reporting period. The clinic employed three members of staff.

The cardiac catheterisation laboratory operated Monday to Friday 8am to 6pm. The cardiac catheterisation laboratory treated 666 patients in the reporting period. Five members of staff worked in the cardiac catheterisation laboratory.

The hospital had four wards. Nickleby ward was open 24 hours a day and seven days a week. Of the 17 beds on Nickleby ward, four of them were adaptable for enhanced care. The Havisham ward had 20 beds available for when the Nickleby ward became full. The Dickens ward was associated with the interventional suite and consisted of 20 bays. The Copperfield ward was used for day case patients, both medical and surgical, and consisted of 17 rooms.

The majority of the surgical cases were orthopaedic, supported by three laminar flow theatres. The most common procedures were injection into a joint (583 procedures), knee replacement (428 procedures) and hip replacement (301 procedures).

Activity (November 2016 to October 2017)

- In the reporting period November 2016 to October 2017, there were 2,056 inpatient and 5,396 day case episodes of care recorded at the hospital. Of these, 58% were NHS-funded and 42% other funded.
- Twenty-seven per cent of all NHS-funded patients and 28% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 33,426 outpatient total attendances in the reporting period; 13,976 of these were first appointments and 19,450 were follow-up appointments. Of these 57% were other funded and 43% were NHS-funded.
- There were 1068 outpatient attendances by children and young people out of the 33,426 attendances. This represented 3% of this total. Children and young people were only seen in the outpatient clinics and no procedures, except blood tests and x-rays, were undertaken.
- Outpatient attendances represented 82% of the hospital's total activity.

Two hundred and fifty surgeons, anaesthetists, physicians and radiologists worked at the hospital under practising privileges. Of these, 101 had carried out 100 or more episodes of care in the reporting period, 64 between 10 and 99, and 69 had carried out no episodes of care. However, this last figure included anaesthetists who did not have their work registered against their name as an episode of care. In the reporting period, 77 consultants had had their practising privileges withdrawn, including 28 because of a lack of activity, 21 due to outstanding documentation and 18 voluntary withdrawals for non-clinical reasons.

Two regular resident medical officers (RMO) were supplied by an agency and worked on a rota of one week

Summary of this inspection

on and one week off. The hospital employed 48.4 whole time equivalent registered nurses, 31.6 whole time equivalent health care assistants and operating department practitioners and 187.1 other staff.

The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- One never event
- Nine hundred and seventy-seven clinical incidents including 647 no harm (66%), 284 low harm (29%), 45 moderate harm (5%), 1 severe harm, no death
- Four hundred and sixty-five non-clinical incidents
- Five serious injuries
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA)
- No incidences of hospital acquired Clostridium difficile (C.diff)
- Five incidences of hospital acquired E-Coli

- Two hundred and seventy-two complaints, one of which was referred to the Independent Healthcare Sector Complaints Adjudication Service. There were no complaints or whistleblowing concerns received by the CQC in the reporting period.

Services accredited by a national body:

- BUPA Accredited Breast care centre
- BUPA Accredited Prostate centre
- BUPA Accredited Cataract full pathway provider

Services provided at the hospital under service level agreement:

- Translation services
- End of Life care
- Laundry
- Non-routine blood tests
- Microbiology
- Blood transfusion services
- RMO services
- EME services

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as good because:

- There were sufficient staffing levels on the wards and in theatres to keep patients safe. Staff had up-to-date mandatory training in key areas to ensure they had the knowledge and skills to keep patients safe.
- Staff followed hospital policies and national guidance around infection prevention and control to reduce the risk of infection to patients. In addition to this there was a named nurse for prevention and infection control.
- The hospital had a clear incident reporting process and staff had good knowledge of this. Staff were encouraged to report incidents and felt they could report incidents openly. They provided examples of learning and where changes had taken place.
- Staff understood duty of candour and we saw evidence the service was open and honest with patients if something went wrong.
- All medical equipment we reviewed was regularly maintained and had safety checks.
- Patient records were kept in secure storage, were legible, dated and had signatures.
- Medicines were stored safely and correctly and the management of medicines was monitored and improved when required. Storage and record keeping of medicines and controlled drugs was good and medicine fridge temperatures were routinely monitored.
- Staff took a proactive approach to safeguarding and focused on early identification. Staff worked well with other organisations in the community to prevent abuse from occurring.

However:

- Not all treatment areas had flooring fit for purpose.
- The safety gate installed at the doorway to the children's waiting room was covered with hazard tape. This itself could lead to potential trips and/or falls.
- Waste bins were not consistently labelled to help users identify the waste types within.
- Chairs obstructed access to hygiene sinks in patient bedrooms.

Good



Are services effective?

We rated effective as good because:

Good



Summary of this inspection

- Policies were kept current and up to date and included guidance that identified standards, best practise and legislation. Departments regularly monitored their adherence to these policies.
- Patients received evidence-based care and treatment in line with relevant national guidance and best practice.
- National benchmarking data showed patients at KIMS Hospital had good outcomes following orthopaedic surgery.
- Pain assessment tools were used for adults and children had age-specific tools. Staff routinely assessed and addressed patients' pain. Staff had an escalation plan if pain medicines were not effective.
- All patients had a nutritional assessment on admission and bariatric patients were offered a separate menu. Catering services were available to all patients and catering staff were flexible to discuss and accommodate requests. Patients gave positive feedback and their family and friends had access to refreshments.
- Care was coordinated through daily team meetings and attended by staff from multiple disciplines. There were pathways for referrals to NHS hospitals; both in an emergency and routine situation, and the wards had good links with specialists at the local hospice.
- The hospital had clear and detailed policies on consent and the Mental Capacity Act 2005. Staff had knowledge about gaining consent for adults and children. They demonstrated awareness of how the Mental Capacity Act 2005 related to their practice and were aware of who to contact if they needed guidance.

Are services caring?

We rated caring as good because:

- We saw staff providing compassionate care throughout our visit. Patients spoke highly of the care they received from staff.
- The hospital's volunteers, the "KIMS Angels", provided emotional support to patients, as well as helping ease the loneliness of older people with no family nearby to visit them.
- The hospital had a quiet room available for all patients and their families. Staff gave patients timely and appropriate support and information to cope emotionally with their care.
- Staff took the time to interact with patients and those close to them in a respectful and considerate manner and respected patient privacy and dignity.

Good



Summary of this inspection

- The Friends and Family Test demonstrated 90% of 356 patients who responded were extremely likely to recommend the hospital to family or friends for similar care or treatment, and 90% of patients rated the quality of the service as excellent.
- Patients and those close to them had understanding of their care and were involved in their treatment if this was required.

Are services responsive?

We rated responsive as good because:

- The service took action to meet patients' individual needs. The importance of flexibility, choice and continuity of care was reflected in services and there was an emphasis on good relationships with local NHS trusts. Staff treated patients as individuals and delivered services to meet their needs. This included patients living with dementia, wheelchair-users and patients that spoke English as a second language.
- The provider had a good understanding of the needs of local people and this was well reflected in their 'Equality, diversity and inclusion strategy'.
- The hospital's discharge policy worked well and was able to manage quick transitions between departments and out to the community. Staff had a good relationship with the local hospice with access to dementia care specialists and carried out thorough assessments to ensure services were delivered to meet patients' individual need.
- Patient feedback leaflets made it easy for patients to complain or raise a concern and there was openness and transparency when handling complaints. Patient satisfaction surveys were displayed, with both positive and negative comments, and encouraged patients to comment on the service they received.
- There were clear processes for dealing with complaints and concerns, which the service followed. The service captured information from informal, as well as formal complaints, to help drive improvements from complaint learning.
- There were minimal cancellations for non-clinical reasons, and the service met the NHS constitution pledge to offer all NHS-funded patients an alternative operation date within 28 days.

Good



Are services well-led?

We rated well-led as good because:

- Leaders had an inspiring shared purpose, to deliver high quality care and to motivate staff to succeed. Successful leadership strategies ensured delivery and developed a highly positive culture.

Good



Summary of this inspection

- There was a governance structure and processes that enabled the hospital to monitor and measure performance and to manage risks.
- There were high levels of staff satisfaction. Staff were proud of the organisation as a place to work and spoke highly of the culture.
- The service had consistently high levels of constructive engagement with staff. Staff had direct links to the board so they could directly communicate their views, ideas and concerns. The service also maintained high levels of engagement with patients and local charities.
- The leadership drove continuous improvement and held staff accountable for delivering change. The service celebrated safe innovation.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Notes

Medical care

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

Are medical care services safe?

Good 

We rated safe as **good**.

At our last inspection, we rated safe as requires improvement. On this inspection, we have changed the rating to good because we have seen improvements in key areas.

Since our last report, KIMS Hospital has:

- Strengthened its incident investigation processes and implemented systems to ensure robust learning from such events.
- Implemented morbidity and mortality meetings.
- Made hand sanitisers available near the entrance of each bedroom to help improve hand hygiene.
- Displayed safety thermometer data in public areas.
- Implemented a plan to remove carpets from all areas of the hospital and created a statement of purpose for the cleaning of the carpets still there.
- Ensured the endoscopy recovery room was fit for purpose
- Ensured reversing agents on the endoscopy unit were easily accessible.

Incidents

- The hospital did not report any patient deaths, related to medical care services, from November 2016 to October 2017.

- The hospital did not report any never events related to medical care services, from November 2016 to October 2017. Never events are serious, wholly preventable, patient safety incidents that should not occur if a hospital has implemented the available preventative measures. The occurrence of a never event could indicate unsafe practice.
- The hospital did not report any serious injuries, related to medical care services, from November 2016 to October 2017.
- From November 2016 to October 2017, the hospital reported 1442 incidents. Of these, 98 incidents (7%) related to medical care; 71 were clinical incidents and 27 were non-clinical incidents. The hospital categorised 57 of these incidents as no harm, 34 as low harm and seven as moderate harm. The high rate of no harm reporting (58%) showed staff had an open and honest reporting culture.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Since we last inspected, the hospital introduced an We spoke to eight members of staff about this system. All eight staff members confidently explained how they used the system to report incidents and near misses.
- When something went wrong, there was a thorough review involving all relevant staff and patients. Staff were involved in the root cause analysis of incidents. Staff told us about when they saw an increase in falls reporting. Staff were tasked to look through patients' notes to identify any risk factors. They were involved in coming up with actions to help reduce the risk of falls.

Medical care

Staff consulted patients and, as a result, the ward introduced non-slip socks. Staff also told us they received individual learning from incidents they had reported.

- Staff communicated incidents and lessons throughout the hospital. Staff discussed incidents at clinical effectiveness meetings; these were monthly meetings and a representative from each department attended. The clinical leads and chief nurse had a weekly meeting to discuss any incidents. There were also daily communication meetings, attended by a representative from each department. We saw minutes of these meetings; they showed thorough discussions of incidents and learning was identified to cascade down to staff.
- All departments learnt from incidents regardless of where they happened. We saw learning from falls had not only taken place on the wards but in other areas of the hospital too. For example, we saw a sign in the endoscopy suite recovery room that said 'Call, Don't Fall'. This sign was encouraging patients to make use of the call bell rather than risk a fall. We also saw patient leaflets throughout the hospital titled preventing a fall during your stay. This leaflet listed ways to reduce the risk of falling.
- Learning from incidents led to improvements in patient safety and staff monitored resulting changes. Staff told us about an incident where a consultant had referred a medical patient to the medical admissions service. When the patient arrived, staff found the patient had an enteral feeding pump. An enteral feeding pump is a device used to provide nutrition to patients, via a tube, into their stomach or small bowel. The consultant had not handed over this information at triage. Staff did not have the skill mix to meet the patient's nutritional needs. Staff arranged an immediate transfer to a suitable hospital and raised an incident report. This incident led to clearer guidelines around the handover of a patient and the exclusion criteria. Nurses now monitor the information they receive and get accurate and thorough information for their triage. We saw evidence of this detail on the MAU referral sheets.
- The mortality and morbidity committee held monthly meetings. The deputy chief nurse, ward managers and the resident medical officer attended. A resident medical officer is a doctor who resides at hospital and is

available to provide continuous patient care. We saw the terms of reference for this committee and minutes from their meetings. The committee discussed and critically analysed the circumstances surrounding specific outcomes of care. These cases included any deaths that occurred at the hospital and any serious morbidity. 'Lessons learnt' was a standing agenda item.

- Openness and transparency about safety is encouraged. Staff described the principle and application of duty of candour, Regulation 20 of the Health and Social Care Act 2008. The duty of candour 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 them with reasonable support. Leaflets titled Being 'Open and Honest' with our patients were displayed at the front desk for patients. This leaflet explained what patients should expect if they were harmed because of a mistake or error in their care. We saw openness and honesty in an incident where a staff member had made a mistake with paperwork. They corrected the mistake, informed both patients, apologised to the patients and completed an incident report.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- Monitoring and reviewing activity enabled staff to understand risks and give a clear, accurate and current picture of safety. The safety thermometer is a national tool used for measuring, monitoring and analysing patient harms and harm-free care. The hospital measured venous thromboembolisms (blood clots in veins), new pressure ulcers, falls, catheter associated urine infections and harm-free care on a monthly basis.
- The ward manager told us the team monitored and reviewed safety thermometer results in team meetings every month. Staff shared any actions from these discussions to all staff.
- The safety thermometer was not easily visible on the ward. Staff displayed this data on a noticeboard low down, in small font and without colour. Although patients could see this data, it did not stand out and required you to bend down to read it. The ward manager recognised this and told us she was planning to make the data more visible.

Medical care

Cleanliness, infection control and hygiene

- The hospital did not report any infections of methicillin-resistant *Staphylococcus aureus* (MRSA), methicillin-sensitive *Staphylococcus aureus* (MSSA) or *Clostridium difficile* (C. diff) related to medical care services from November 2016 to October 2017. MRSA is a type of bacterial infection that is resistant to many antibiotics and capable of causing harm to patients. MSSA is a type of bacteria in the same family as MRSA but is more easily treated. C. diff is a bacterium that can infect the bowel and cause diarrhoea.
- The hospital did not report any cases of *Escherichia coli* related to medical care services from November 2016 to October 2017. *Escherichia coli* is a type of bacteria that can cause diarrhoea, urinary tract infections, respiratory illness and other illnesses.
- < > cardiac catheterisation laboratory screened new admissions for MRSA, *Clostridium difficile* and MSSA for those patients who had been inpatients at another hospital in the last six months. Staff maintained standards of cleanliness and hygiene throughout the areas where medical care took place. All areas were visibly clean and tidy. The ward manager told us that staff deep cleaned rooms after every patient. All equipment we checked had an 'I am clean' label and we saw daily monitoring cleaning sheets at the one-stop breast clinic.
- Safety systems and processes were clear and worked well. The ward manager told us that staff identified patients with a latex allergy, at the pre-assessment stage. Staff gave these patients red wristbands to identify them as having a latex allergy. Staff sought to improve processes and systems. For example, the hospital was planning trials to go latex free.
- There were reliable systems to prevent and protect people from infections. We saw alcohol hand sanitisers at the entrance of each patient bedroom so staff could decontaminate their hands at the point of care. This was compliant with the Department of Health's "
- All bedrooms had a dedicated clinical hand-wash basin. This was compliant with
- Hand hygiene leaflets were available on the ward; they outlined the five moments of hand hygiene. The five moments of hand hygiene are key moments that healthcare staff should clean their hands. We saw a member of staff thoroughly wash their hands between patients. Staff completed hand hygiene audits weekly. The most recent audit showed that hand hygiene compliance was 100%.
- The endoscopy unit managed and decontaminated endoscopes in line with national guidance. We did not see any endoscopy procedures but staff walked us through the decontamination process. This process was in-line with guidance from the Department of Health's "Choice Framework for local Policy and Procedures 01-06 – Decontamination of Flexible Endoscopes: Operational Management".
- The decontamination process started with an initial detergent wipe down of endoscopes before staff took them into the dirty utility room for manual cleaning. Staff used one sink for washing the scope. We saw staff could dispense an enzymatic solution in exact quantities at the touch of a button. Staff used the second sink for rinsing where only water was used to flush through the endoscope. This was compliant with Health Building Note 00-09: Infection control in the built environment that recommends; "For decontamination, two sinks will be needed – one for decontamination/ washing and one for rinsing".
- Following manual cleaning of endoscopes, staff used the washer-disinfector for decontamination. The endoscope was scanned and barcoded. We saw that the machine printed a receipt; this provided assurance the machine had performed complete decontamination after a cycle. Staff told us the printout alerted them if the machine had not worked correctly. This meant staff could resolve faults and re-process the endoscopes to ensure complete decontamination.
- There were processes to ensure staff reprocessed scopes at the appropriate time. Staff removed clean endoscopes from the other side of the washer-disinfector, in the clean utility room. Staff scanned the endoscopes into the drying cabinet where they could be stored for up to three days. Electronic displays on the drying cabinet alerted staff when the three-day period was ending.

Medical care

- Staff told us they used and regularly changed personal protective equipment, while decontaminating endoscopes. Staff told us they used a new visor each day and they changed disposable gloves, gowns and arm covers for every endoscope they decontaminated.
- Staff in the endoscopy unit told us that Facilities completed all water testing results for the Water Safety Group to review. We saw water testing certificates and these were completed weekly. We reviewed the minutes of the Water Safety Group meetings that showed test results were circulated to attendees. These meetings were attended by a number of staff from varying departments including the chief operating officer, the decontamination lead, the facilities manager and the consultant microbiologist.
- The endoscopy unit maintained standards of cleanliness and hygiene. The unit had an infection prevention and control audit every six months. Their last result (September 2017) was 95% compliant, against a target of 90%.
- A patient-led assessment of the care environment (PLACE) is a system for assessing the quality of the patient environment. The latest PLACE data for cleanliness reported 99% compliance; this was higher than the England national average of 98%. The assessment of cleanliness covers areas such as patient equipment, baths, showers, toilets, floors and other fixtures and fittings.
- However, we saw in each patient room on Nickleby ward, that a chair was placed between the hand hygiene sink and the bed. This would have obstructed access for staff, patients and visitors to wash their hands.

Environment and equipment

- The hospital was visibly clean and tidy both inside and out. There was information displayed on noticeboards and photos of staff and their roles. The latest PLACE data for facilities reported 97% compliance. This was higher than the England national average of 94%. The assessment of facilities covers the condition, appearance and maintenance of the environment.
- The design and use of the hospital building kept people safe. On inspection, we found the design of the building had patient access and safety in mind. The building and ground layout helped when discharging patients. The

layout of the hospital meant cars could safely pull up at the entrance of the hospital where staff helped discharged patients into the vehicle. The endoscopy unit had incorporated this as a standard part of their discharging procedure.

- Whilst we were on inspection, we noticed the main car park was often full. There was an over flow carpark that was a short walk from the main entrance to the hospital. We saw a car parked, partly, on the curb because there was not space in the main car park. Staff used off-site parking to keep spaces available for patients.
- Staff told us they knew how to report faulty equipment and did so by phone or email. Staff said it was an effective system and repairs were carried out promptly.
- All equipment we checked had evidence electrical safety testing. Some equipment we viewed had electrical safety testing stickers that were due to expire. The hospital electrical safety testing schedule had set out a clear program to service equipment. The equipment we saw, near expiry, was accounted for on the electrical safety testing schedule. We also saw confirmation that servicing was due to begin before the equipment expired.
- We saw an emergency chemical spill-kit, in the sluice, on Nickleby ward. This was clearly signposted and staff knew how to access the spill-kit.
- Resuscitation equipment was available and fit for purpose. We checked one resuscitation trolley on Nickleby ward and one in cardiac catheterisation laboratory. We checked for 29 items of medical equipment on the resuscitation trolleys and all 29 items were present. We found one item of disposable equipment that did not have an expiry date on it and staff immediately replaced this.
- Both resuscitation trolleys were secure and tamper-proof. We saw records of up to date consumable checks. We also saw regular maintenance checks were completed on both the defibrillators and suction units.
- The X-ray unit in cardiac catheterisation laboratory was equipped with the most recent development of X-ray equipment with the newest features. For example, we

Medical care

saw equipment that was enhanced to give the best image quality at a low dose. We also saw that weekly output tests were completed and the unit was serviced quarterly.

- Safety systems and processes were monitored to check equipment and keep people safe. The endoscopy suite used a room checklist on all equipment in the suite. We saw staff had correctly completed this on a daily basis. We also saw a service care plan that showed all equipment had been serviced up until May 2018.
- On our last inspection, we saw the recovery room for endoscopy was cluttered. It was full of tools and other items making access to the patient difficult. On this inspection, the recovery room was visibly tidy and had open floor space for staff to access the patient easily.
- Our previous report said the provider must ensure flooring in clinical areas complied with the requirements of Health Building Note 00-09: This meant carpets needed to be removed from areas where patients were cared for or treated. At this inspection, on the Nickleby ward we saw the provider had removed all carpets from the areas where patients were cared for or treated. We saw the hospital carpet replacement programme that planned to remove the carpeted areas on Havisham ward during April 2018 to April 2019. There were no carpeted areas in endoscopy, the one-stop breast clinic or cardiac catheterisation laboratory.
- Staff carried out quarterly infection prevention and control audits that included spot-checks of carpeted rooms. We also saw the carpet cleaning standard operating procedure. The standard operating procedure stated that carpets would be deep cleaned every six months for consulting rooms, every three months on wards or when soiled. All carpets we saw appeared clean and free from stains or contaminants.
- During our inspection, we saw there were no labels on waste bins on the ward or in patient rooms. This was not compliant with “Health Technical Memorandum 07-01: Safe management of healthcare waste (5.23)” that states, “The container labels should clearly identify the waste type(s) present within”. Correct labelling of waste bins is important to avoid the mismanagement of clinical or infectious waste.
- Staff monitored and improved their management of medicines, when required. Staff completed a medication management audit for September 2017 that showed low compliance for Havisham (80%) and Nickleby (60%) wards. The audit noted staff had left keys in the medicine cupboard, the medication trolley was open and there was one expired drug. Results of the medicines management audit went through the clinical effectiveness committee. Staff created an action plan to address the concerns raised from the audit. We saw that reminders were sent to staff regarding the expiry dates and the importance of key security.
- We inspected four months after the September 2017 audit. On inspection, we found medicines were stored safely and securely. We checked three medicine cupboards on the Nickleby ward, Havisham ward and in the endoscopy unit. Staff had locked all three medicine cupboards and kept the keys in a key safe that only trained nurses knew the code. We did not see any expired medicines during our checks. This showed their action plans were effective and improvements were being made to the management of medicines.
- Medical gases were stored safely. We saw the medical gases store cupboard on Nickleby ward was locked. The ward manager told us they did not routinely store medical gases. Medical gases were requested when a patient required them, for example, Entonox. Entonox is an inhaled gas used as pain medication. Oxygen was not stored in the medical gases store cupboard because it was supplied at bedsides through flow meters.
- We observed good storage and record keeping of controlled drugs on the wards. On inspection, staff had locked and secured the controlled drugs cupboard. The controlled drugs were only accessible by the ward nurse in charge. Staff had filled out the controlled drugs register correctly and the documented quantities were also correct.
- Staff administered medicines safely. We saw staff confirm the name and date of birth of a patient before administering their medication. The staff member showed each medicine to the patient and confirmed its name along with the reason it had been prescribed.
- Staff were familiar with the Safe Management of Controlled Drugs policy and could describe how they

Medicines

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would implement it. Staff told us that two members of staff carried out the preparation, checking and administration of controlled drugs. This was as outlined in the policy.

- Staff effectively monitored and maintained the temperature of medicine fridges. The hospital used a digital system to monitor fridge temperatures. This system monitored the fridge temperatures every 15 minutes, alarmed when it was outside of its limits and produced a report.
- Staff told us how they responded to the alarm when it notified them that fridge temperatures were out of range. The digital system would send an email to pharmacy, during opening hours, or would send a message to the lead nurse, during out of hours. This alerted staff to the fridge recording above or below the temperature limits. Staff told us they would go to the fridge and check what had caused the temperature change.
- We saw the report for medicine fridge temperatures for December 2017. The report showed fridge temperatures stayed within range for this entire period. Staff told us that alerts for out of range fridge temperatures were uncommon. Staff also explained; when the digital system had alarmed in the past it had been due to a fridge being open too long whilst retrieving or restocking medication.
- The endoscopy unit had ready access to reversal agents for patients recovering from sedation. We saw evidence of reversal-agent availability checks both signed and completed. Staff completed these daily at the start of every list. Staff also completed a monthly check that reviewed medication, fluids and reversal agents. Reversal drugs were stored in a locked cabinet and the endoscopy staff held the keys. Staff checked the contents using a checklist every day. The pharmacy team were responsible for checking medicine stock on the wards. The pharmacy staff told us they checked stock twice a week and used a red dot system to highlight medicines that were due to expire.
- The pharmacy team had a rotate and top-up system for medicine trolleys. Staff locked and secured the medicine trolley, to a fixed object, when it was not in use.
- The pharmacy department dispensed take home medicines and provided patients with an information leaflet about their medication. The pharmacy staff told us they explained take home medicines to patients before they were discharged. They explained the reason for use, the dosage, any side effects and the duration of treatment.
- Staff signed and clearly completed prescription charts. We reviewed 11 prescription charts. We saw staff had filled in all charts with medicine frequency, dosage and staff signatures to confirm administration. When an allergy had been reported we saw that the 'type of reaction' field had not been completed. The pharmacy team confirmed they would expect to see this complete.
- Prescribers did not always complete thorough and clear documentation when prescribing antibiotics. We reviewed one prescription chart that documented a prescribed antibiotic. Staff had not documented the stop date or rationale for the prescription. There was no review recorded and although staff told us the microbiologist had been consulted this had not been clearly documented in the record. The pharmacy team confirmed this was not in line with policy. This is also not in line with the National Institute for Health and Care Excellence QS121 statement 3 that states 'People prescribed an antimicrobial have the clinical indication, dose and duration of treatment documented in their clinical record'.
- We observed three bags of patient take-home medicines stored outside of the locked medicine cupboard, on Nickleby ward. These were placed down the side of the medicine cupboard. We were told this was because those patients were about to be discharged. This was not in line with the hospital's management of medicines policy that said the department manager must ensure that all medicines are in properly secured cupboards.

Records

- Patient records were written and managed to keep people safe. We reviewed 11 sets of patient records. Although one of the records was missing information about an antimicrobial the rest of the records were accurate, complete, legible and up to date.
- We saw staff had completed patient risk assessments for the 11 records we reviewed. All risk assessments

Medical care

followed national guidance. For example, all patients were risk assessed on admission for their risk of hospital-acquired venous thromboembolism; this was in line with the National Institute for Health and Care Excellence QS3 – statement 1 that states; “All patients, on admission, receive an assessment of VTE”.

- We reviewed one set of patient records in endoscopy; this was the ‘procedure care pathway’ record for a patient. This was accurate, complete, legible and up to date but missed a signature to insertion. Staff had placed a traceability sticker, for the endoscope used, in the record. We also saw the World Health Organisation ‘five steps to safer surgery’ checklist for an endoscopy procedure and this was complete.
- We saw patient notes were stored in a lockable trolley within the nurses’ station out of sight of patients.
- Patient records were organised and clearly laid out. For example, we could easily see where a pharmacist had reviewed medication or added comments because they wrote in purple.
- Staff carried out a nursing documentation audit for both Havisham and Nickleby wards. This scored 82% compliance against the hospital target of 85%. The audit reviewed 10 sets of patient records and checked 56 areas of compliance against national guidance. Where compliance was low, an action plan was created. The areas of low compliance were the recording of individuals making notes (70%), Malnutrition Universal Screening Tool (MUST) score given (70%), unintentional weight loss recorded (70%) and MUST carried out and counter signed (50%).

Safeguarding

- Staff understood their responsibilities and adhered to safeguarding policies and procedures. Staff told us they reported safeguarding concerns online and had access to paper copies as stated in the policy. Staff knew to send all reports to the safeguarding lead and knew this was the chief nurse. In the absence of the chief nurse, staff knew to report any concerns to the deputy chief nurse who was the deputy-safeguarding lead.
- Staff took a proactive approach to safeguarding and focused on early identification. Staff could tell us types of abuse and the signs or indicators that may be present. The process for identifying abuse was reliable

and minimised the potential for error. Staff told us they discussed any signs of abuse with their colleagues and the lead nurse. Once staff raised the report, the safeguarding lead reviewed it and referred the concern to the central duty team. This collective input supported staff to be confident in identifying signs of abuse.

- We saw the safeguarding policy was in date, ratified and regularly up for review. Staff planned a review every three years and the policy covered all types of abuse including female genital mutilation.
- Staff were familiar with the safeguarding policy. Staff we spoke to could tell us where to find the policy and told us they had signed to say they had read and understood it. Agency staff were provided with a hard copy of the policy.
- Staff took steps to prevent abuse from occurring, responded and worked effectively with others to implement protection plans. Staff told us about when they contacted the local authority and police about a patient who was suffering from domestic violence. Staff told us they completed a safeguarding referral and made a courtesy call, the day following discharge, to check the patient’s safety. This showed staff gave the safeguarding of vulnerable adults sufficient priority and worked effectively with other relevant organisations.
- Under the mandatory training policy, staff were required to complete safeguarding training every three years. Compliance rates for safeguarding training could not be separated for medical care as staff cared for both medical and surgical patients. The most recent data showed 98% of clinical staff were trained to the level required for safeguarding adults. This data also showed over 99% of clinical staff were trained to the level required for safeguarding adults. This is better than the providers’ compliance target of 95%. The safeguarding lead and deputy-lead were both trained to safeguarding level four in adults and this is in line with national guidance.
- Over 98% of clinical staff were trained to the required level for safeguarding children. Data showed that 99% of non-clinical staff were trained to the appropriate level. The safeguarding lead and deputy-lead were both trained to safeguarding level three for children; this is in line with national guidance.

Medical care

- There was active engagement with staff around safeguarding. In December 2017, the provider held an in-house training session for all staff. Staff told us this was scenario based safeguarding training and helped them build confidence around identifying signs of abuse.

Mandatory training

- Staff completed mandatory training. This covered a variety of areas through a mixture of online and face-to-face training sessions. The training included moving and manual handling, Infection prevention and control, sepsis management and consent. Staff told us the training was effective and additional training was available to reinforce their learning.
- We saw up to date mandatory training records for staff. Compliance rates could not be separated for medical care as the same staff cared for medical and surgical patients. Overall, completion rates for the hospital in December were 98% against a target of 95%.
- The provider monitored mandatory training effectively. Ward managers told us they kept up-to-date with the training needs of their staff. They also told us the provider employed a trainer to monitor all training needs and non-compliance.
- Resident medical officers were employed through an agency that was responsible for their training. The provider confirmed resident medical officers had up to date and suitable training by checking their curriculum vitae and requesting training certificates. In house training was also provided to resident medical officers as and when required.

Assessing and responding to patient risk

- Risks to patients were assessed, monitored and managed daily or when there was a change to the patient. We saw 11 patient records and all showed the completion of daily risk assessments. These covered risk of pressure damage, falls and malnutrition.
- When assessments identified a risk, staff developed risk management plans to manage that risk. For example, staff placed a magnet next to a patient's name to alert staff to a falls risk. Staff displayed this in the nursing station out of the view of patients. This enabled all staff that interacted with that patient, to be aware of any additional support needed.

- Patients were involved in managing risk. The patients identified as a falls risk were given a leaflet titled, "Preventing a fall during your stay". This gave patients clear guidance on how to reduce their risk of falling and explained the responsibility of staff. For example, the leaflet explained the importance of using call bells and outlined some exercises that may help improve patient stability and strength. The leaflet also eased any worries patients may have had about asking for help.
- A senior nurse triaged medical admissions to manage risk. The medical assessment unit had an exclusion criterion to ensure patients with unmanageable risks were not accepted. The senior nurse used the exclusion criteria that clearly set out which patients the ward would not accept. The senior nurse asked additional questions to get a thorough hand over. A consultant then reviewed the handover to act as an additional check.
- Staff recognised and responded to deteriorating patients. Three enhanced care bays were available on Nickleby ward and four of the rooms on Havisham Ward could be used as enhanced care bays. Staff told us they used the enhanced care bays when they felt a patient required closer monitoring and a higher level of nursing care. If a patient deteriorated beyond their management, staff arranged a transfer for the patient to a suitable hospital.
- We reviewed service level agreements, regarding emergency transfers, between KIMS Hospital and three local NHS trusts. This detailed that KIMS Hospital's resident medical officer would complete a transfer letter that clearly summarised the patient's history and an agreement would be made whether to send the patient directly to critical care or to the receiving trust's accident and emergency department. The agreement stated that KIMS Hospital would be provided with feedback on the care and development of the patient within 24 hours of the transfer.
- We saw the hospital policy for The Transfer of Deteriorating Patients. This policy had been ratified and a review was scheduled every two years.
- Resuscitation equipment was suitable and easy to access. All staff, we spoke to, could tell us where the resuscitation trolley was and knew how to find the equipment quickly.

Medical care

- The hospital used the National Early Warning System (NEWS) track and trigger flow charts. NEWS was a simple scoring system to help identify patients whose conditions may be deteriorating. In the 11 records we reviewed, staff completed NEWS assessments accurately and had documented a total NEWS score. The most recent NEWS audit (December 2017) showed 92% compliance against a hospital target of 100%.
- We saw that staff used NEWS assessments in the endoscopy procedure care pathway. The endoscopy nurse stayed with their patient throughout recovery. The nurse could access an emergency buzzer if the patient deteriorated. Both endoscopy and ward staff responded to the emergency buzzer.
- The cardiac catheterisation laboratory carried out comprehensive risk assessments for all patients. A cardiac catheterisation laboratory is where imaging equipment is used to view the arteries and chambers of the heart. Tests and procedures are carried out to diagnose and treat any abnormalities found. The laboratory had robust documentation to assess patients and minimise risks. All patients received a guide and information sheet for their procedure. We saw a pre-assessment and discharge checklist and specific pathways for each procedure. Based on risk assessments, staff had included additional checks to the World Health Organisation 'five steps to safer surgery' checklist.

Nursing staffing

- Staffing levels and skill mix were planned, implemented and reviewed to keep patients safe at all times. The ward manager told us they created rotas a month in advance and reviewed them weekly.
- The ward manager checked their staffing numbers and skill mix to ensure staffing was appropriate for the patients on the ward. When a medical admission was requested, the senior nurse made a decision based on the current staff skill mix along with the exclusion criteria.
- Staff shortages were managed and responded to quickly. On our inspection, we saw that four nurses and two healthcare assistants were required; the staffing levels met those needs. The Nickleby ward was always open and Havisham ward opened if there was a need for it. The ward manager told us they always planned

enough staff for two open wards. This was to ensure there was enough staff to manage if Havisham ward opened during a shift. There were also two bank nurses included on the rota because they had committed to regular shifts.

- Staff told us they were flexible with shifts and happy to adjust them to suit patient need. If a patient deteriorated and needed transferring to an enhanced care bed, the ward manager would increase the nursing staff.

Medical staffing

- The one-stop breast clinic was led by consultant breast surgeons. The clinic had dedicated breast radiologists, mammographers and a Macmillan breast cancer nurse. Patients attended the clinic if they experienced symptoms or concerns associated with breast cancer. Patients met with their consultant who discussed their concerns and examined them. The consultants referred patients for diagnostic scans and a biopsy could be completed on the same day, if required. The consultants then reviewed the diagnostic results and discussed them with their patient. If the consultant recommended further treatment, they discussed the options with their patient. The clinic did not offer chemotherapy; patients were transferred for chemotherapy elsewhere and could return for breast surgery at KIMS Hospital. The Macmillan breast cancer nurse was with the patient throughout the appointment to offer support.
- The one-stop breast clinic employed two mammographers and a lead mammographer. We saw that a radiologist, mammographer and breast surgeon were available to offer the one-stop service during opening hours. Staff told us there was always a lead radiologist available at the times the one-stop breast clinic was seeing patients. This was to provide additional support if it was required.
- Resident medical officers were available 24 hours a day and seven days a week. They worked a rota of one week on and one week off.
- The resident medical officer attended ward meetings every morning to get any updates on patient risks or staffing changes. Staff told us that a second resident medical officer could be requested for support if needed.

Medical care

- A consultant saw their patients daily. Staff told us that consultants were easy to contact and responded quickly if needed and patients told us they were happy with the visibility of their consultant.
- This service operated two inpatient wards that shared with surgical patients. The medical staffing arrangements are reported on under the surgery service within this report.

Major Incident awareness and training

- Staff told us they had completed training in major incident awareness and were attending additional, scenario-based, training at the end of January 2018.

For our detailed findings, please see this section in the surgery report.

Are medical care services effective?

Good 

We rated effective as **good**.

At our last inspection, we rated effective as good. On this inspection, we have kept the rating as good because the provider has maintained effective care and treatment that meets patient needs.

Evidence-based care and treatment (medical care specific only)

- We saw relevant and current evidence based guidance. Standards, best practice and legislation were identified and used to develop how services, care and treatment were delivered. Although the hospital did not routinely offer end of life care, they had an end of life policy that referred to national guidelines. We saw reference in the policy to the national end of life strategy, guidance from the "More care, Less Pathway" (A review of the Liverpool Care pathway July 2013) and NICE guidelines for the "Care of Dying Adults".
- The provider kept policies current and up to date. We reviewed 24 policies, all of them were in date, approved and had reviews planned within three years. For example, we saw the mental capacity and deprivation of liberty policy, the antimicrobial stewardship policy and

the Endoscope decontamination policy. We also saw version numbers covering the past three years, this was to make changes following a review or to reflect changes to best practise guidelines.

- Departments regularly monitored their adherence to national guidelines and routinely reviewed updates. Staff told us that the one-stop breast clinic had been mapped out against national guidance. A representative from the one-stop breast clinic attended the breast specialty meetings. Staff held these quarterly where NICE guidance was a standing agenda. The clinical leads sent out new national legislation, regulations and guidance to relevant people, for example the urology guidelines.
- The endoscopy unit did not have Joint Advisory Group (JAG) accreditation at the time of inspection. The JAG accreditation scheme is a patient centred scheme that independently assesses endoscopy units against standards. To achieve JAG accreditation an endoscopy service must provide clear evidence they have met all of the standards. The lead practitioner told us they were working toward JAG and felt the clinical aspects of the service suited JAG standards but the facilities, placement of the unit and patient flow did not.

Pain relief (medical care specific only)

- Staff regularly assessed pain. The National Early Warning Score (NEWS) chart improves detection of a deteriorating patient by regularly reviewing six physiological findings and one observation. The NEWS chart also has a pain assessment section where staff can easily monitor pain over time. We saw 11 sets of patient records; all 11 showed staff had recorded pain scores at every set of routine observations.
- Staff effectively monitored and managed pain. Staff assessed pain for medical patients using the numeric rating scale (NRS-11). The NRS-11 is an 11-point scale used for adults and children, aged 10 and above, to self-report their pain. Patients were asked to rate their pain out of 10, 10 being the worst pain and zero being no pain. We saw evidence that staff used and managed these ratings. Out of 11 records, two showed a pain score of two out of 10, both patients received prompt pain relief medicine. The remaining nine patients had rated their pain as zero.

Medical care

- There were processes to make sure pain relief medicines were effective for patients. Staff told us that they had a pain escalation plan if the standard pain relief medicine was not effective. A consultant would reassess the patient and prescribe as needed pain relief medicine. As needed pain relief medicine was usually a stronger pain relief medicine for staff to administer when the patient's pain was unmanageable.
- Staff completed regular pain management audits. The most recent audit (October 2017) reviewed 20 sets of records for both medical and surgical patients. Staff were 100% compliant in recording pain scores at every set of routine observations. However, staff were only 65% compliant in re-checking pain scores 30 minutes after administering pain relief medicine. This suggests staff were routinely checking pain scores but they were not routinely checking the pain relief had been effective. This meant it could take longer to recognise a patient needed stronger pain relieving medicine. This risked leaving patients in pain longer than necessary.
- The hospital used a quality dashboard to cover five areas of patient outcome. Staff discussed and reviewed the submitted data at governance committee meetings. This data monitored patient outcomes such as hospital-acquired venous thromboembolism and mortality rates.
- We saw the one-stop breast clinic regularly monitored patient outcomes. Staff completed breast clinic audits quarterly and staff discussed the results at quarterly breast specialty meetings.
- The one-stop clinic is a service offered to patients who have symptoms associated with breast cancer. The idea of 'one-stop' is that patients can book one appointment and have all diagnostics and tests completed in one visit. This is particularly important for patients who are concerned about their symptoms. The examination, diagnostic tests, scan results and consultation are completed on the same day.
- Previously, due to staffing, the one-stop clinic could not always deliver the service in one day. This meant that some patients attended appointments and were told they had to return to complete tests. After review and discussion around patient outcomes, the provider created assurance processes to guarantee the consistency of the one-stop clinic. During the reporting period, 111 patients attended the one-stop breast clinic. The clinic was able to provide the one-stop service to 107 of these patients.
- Accurate and up-to-date information about effectiveness was shared and understood by staff. The hospital participated in regular local and national audits such as the Saving Lives audit. The Saving Lives audit is used to monitor healthcare associated infections and the related risks. Staff told us about the five points of care from the Saving Lives campaign and they understood the effectiveness of washing their hands at those key moments.
- Staff created action plans to address deviations from targets identified by audits. Staff told us that missed targets were discussed, at clinical effectiveness meetings, to action improvement. For example, the November NEWS audit showed 60% compliance against a target of 85%. Staff reviewed this audit and implemented an action plan to improve compliance. This action plan included discussing the importance of

Nutrition and hydration

- Staff assessed patient nutrition and hydration needs. Staff completed a documentation audit for September 2017 that showed low compliance (70%) that a malnutrition universal screening tool (MUST) score was recorded, against a hospital target of 85%. We inspected four months after the September audit. On inspection, we found all patients had a nutritional assessment on admission. We reviewed 11 patient records. Staff had screened all 11 patients for malnutrition and noted a MUST score. This showed, since their September audit, improvements had been made regarding MUST documentation.
- The patient-led assessments of the care environment (PLACE) data in August 2017 for food reported 89%; this was slightly below the England national average of 90%. The assessment of food covers the taste, presentation and temperature of food on offer to patients.

Patient outcomes (medical care specific only)

- The hospital routinely collected and monitored information about patient care and treatment, and their outcomes. The hospital submitted data for patient outcomes to all nationally recognised data submissions. This is so their data could be monitored in line with other national data and organisations.

Medical care

the NEWS system with staff and shadowing the completion of NEWS to provide support and advice. In December 2017, the same audit showed 92% compliance. This showed the hospital had a culture of working together to improve care, treatment and patient outcomes.

Competent staff

- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. In the cardiac catheterisation laboratory, we saw that staff were well-informed and showed competence. We saw competency packs for new starters, agency staff and current staff competency records were complete and up to date. For example, all cardiologists were Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) certified.
- The lead mammographer had created competencies for staff as well as a specific competency pack for mammographers. We saw three competency records that were complete and up to date. The lead mammographer alternated between staff each week on a one-to-one basis to build on competencies. This meant staff received one-to-one competency reviews every three weeks.
- We saw competency folders for endoscopy staff that showed all training was in date, complete and covered the required competencies for endoscopy. Theatre nurses, who worked in endoscopy, updated their competencies yearly or as and when required.
- The provider identified the learning needs of staff and implemented training to meet these learning needs. The provider offered staff a variety of in-house training sessions to help reinforce their learning. In December 2017, staff completed a safeguarding and Mental Capacity Act (MCA) workshop. Staff told us this was a learning need. This showed the provider was listening to staff and providing effective training.
- The provider supported staff to maintain and further develop their professional skills and experience. Staff had access to additional training such as national vocational qualifications (NVQs). The provider had a management development programme delivered by a local college. Staff were required to express an interest and apply via an interview to be accepted. We spoke with three staff members who were completing stage three of the leadership and management course.
- The hospital supported staff to build relationships with other hospitals to improve their skills. The lead mammographer, in the one-stop breast clinic, attended a teaching hospital in London, every three months, for a shift. This was to observe, detail learning and identify what processes or ideas could be brought to the one-stop breast clinic.
- The induction process, offered to new staff, supported them to deliver effective care and treatment. The induction pack for new starters included an orientation pack that took a year to complete. The pack included the signing off of all policies, processes and procedures. The pack also covered areas such as equality and diversity, moving and handling, and communication and documentation. We observed meaningful supervision where staff gave a new member of staff both support and advice. A new starter on Havisham ward told us they felt very well supported by the entire team. They had a buddy who checked on them every hour to provide support.
- Bank staff receive the same mandatory training as permanent staff.
- Staff told us that appraisals took place and these included going over equipment competencies. We reviewed the appraisal rates and found that 100% of the staff in the endoscopy unit, the cardiac catheterisation laboratory and the one-stop breast had completed their yearly appraisal. We also saw that 23 out of 24 (96%) ward staff had completed their yearly appraisals.
- When we last inspected, the endoscopy unit only performed four to five procedures per week. This was a low number of procedures with which to maintain skills and competencies. When we inspected, the unit was completing 15 to 20 procedures per week. The number of procedures has more than tripled. Staff felt the number of procedures was enabling them to maintain their skills.

Medical care

- The hospital provided training to staff and offered additional resources to help embed their learning. All staff had received sepsis training. We also saw a sepsis box on the ward. This held the sepsis six pathway, the sepsis assessment tool and the sepsis policy.

Multidisciplinary working

- Staff delivered care in a coordinated way when different teams were involved. At the nurses' station, out of sight of patients, we saw a board with differing magnets against patient names. We saw magnets that represented a falls risk, bloods needed, bloods taken, safeguarding concerns, an infection alert and so on. This system was set up so any member of any team could check the whiteboard and clearly see what their patient needed along with any risks they had. This was an effective way of making sure all teams communicated in a coordinated way.
- We saw the magnet system in action. A physiotherapist cared for a patient and then removed the 'physiotherapy' magnet from the patients' name on the white board. When a nurse looked at the patient's name, later on, she knew immediately that the physiotherapist had been.
- Care was coordinated through daily team meetings. A representative from the pharmacy attended the ward team meetings every morning along with the resident medical officer and nurses. In addition, a representative from all departments attended the daily communications meeting. These regular multidisciplinary meetings gave staff the opportunity to discuss patients moving from one service to another.
- There were pathways for referral to NHS hospitals both in an emergency and routine situation. If needed, the one-stop breast clinic referred patients to an NHS hospital to undergo chemotherapy and then the patient could return to KIMS Hospital for surgery. Staff told us this was a seamless process and worked well for patients.
- Staff worked together to understand and meet the range and complexity of patient needs. The wards had good links with the end of life champion at the local hospice. Staff worked closely with the hospice when caring for an

end of life patient. The mammographers at the one-stop breast clinic had links with the lead mammographer supervisor, at an NHS hospital, who was available to provide support and advice.

- The hospital shared important information with relevant healthcare professionals so patients could have good continuation of care after discharge. The cardiac catheterisation laboratory had a comprehensive discharge checklist and shared this with their patients' general practitioners. On the ward, staff had good access to community services. The ward had a shared drive for referrals and staff contacted social services where necessary to arrange extra support for patients.
- In our last report, we told the provider to implement arrangements for end of life care patients to be referred to palliative care specialists and to be included in local palliative care multidisciplinary team networks. We saw the referral pathway to a local hospice and saw the end of life care policy. The policy outlined the responsibility of staff to coordinate an individual care plan with the hospice team.

Seven-day services

- The medical admissions service was open for admissions 24 hours a day and seven days a week.
- Patients in the endoscopy unit were given the ward phone number and main hospital number, following their discharge, so they had access to support 24 hours a day and seven days a week.
- The consultant database and drive was accessible via the buddy system. If a consultant was on leave their buddy would cover. Staff told us, all consultants were happy to be contacted at weekends and out of hours.
- Ward staff told us, the haematologists had an on call rota so they could be accessed at any time of day.
- Resident medical officers were available 24 hours a day and seven days a week.
- The pharmacy was open Monday to Friday 9am to 5pm and they had an on call rota so staff could contact them outside of these hours.

Access to information (medical care only)

Medical care

- The hospital standard for the one-stop breast clinic was for mammogram reports to be available on the same day. The hospital showed us a random selection of 10 patients, all 10 patients had imaging and reporting on the same day.
 - All information needed to deliver effective care and treatment was available to staff in a timely way. For example, the lead mammographer had access to patients' previous mammogram images from all NHS hospitals. Access to these enabled the radiographer to compare current images with previous ones and made identifying any irregularities easier.
 - On discharge, staff sent care summaries to the patient's general practitioner (GP) to ensure continuity of care within the community. Information on discharges was emailed, manually, to the GP. Staff told us they were hoping to have a system that did this automatically in the future. The cardiac catheterisation laboratory also routinely sent results and a discharge letter to their patients' GPs.
 - The endoscopy unit had arrangements to ensure diagnostic imaging and endoscopy results were available in a timely manner. Patient records were kept at the hospital and the endoscopy report was automatically generated while the patient was still in theatre. Staff discharged patients from endoscopy with a discharge summary and a copy of the endoscopy report that gave details of the findings. Staff sent a copy of the discharge summary to the patients' GP and staff kept a copy at the hospital to ensure continuity of service.
 - The ward clerk was able to access medical records for patients if required. This could be accessed instantly on a shared system and then made available to staff so they could provide suitable care or treatment to their patient.
 - When the hospital admitted a patient to the endoscopy unit the nurse went through a 'procedure care pathway' booklet, this included a consent section. The consultant then formally gained consent from the patient. This was a separate consent form and sat in the medical notes.
 - The provider supported staff with relevant training to give them the skills and confidence to adhere to legislation and guidelines around mental capacity. All staff completed Mental Capacity Act training. In December 2017 staff attended a workshop on the Mental Capacity Act that gave them scenario based training.
 - When patients lacked capacity to make decisions, staff supported each other by arranging a best interest meeting. A best interest meeting was held when patients lacked capacity to make decisions for themselves; this is so staff can make informed decisions for the patient's best interest. Staff told us they felt confident to carry out a mental capacity assessment and had good links with a dementia care specialist to get advice on dementia concerns.
 - The provider ensured it met the responsibilities within legislation and followed relevant national guidance. We reviewed the hospital's "consent to investigation or treatment" policy. This referred to guidance such as the Department of Health reference guide to "consent for examination of treatment". The policy was in date and due for review within 3 years. Staff were aware of their responsibilities around consent and although the policy was new (issued December 2017); they were already familiar with it.
 - Staff from the cardiac catheterisation laboratory completed mental capacity assessments during the pre-assessment of a patient. Staff placed consent stickers onto patient records to confirm consent had been received. This made it visible if a patient had or had not consented to the procedure.
 - The lead radiographer recalled one occasion where staff had not picked up capacity concerns at pre-assessment stage. Concerns were not identified because the patient was in the early stages of dementia. Before the procedure, the consultant felt the patient was unable to consent. Staff delayed the procedure and held a best
- Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (medical care patients and staff only)**
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Staff we spoke to could describe their responsibilities to ensure patients consented when they had the capacity to do so.

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interest meeting. It was then that staff became aware of the patient's early onset dementia. This showed that safety processes were effective when identifying the capacity to consent.

- Staff understood the 'do not attempt cardio-pulmonary resuscitation' (DNACPR) decision making process and described working with families through the process. At the time of inspection, there were not any medical patients with a DNACPR.
- The hospital audited their DNACPR process in January 2017. The data showed 85% compliance against a target of 100%. The audit highlighted that staff were making decisions verbally but not always recording those decisions. We saw an action plan to raise the areas of non-compliance. There had not been any patients with a DNACPR since the audit in January 2017 was carried out.

Are medical care services caring?

Good 

We rated caring as **good**.

At our last inspection, we rated caring as good. On this inspection, we have kept the rating as good because the provider has continued to support patients, treat them with dignity and respect and involve them as partners in their care.

Compassionate care

- Staff took the time to interact with patients and those close to them in a respectful and considerate manner. We spoke to a medical patient who told us that staff did their best to make her and her husband feel as comfortable as possible. The patient said cleaning staff, nursing staff and consultants stopped to say hello and she regularly had staff sit and chat with her. The patient's husband told us that he too was pleased with the level of care and compassion the staff showed them. We observed friendly, welcoming and respectful interaction between this patient and staff.
- Staff respected patient privacy and dignity. Both Havisham and Nickleby wards had single bedrooms with adjoining bathrooms and we observed staff knocking before entering them. The patient-led

assessments of the care environment (PLACE) data for privacy, dignity and wellbeing released in August 2017 reported 95% compliance; this was well above the England national average of 84%.

- The hospital placed CQC comment cards around the hospital so we could get patient feedback about what patients thought of the service they received. We reviewed 28 comment cards related to medical care and all 28 were positive.
- The hospital carried out monthly patient satisfaction surveys. We saw 13 comments directly praising the one-stop breast clinic where patients regularly commended the lead mammographer. We also spoke with two patients at the cardiac catheterisation laboratory who were very satisfied with their care and both commended the staff for their work.
- Staff showed an encouraging, sensitive and supportive attitude to patients. The one-stop breast clinic cared for patients often at a time of anxiety and stress. The team told us they felt very strongly about making patient assessments as relaxed as possible and were very aware of psychosocial aspects of care. The lead mammographer took the time to ring all patients, a few days after they had attended the clinic, to offer support and answer any questions they may have had. One patient commented that the lead mammographer 'was very good at making me feel comfortable and made the procedure very bearable'.
- We observed staff introducing themselves to patients and their relatives throughout our inspection.
- We saw staff responded to patients' call bells in a timely manner.

Understanding and involvement of patients and those close to them

- Staff recognised when patients and those close to them needed additional support to help them understand and access the services. Staff told us about a husband who requested information from the one-stop breast clinic for his wife. The husband was very concerned and wanted someone to explain the service to him. The lead mammographer made the time to sit down and

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explained the services in a way he could understand. The lead mammographer then wrote down all the information they had discussed so that he could relay the details to his wife.

- Staff communicated with patients so that they understood their care and treatment. We reviewed patient feedback that said the one-stop clinic team ‘explained exactly what they were doing prior to any action, took care of my comfort, and was able to put my mind at ease’.
- Staff made sure patients were able to find further information and ask questions about their care. The cardiac catheterisation laboratory carried out a ‘topic of the month’ for patients to read in the waiting area. They also displayed monthly patient survey results for patients to view. Staff sent patients all information, prior to assessment, to ensure that patients fully understood what was going to be done during the procedure. Staff told us they routinely asked, before and after the procedure, if patients had any questions.

Emotional support

- Staff provided emotional support and information to those close to patients using the service. The hospital did not routinely offer end of life care. Staff arranged to offer end of life care to a medical patient who requested it at the hospital. Staff worked with the local hospice to ensure both the patient and his family had the right support. The patient’s wife wrote a thankyou letter to all staff and referred to each staff member that cared for her husband by name. The patient’s wife wrote ‘what came to us at KIMS . . . was loving kindness, if I ever saw loving kindness . . . the tenderness that came to us in our time with you, money cannot buy’.
- Staff gave patients timely and appropriate support and information to cope emotionally with their care. A Macmillan breast cancer nurse was an important part of the one-stop clinic service. A Macmillan breast cancer nurse is trained to support patients from screening to diagnosis. They provide patients with the information they need to make informed decisions about their treatment.
- The Macmillan breast cancer nurse stayed with the patients at all times during the one-stop clinic appointment. This was to provide support, explain the process and answer any questions. If the breast cancer

nurse was on holiday then the clinic had suitable cover to fulfil this role. Staff told us that information was not delivered to patients without the breast cancer nurse present.

- Staff understood the impact a patients’ care could have on their wellbeing. Staff at the one-stop breast clinic told us they spent more time with patients who needed reassurance and support. Staff told us they knew when it was best to leave the room and give a patient some time to themselves. A patient thanked the one-stop breast clinic team for “paying attention and care to my anxiety”, another said “thank you for treating me as an individual and not another number”.

Are medical care services responsive?

Good 

We rated responsive as **good**.

At our last inspection, we rated responsive as good. On this inspection, we have kept the rating as good because the provider had continued to organise services so they met patients’ needs.

Service planning and delivery to meet the needs of local people

- The hospital aimed to serve the people of Kent. Medical care services were provided to adults. The hospital had an ‘Equality, Diversity and Inclusion’ strategy. This strategy had an ‘about Kent’ section. This covered the profile of residents in Kent and how they represented protected characteristics according to age, disability, diversity, religion, gender and sexual orientation. This strategy showed that the hospital had a good understanding of the needs of local people.
- At our last inspection, we identified there were no policies or guidelines to provide a comprehensive one-stop breast clinic with support services. Many appointments were cancelled or the one-stop service was not offered. Staff used this to inform how they planned and delivered services. At this inspection, staff told us they made sure they had a breast surgeon, a mammographer and a radiologist present on the day of a patient’s appointment. Feedback from patients said they would rather be informed, ahead of time, of

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cancellations than arrive and have to return because the one-stop facilities were not all available. If not all three specialists were available the lead mammographer cancelled appointments ahead of time.

- The importance of flexibility, choice and continuity of care was reflected in services. We saw an example of this at the one-stop breast clinic. If an ultrasound detected an area of concern, the consultant requested the patient to have a biopsy. Due to financial considerations, patients were not obliged to have their biopsy at KIMS Hospital. Patients could be referred to a NHS hospital for a biopsy. If a patient was diagnosed with cancer at KIMS Hospital, staff referred them to the NHS care pathway and patients were welcomed to return for breast surgery.
- Staff planned and delivered services in a way that met the needs of individuals. The provider employed a Macmillan breast cancer nurse to work at the one-stop breast clinic. This nurse met with the lead mammographer to discuss patients, in advance, so they were prepared for each patient, as individuals, and took into account both mental and social factors.
- The provider implemented processes and ensured they planned procedures ahead of admission. For example, the endoscopy unit made sure staff had completed the 'procedure care pathway booklet', on the phone, before the patient attended the unit. The 'procedure care pathway booklet' was an information booklet the nurses used to document advance information on the patient and to go through the process with them. We also saw the one-stop breast clinic held information on their patients meaning they could plan for assessments. The lead mammographer contacted the relevant hospital to get copies of previous scans and had them available on the day so the radiologist could compare with them.
- Care and treatment was coordinated with other services and providers. There was an emphasis on a good relationship with local NHS trusts. The cardiac catheterisation laboratory treated 666 patients from November 2016 to October 2017. Out of the patients treated, 321 of these were NHS patients. The NHS patients had been referred to the cardiac catheterisation laboratory from local NHS trusts to help fulfil extra capacity requirements.

- There were arrangements for food and drink provision for relatives. Patients' friends and relatives had access to refreshments. There was a new café for hospital visitors to get hot drinks and light snacks. We saw ward staff offer relatives tea and coffee. There were not any visiting hours, family were free to visit as, and when they wished, this was because patients were admitted at different times for differing lengths of stay. Staff told us if a family member wanted to stay overnight, the hospital could accommodate them.
- Staff treated patients as individuals regardless of their admission route. The wards, endoscopy and cardiac catheterisation laboratory were accessible to NHS, self-funded and medical insured patients. The chief executive officer told us that private and NHS patients were treated the same throughout the hospital. We saw that the rooms, the waiting times and the care provided did not differ between private and NHS patients. We reviewed patient feedback from a patient who had experienced being a private patient and was now concerned they would be treated differently as an NHS patient, they said 'so far so good, I can go forward with my treatment with confidence.'

Access and flow

- The average referral time to treatment for the endoscopy unit and the cardiac catheterisation laboratory was two weeks. The average referral time to treatment for the one-stop breast clinic was one week. This average referral time to treatment was only available for NHS patients as private patients could begin their pathways elsewhere. This was within the hospital referral to treatment time target.
- Waiting times and delays were minimal and managed appropriately. In the endoscopy unit, rather than give patients a specific time slot, staff let patients know if they were on a morning or afternoon list. This was to manage patient expectation and account for any potential delays.
- Staff kept patients informed of any disruption to their care. For example, staff told us that in the endoscopy unit nurses kept patients informed of any delays at least every 30 minutes.
- Cancellations were minimal, patients were informed in good time, and alternative arrangements were made available. In the reporting period, 111 patients required

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the one-stop breast clinic. Staff cancelled only four of these appointments (less than 4%). If staff needed to cancel services, they contacted the patient as soon as possible and offered an alternative appointment.

- Patients could access services via a number of routes. The cardiac catheterisation laboratory accepted private, self-pay and NHS patients. These were arranged via consultant referrals. The cardiac catheterisation laboratory had contracts with Medway NHS Foundation Trust. They received transfers from Medway as 'treat and return' patients. This was for the more stabilised patients who were safer to transfer.
- Patients could access the right care at the right time. Medical patients could access care and treatment at a time to suit them. The medical admissions service was open for admissions 24 hours a day and seven days a week. The lead nurse triaged patients to ensure the unit had the right care available for the patient.
- Patients were admitted to Havisham ward using the medical admissions referral system. Referrers were usually GP's or consultants. We saw the medical admissions flow chart that outlined the pathway for a medical patient to be admitted to KIMSHospital. The referrer called the senior nurse who took a basic triage and declined any patients who met the exclusion criteria. For accepted patients, the nurse contacted the consultant on-call to confirm suitability of the patient. If any further information was required, the consultant contacted the referrer within 30 minutes. Confirmation of admission was communicated with the referrer and reservations allocated a room to the patient. Staff gave patient details to the resident medical officer and reception desk so they knew to expect the patient.
- Staff managed access to care to take account of peoples' needs. The medical admissions service had an exclusion policy; the lead nurse used the exclusion policy and skill mix of the staff, on shift, to decide whether they could provide access to the right care. If an inappropriate referral for admission was received, the referring clinician was advised immediately and given appropriate advice. Staff told us when a referral was made for an acute stroke patient. Acute stroke was on the admissions exclusion list. The staff member declined the referral at the first stage of triage and advised the patient to be referred to a hospital with a Hyper Acute Stroke Unit attached.

- The appointment system was easy to use and supported people to make appointments. The one-stop breast clinic was open Tuesday and Wednesday from 6pm to 8pm. Patients could call the admissions line or send an email to the hospital to request an appointment. We saw the contact details to do this were provided on the breast clinic information leaflet. The secretary managed the appointments and liaised with patients to provide them with an appointment time that best suited them.
- We reviewed patient feedback where a patient said they were "given an appointment within a week and it was well carried out . . . quick, friendly professional and appointment on time", another said they "didn't wait hardly any time for [their] appointment".

Meeting people's individual needs

- Staff had a suitable discharge plan. The wards ensured all necessary documents were completed and available for both the patient and their GP before discharge. Staff recognised areas for improvement. There was not a discharge team but the ward manager recognised this was an area to develop and had prepared to recommend this to the board.
- Staff responded to patients' individual needs by providing quick and efficient discharging when needed. Staff told us about an end of life patient who was being cared for at the hospital but then decided that he wanted to be at home. This discharge needed a quick transition time so staff could fulfil the patient's wishes. With the support of the local hospice, the team rallied together and managed to discharge the patient, on the same day, with an implemented care plan.
- Staff took action to remove barriers when people found it hard to access services. Staff told us they had access to a language line interpreter and they knew how to access this. Staff communicated using picture books with patients who had difficulty verbalising.
- Staff planned, delivered and coordinated services to take into account patients with complex needs. Staff told us about their care of dementia patients. Staff had a good relationship with the local hospice and access to dementia care specialists. Staff told us about concerns they had for a patient living with dementia who did not have capacity. Staff arranged a best interests meeting

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and spoke to a dementia care specialist at the local hospice. The dementia care specialist knew the patient and so was able to offer advice and a history so staff could better assess what was best for the patient.

- Staff planned services to take into account the needs of different people by offering alternative ways of communicating information. We saw leaflets were available to send home with patients after they had visited the one-stop breast clinic. These leaflets had the clinic phone number on so that patients could contact the clinic with any concerns, questions or worries. Staff in the endoscopy unit told us that once patients were ready to be discharged the consultant returned to see them and gave further advice and information before they left. We also saw an aftercare leaflet available for patients in the cardiac catheterisation laboratory and staff told us they called the patient three days after discharge for an after care check-up.
- Staff carried out thorough assessments to ensure services were delivered to meet patients' individual needs. Staff told us about a patient whose family requested a transfer to the medical assessment unit. The patient was confused and so the lead nurse was concerned the staffing numbers were not high enough to offer the patient safe care. The team completed comprehensive checks to see if they could adjust staffing to get the right skill mix for the patient. Following risk analysis, staff offered one-to-one enhanced care that the family gladly accepted.
- There were no protected meal times. Staff told us patients chose when they wished to eat, and so meal times differed from patient to patient.
- Catering services were available to patients. The menu had a wide range of sandwiches and hot meals. The menu did not change regularly because of the variety of meals available. If patients did not find anything to their taste the chef would visit the patient, discuss and accommodate requests. We also saw a separate menu for bariatric patients, this followed guidelines concerning protein, fat, sugar and overall calories.
- Patients gave good feedback on the menu. A patient told us the food was 'very good'. We saw patients' water being re-filled promptly and we saw a patient given raspberry leaf tea as staff knew it was her favourite.

- Patients' friends and relatives had access to refreshments. There was a new café for hospital visitors to get hot drinks and light snacks and we saw ward staff offer tea and coffee to family members.
- The hospital had a quiet room available for all patients and their families. The hospital also offered patients access to a counsellor.
- Staff were trained to be aware and understand the needs of different people. All directors, clinical and non-clinical staff had completed 'Equality, Diversity and Human rights - general awareness' training. All directors, clinical and non-clinical staff had completed 'Equality, Diversity and Human rights - promoting understanding' training.
- The aim of the hospital's 'Equality, Diversity and Inclusion' strategy was 'to provide world class healthcare to patients and service users from all diverse communities by a modern and diverse workforce'. This strategy also aimed for KIMS Hospital to be an employer of choice by people from diverse communities.

Learning from complaints and concerns

- The provider listened and responded to complaints and concerns in a timely way. The hospital received 42 complaints in the reporting period from medical patients. The ward manager told us that the chief executive officer personally reviewed complaints and often visited the wards to enquire about complaints and their resulting actions. This showed us that senior management had good oversight of complaints, listened and monitored the resulting actions.
- Staff made improvements to the quality of care as a result of complaints and concerns. Following a concern raised about staff inability to manage patients suffering from post-traumatic stress disorder (PTSD), the ward manager arranged PTSD training for all members of staff. We received feedback that staff were notably better equipped to manage PTSD. This meant that staff had the skills to help patients suffering with PTSD to feel safer and more confident in their care.
- Staff treated patients with compassion when they complained or raised a concern. The ward manager told us that if a patient complained then the chief nurse, where possible, would go and meet the patient face-to-face with the core service lead. Staff felt this was

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more personal and enabled them to deal with complaints as soon as possible. Staff told us this gave them an opportunity to improve the patient's experience.

- It was easy for patients to complain or raise a concern. We asked two patients if they knew how to make a complaint or raise a concern. Both patients were able to point us to the patient feedback leaflets. Staff clearly displayed patient feedback leaflets at the main reception of all departments. One patient told us they felt comfortable to raise any concerns with the nursing staff, they told us 'staff are always checking that I am okay and if there is anything they can do for me'. We saw a link on the hospital website for feedback and complaints and we saw it was very easy to leave feedback via the hospital Facebook and Twitter pages.
- There was openness and transparency when handling complaints. We saw a noticeboard in the ward corridor that showed December 2017 patient feedback data. The cardiac catheterisation laboratory left copies of the patient satisfaction survey for patients to read whilst they waited for their appointment. The results of this survey showed both positive and negative comments. This was a good example of openness and transparency and encouraged patients to comment on the service they received.

Are medical care services well-led?

Good 

We rated well-led as **good**.

At our last inspection, we rated well-led as requires improvement. On this inspection, we have changed the rating to good because we have seen improvements in the following key areas:

Since our last report, KIMS Hospital has:

- Ratified all policies and procedures and arranged appropriate review dates
- Sufficient oversight of the endoscopy service with an environment fit for purpose
- Finalised the end of life care process and ratified the end of life care policy.

Overall, the leadership, governance and culture promoted the delivery of high quality person-centred care.

Leadership and culture of service

- Leaders were visible and approachable. The chief executive officer was appointed in June 2015. This was three months before our last inspection. The chief operating officer had a new team and a new strategy focusing on the 'basics'. Staff told us that senior management were visible and regularly visited the wards. We saw that the chief executive officer knew all staff he came across, by name, and stopped to ask them about their personal interests. Staff mirrored this appreciative and kind interaction between each other.
- Staff told us management were always available to give advice and encouraged staff to approach them with any concerns. The chief executive officer acted as a good example of appreciative and supportive relationships between colleagues.
- All staff we spoke to were very positive about working at the hospital and spoke highly of the chief executive officer and chief nurse. One member of staff described them both as a 'breath of fresh air'. Staff were proud of the progress they had made over the past year and told us this was down to, not only the hard work and commitment from staff, but also the good leadership from senior management.
- Management were available to give advice and support. Staff told us that hospital managers were contactable when at home and not on call, and the team regularly picked up the phone for advice. All staff, we spoke to, worked in this way and described their colleagues as their extended family.
- All staff, we spoke to, worked collaboratively. We saw that management and staff worked together to cover shifts so that their colleagues could attend important events and to meet the needs of patients.
- Staff felt respected and valued. Staff told us they felt they had a voice and their voice was not only heard but also listened to. Staff felt appreciated and said management regularly thanked them for their efforts.
- Staff felt able to raise concerns about behaviours that were inconsistent with the vision and values regardless of seniority. Ward managers told us when they reported

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a consultant for being rude to staff, senior management addressed this immediately, resulting in the consultant now being a pleasure to work with. Staff told us this made them feel encouraged to raise their concerns.

- Staff were valued and recognised for their achievements. Staff received vouchers and cupcakes for reaching milestones. Staff told us this made them feel that all staff were valued equally as an important part of the hospital.
- The cardiac catheterisation laboratory had a good team ethos. The staff said they felt valued and respected. We saw a thankyou card to the lead radiographer giving thanks from staff for all the support they had received over the past year.
- The good leadership and culture of services was well embedded and noticed by patients. We read a thank you letter from a patient that said 'The happy togetherness of colleagues could come about only from calm wisdom at the top'.

Vision and strategy for this core service

- There was a clear statement of vision and values driven by quality and safety. The hospital's mission was to provide the highest quality of care in a world-class environment for the people of Kent. Their key values were to be caring, confident, dynamic and respect people. Their values were also to communicate with integrity as a team to bring quality and value.
- Staff knew and understood what the vision and values were. We spoke to staff who told us that the patient was at the centre of their mission and felt there was good cohesion between departments to deliver this mission.
- The one-stop breast clinic team were passionate about the service they provided and had a clear vision to offer reliable and supportive advice at every step of a patient's journey through the breast clinic.

Governance, risk management and quality measurement (medical care level only)

- The provider had an effective governance framework to support delivery of good quality care. The framework put patients at the centre, and prioritised good quality care for the patient.
- Staff had improved the governance structure since we last inspected. All teams reported to the quality

governance committee who met monthly. The quality governance committee discussed key issues such as staffing, accidents, lessons learnt, complaints and compliments and the quality report. These discussions fed key concerns up to the board.

- We saw minutes from quality governance committee meetings. Members were made up of staff from all departments and senior management. The last two meetings did not have the necessary number of members present to make decisions. The minutes reflected discussion on this and showed that members were going to prioritise the quality governance committee meetings going forward.
- There were robust arrangements for identifying, recording and managing risk. We saw a number of meetings that discussed risk, incidents and complaints. For example, clinical effectiveness meetings and specialty group meetings. Staff passed key concerns up to quality governance committee meetings and shared learning between departments. This two-way communication meant all areas of the hospital had clear oversight of any key areas for concern.
- There was an alignment between what was on the risk register and what staff considered their departmental risks. This included nurse recruitment shortages and management of end of life care patients.
- The policies we reviewed were in date and ratified. There was also evidence of regular updates to policies. The risk register identified policies that required updating and the visibility of those policies to staff.

Public and staff engagement

- Management tried to resolve complaints directly with those who made the complaint. Working directly with patients who experienced problems helped to drive meaningful quality improvement.
- The hospital reviewed patient satisfaction surveys at a number of meetings and displayed the results of these surveys throughout the hospital for patients to view.
- Staff had direct links to the board so they could directly communicate their views, ideas and concerns. "KIMS' voice" was a group that was set up to represent the views and ideas of hospital staff and was part of the

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governance structure. Out of "KIMS' voice", the provider gave all staff a day off work on their birthday. This was a good example of staff being listened to and showed engagement was effective.

- Staff were encouraged to socialise and have fun. Staff told us activities were often set up at the hospital. For example, a tug-of-war contest. Staff described the event to us with smiles and laughter and they clearly had a good time. Staff were also very proud to tell us their chief executive officer took part in these activities alongside them.
- Staff told us they liked working at the hospital because the hospital had good staff that cared for their patients and each other. Ward managers told us they worked on the principle; if you look after staff, they look after their patients.
- KIMS Hospital provided the location for a patient support group to meet monthly 7pm to 9pm. This support group was for women with the breast cancer gene (BRCA). This meeting was run by a group of volunteers and was independent of any trust. KIMS Hospital provided the venue as the group was set up to provide support for local women, in Kent, who had been diagnosed with BRCA.
- KIMS Hospital used varying platforms to engage with the public. KIMS Hospital had a social media page. They regularly posted on the page providing information on a variety of topics such as; patient feedback results, support group dates and times, upcoming events and

quotes from patients. Over 3,000 members of the public followed this page. When we viewed the page, a pop up window appeared that allowed the public to ask a question and receive a reply within a few hours.

- We also saw that 225 members of the public had left a review on social media for KIMS Hospital. These reviews gave the hospital an average of 4.8 out of 5 stars. One review gave the hospital one star. This was due to a five hour waiting time. This patient still wrote 'the care I received was second to none . . . the room was immaculate, modern and lovely with lovely views . . . nurse staff explained everything to me clearly' and ended the review with; 'Thank you for making what is normally a worrying horrible experience so much easier'. Every review, we saw, had been responded to by KIMS hospital.

Innovation, improvement and sustainability

- Staff were focused on continually improving the quality of care and encouraged by leadership to do so. As part of the leadership and management course, staff were encouraged to present an innovative idea to lead organisational change.
- The lead radiographer in the cardiac catheterisation clinic created and presented the use of cardiac packs to the board. The board approved and adopted the packs at the hospital. The packs held all instruments needed for differing procedures. This meant that one pack could be opened that contained everything needed rather than opening 38 different packets for one procedure. We saw these packs in use during our inspection. This was a good example of leadership supporting staff to improve care through innovation.

Surgery

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

Are surgery services safe?

Good 

We rated safe as **good**.

At our previous inspection in September 2015, we rated safe as inadequate. Following significant improvements in incident reporting, investigation and learning, and infection prevention and control, we now rate safe as good.

Incidents

- The service reported one never event in the reporting period (November 2016 to October 2017). Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. This incident, which occurred in December 2016, related to a wrong-side anaesthetic block. An anaesthetic block is an injection of local anaesthetic to numb the nerves and prevent patients feeling pain during surgery.
- We saw that the service fully investigated the wrong-side block never event and shared learning with relevant staff to help prevent a recurrence. We reviewed the root cause analysis (RCA) investigation into this incident. We found that the service had fully investigated the incident and found the root cause. The service identified and shared learning with theatre staff and anaesthetists to help prevent a recurrence. Staff involved in the incident also researched “stop before you block” incidents and gave a presentation to share learning with other theatre staff and anaesthetists. Following implementation of the learning from this incident, the hospital reported no further never events. This demonstrated a learning culture that helped improve patient safety.
- We reviewed six further RCA investigations following incidents involving surgical patients. In all cases, we found that the service had fully investigated the incidents and made appropriate changes to practice or shared learning to help prevent a recurrence. This was an improvement from our last inspection in September 2015, when we found RCA reports that lacked sufficient analysis and recommendations.
- Following our previous inspection in September 2015, the hospital provided RCA training for all staff expected to carry out RCA investigations. We saw copies of seven certificates that demonstrated staff competence for the seven members of staff that carried out RCA investigations.
- The hospital reported 607 incidents for surgery between November 2016 and October 2017. Of these, 371 were no harm, 212 were low harm, 23 were moderate harm and one resulted in severe harm. This meant 96% of incidents reported were either no harm or low harm. This was indicative of the positive incident reporting culture we observed during our inspection.
- The incident resulting in severe harm involved a patient sustaining damage to their vision in one eye. We reviewed the RCA investigation for this incident and saw the service investigated thoroughly. The service identified the root causes of this incident and took action to ensure this could not happen again to another patient.

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- We found effective processes around incident reporting and learning. The service introduced an electronic incident-reporting tool in January 2016. This was following feedback after our previous inspection in September 2015, where we found a paper-based incident reporting system in use that did not allow the analysis of incident trends. All staff we spoke with knew how to report incidents using the electronic incident-reporting tool.
- The relevant manager, such as the ward or theatre manager, investigated incidents and gave feedback to staff. Managers attended a weekly incident review meeting with the chief nurse, deputy chief nurse and quality and governance lead to review all incidents reported during the past week. Staff told us they received feedback on incident learning in team meetings, and we saw evidence of this in the ward meeting minutes we reviewed. In theatres, we saw details of learning from recent incidents displayed on the noticeboard in the theatre staff room. We also saw a folder containing learning from previous incidents should staff need to refer to this, such as new staff to the department.
- Staff we spoke with were able to describe learning from incidents and changes to practice to help prevent recurrences. This included the introduction of red folders to hold patient bedside notes to alert staff of patients at high risk of falls. Other learning from incidents staff described included the need to perform a bladder scan on patients within 30 minutes of returning to the ward post-surgery. This further demonstrated the effective incident reporting and learning processes we observed.
- The hospital's morbidity and mortality committee met quarterly and we reviewed the minutes of the last three meetings. We saw that the committee reviewed unplanned transfers to hospitals with critical care facilities as a standard agenda item. Although representatives from theatres, pharmacy and the enhanced care lead attended the meetings, the minutes showed no consultants attended. This meant consultant anaesthetists might have missed the opportunity for multidisciplinary review of out-of-hospital transfers.
- Staff we spoke with were aware of the duty of candour under the Health and Social Care Act (Regulated Activities Regulations) 2014. The duty of candour 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 them with reasonable support. Staff knew what duty of candour meant and gave us examples of incidents that triggered duty of candour. These included the never event involving a wrong-side block, and an incident that resulted in damage to a patient's vision. We also saw evidence in RCA reports we reviewed that the hospital had written to patients and met with them to offer an explanation and apology following "notifiable safety incidents" in line with duty of candour. The hospital also informed CQC promptly of serious incidents throughout the reporting period as part of ongoing provider engagement and shared any further information we requested such as RCA reports. This was a significant improvement from our previous inspection, when staff were unaware of their regulatory duties relating to duty of candour.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The service reported no catheter-acquired urinary tract infections and no hospital-acquired pressure ulcers between November 2016 and October 2017.
- The service reported three falls with harm during the reporting period. Hospital data showed two falls in March and May 2017 resulted in fractures. One fall in April 2017 resulted in a dislocated prosthetic joint.
- We reviewed RCA reports that demonstrated the hospital had fully investigated the falls. We saw that the hospital made changes to practice to help prevent further falls. These included red folders to hold the bedside notes for patients at increased falls risk to alert staff, non-slip socks, and urine bottles at the bedsides of male patients at increased falls risk. Since implementing the additional falls prevention measures, there had been no further inpatient falls. These changes complemented previously existing falls prevention measures such as "call don't fall signs", which we saw in all patients rooms we visited. We also saw evidence of completed falls assessments in all five sets of notes we reviewed.
- The service reported 10 incidents of hospital-acquired venous thromboembolism (VTE, or blood clots in veins)

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between November 2016 and October 2017. Hospital data showed the service had risk-assessed 100% of patients for VTE on admission during the reporting period. We also saw evidence of completed VTE risk assessments in all five patient records we reviewed. We observed the use of VTE prophylaxis such as anti-embolism stockings where clinically indicated. Anti-embolism stockings are compression stockings worn after surgery to reduce the threat of blood clots forming in patients' legs while they are recovering from surgery and less active than usual. We saw that nurses gave patients verbal and written information regarding continuing VTE prophylaxis upon discharge to help manage VTE risk.

- During our visit, one patient had not put their anti-embolism stockings back on after showering. We saw that a nurse reiterated to the patient the need to continuously wear the stockings and to only remove them while bathing or showering. The nurse subsequently arranged for a colleague to assist the patient in putting their stockings back on.
- Hospital data showed the harm-free care rate was 99% between November 2016 and October 2017. There was no national benchmarking data against other independent hospitals available for the reporting period.

Cleanliness, infection control and hygiene

- All clinical areas we visited were visibly clean and tidy. On Nickleby Ward, we saw completed daily cleaning schedules providing assurances of the daily cleaning tasks undertaken. A housekeeper we spoke with was able to describe the colour coding system they used for cloths, mops and other cleaning equipment. This was in line with the National Specifications for Cleanliness in the NHS. The use of specific coloured reusable cleaning equipment such as mops and cloths in different clinical and non-clinical areas helps minimise the spread of infections. We saw details of the National Specifications for Cleanliness colour coding displayed in the cleaning store on Nickleby Ward for staff to refer to if needed.
- The hospital carried out monthly mattress audits. We saw a copy of a completed mattress audit for Nickleby Ward. This provided assurances all mattresses were clean and fit for purpose.
- All staff we met were “bare below the elbows” to allow effective handwashing. Alcohol hand sanitiser and clinical wash hand basins were available in all clinical areas. We saw staff using hand gel appropriately, such as when entering a ward. We saw that all clinical wash hand basins, including those in patient bedrooms on the wards, were compliant with the Department of Health’s Health Building Note 00-09: Infection control in the built environment.
- We saw personal protective equipment (PPE) such as gloves and aprons available to staff on the wards. We observed staff using PPE appropriately, such as when changing a patient’s dressing.
- In theatres, all staff were required to change into clean theatre clothes and shoes, and cover their hair with a disposable theatre hat before entering the department. We saw that all staff in theatres were compliant with this policy to help minimise the risk of infections.
- The hospital’s infection prevention and control lead carried out hand hygiene audits to monitor staff compliance with relevant national guidance and best practice. This included compliance with the World Health Organisation’s “Five Moments for Hand Hygiene” and “bare below the elbows”. We saw evidence of weekly observational hand hygiene audits carried out between August and December 2017. The results demonstrated 100% compliance for staff in theatres and the wards. This provided assurances staff complied with the hospital’s hand hygiene policy to help prevent infections.
- At our previous inspection in September 2015, all patient bedrooms had carpeted floors. This was not in line with Health Building Note 00-09, which states “carpets should not be used in clinical areas”. This is because of the risk of contamination with bodily fluids. Since our last inspection, the provider introduced measures to minimise the infection risks associated with carpets on clinical areas. The provider implemented a five-year programme to replace all carpets in the hospital. On this visit, we saw that the hospital had replaced all carpets on Nickleby Ward with hard flooring. The new flooring was in line with HBN 00-09 and allowed effective cleaning of any blood or bodily fluid spillages.

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- The hospital had also replaced carpets in the corridor on Havisham Ward. However, patient bedrooms on Havisham Ward still had carpets. To mitigate this risk, the hospital had a carpet cleaning standard operating procedure which required that all carpets on wards had a deep-clean at least every three months, or immediately in the event of blood or bodily fluid contamination. We saw cleaning records providing evidence all carpets on Havisham Ward received a deep clean at least every three months in line with the policy. A housekeeper we spoke with was able to describe the deep cleaning they would carry out in the event of blood or bodily fluid spillages on carpets. The housekeeper also showed us a copy of the hospital's cleaning policy for blood and bodily fluids, which was available in the cleaning store on Nickleby Ward for domestic staff to refer to if needed.
- To further mitigate the risks of carpets, staff told us they always allocated inpatients to rooms on Nickleby Ward, which had hard floors, wherever possible. If Nickleby Ward was full, the service subsequently opened Havisham Ward to accommodate any additional surgical inpatients. The infection prevention and control lead told us any patients that posed an infection risk always had rooms on Nickleby Ward. Day case patients had bedrooms on Copperfield Ward, which had hard flooring in line with HBN 00-09.
- The hospital carried out monthly "49 steps" cleaning audits to provide assurances around the cleanliness of clinical areas. We reviewed the monthly results for May to November 2017. These demonstrated cleanliness scores between 96% and 99% for Copperfield and Havisham Wards, and 95% to 99% for Nickleby Ward during this period. During this period, all three wards used for surgical patients consistently achieved scores better than the national standard of 85% for ward areas.
- The 49-steps cleaning audit results for the enhanced care bays on Nickleby Ward met the national standard of 98% for enhanced care areas in five out of seven months between May and November 2017. However, for two months during this period, the score fell to 97%, which was slightly worse than the national standard. During the first four months of the same period, the theatre department achieved a cleanliness score of 96% on one occasion and 97% on three occasions. This was slightly worse than the national standard of 98% for theatres.
- We saw that staff in the relevant areas received feedback and an action plan for any areas that did not meet a particular standard following a 49-step cleaning audit. For example, staff had received feedback after a blood splash was identified on the theatre ceiling. Staff took corrective action, and we saw that the cleanliness scores for theatres improved to 98% in September 2017 and 100% in October and November 2017. This meant the theatre department had consistently met the national standard for cleanliness between September and November 2017.
- In all clinical areas we visited, we saw the correct segregation of clinical and non-clinical waste into different coloured bags. This was in line with Health Technical Memorandum (HTM) 07-01: Safe management of healthcare waste.
- The hospital had an onsite sterile services department for the sterilisation of surgical instruments, which was open six days a week. The service offered a two-hour urgent turnaround time if theatres needed particular instruments more urgently. The department used an electronic traceability system to enable the tracking and tracing of instruments for quality assurances purposes. This allowed the service to establish which individual instruments were used on which patients, and when. The department had an annual traceability audit carried out by a third party to provide assurances of the traceability system.
- The sterile services department had a "two door system" to ensure dirty instruments did not contaminate clean areas. Dirty instruments went into washers through one door and came out of a second door into the "clean" room. There were no personnel doors between "clean" and "dirty" areas. This meant staff could not move inappropriately between these areas. We saw that all staff in the sterile services department wore appropriate theatre clothing. Before entering the "clean" room, we saw staff change their shoes and hats, wash their hands and put on a sterile gown. This was important to maintain the cleanliness of this environment.

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- We saw daily and weekly cleaning schedules for the sterile services department. We saw staff had signed and dated all relevant areas to provide assurances of daily and weekly cleaning.
- Hospital data showed the service had reported 31 surgical site infections (SSIs) between November 2016 and October 2017. Hospital data showed there were no deep infections during this period. All infections were superficial and resolved following antibiotic treatment.
- At the pre-operative assessment stage, staff screened all patients for Methicillin-resistant Staphylococcus aureus (MRSA) and swabbed high-risk patients to determine Methicillin-susceptible Staphylococcus aureus carrier status. High-risk patients included those scheduled for orthopaedic surgery, those who had recently been in hospital or a care home and patients who had previously tested positive for the bacteria. This was in line with Department of Health: Implementation of modified admission MRSA screening guidance for the NHS (2014).
- The infection prevention and control lead had a daily meeting with a consultant microbiologist, who signed off all MRSA swab results. We spoke with a pre-assessment nurse, who explained the process for any patients that screened positive for MRSA at pre-assessment. Patients underwent decolonisation (antibiotic treatment to kill MRSA) for five days. The patient subsequently returned for a repeat MRSA swab a minimum of 48 hours after completing the course of decolonisation. This was important to check that the antibiotics had fully treated the MRSA to prevent infection spreading to other patients in hospital.
- The service reported no MRSA infections between November 2016 and October 2017. The service reported one case of Methicillin-sensitive Staphylococcus aureus in the same period. A consultant microbiologist investigated this infection in collaboration with the infection prevention and control team at a local NHS hospital where the patient had previously received treatment. The investigation found that the patient had acquired MSSA at the local NHS hospital before they came to KIMS Hospital for surgery. This meant they had not contracted the infection at KIMS Hospital.
- The service reported no cases of Clostridium difficile (C. diff) between November 2016 and October 2017.

- The service reported five cases of Escherichia coli (E. coli) between November 2016 and October 2017. Hospital data showed these infections occurred at different times of the reporting period, related to different surgical specialties and none of the five patients stayed in the hospital at the same time as each other. This meant that none of the five patients could have acquired E. coli from one of the others affected

Environment and equipment

- We checked the resuscitation trolley on Nickleby Ward. We saw that all emergency drugs were within their use-by dates and within sealed packaging. We randomly checked 10 single-use items on the trolley and saw all were sealed and within their use-by dates. We also saw checklists for the resuscitation trolleys on Nickleby Ward and in theatres showing evidence staff checked the trolleys and tested the defibrillators daily. This provided assurances resuscitation equipment was safe and fit for purpose.
- We reviewed the anaesthetic machine logbook, which provided evidence theatre staff had checked the anaesthetic machine at the start of every theatre session. This was in line with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines. The logbook showed staff changed the machine's breathing tubing once a week to maintain its function. The theatre manager confirmed staff did this every Friday.
- We reviewed the difficult airway trolley logbook for theatres. This showed staff checked all items on the trolley daily to provide assurances the trolley was safe and fit for purpose. However, the checklist noted that a specific single-use item on the trolley had passed its recommended use-by date and that no replacement was available. We raised this issue with the theatre manager, who showed us an email from the manufacturer saying that this item was discontinued. The theatre manager subsequently removed the out-of-date item from the trolley and was able to describe several alternative pieces of equipment available on the trolley that staff could use to keep a patient's airway open if needed. This meant the trolley contained sufficient equipment for it to be safe and fit for purpose.

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- We reviewed the theatre “recovery opening and closing procedures” checklist, which detailed daily equipment checks carried out. This provided evidence theatre staff checked oxygen and suction, call bells and monitors every day. We also saw evidence of daily oxygen and suction checks in a patient room we inspected on Copperfield Ward. This provided assurances equipment functioned correctly and was safe for use.
- During our visit, we saw that a machine used to monitor oxygen saturation stopped working partway through a theatre list. We saw that replacement equipment was available, and staff replaced the affected monitor immediately. This allowed them to continue to monitor the patient safely.
- We saw an asset register for theatres. This provided evidence of annual servicing carried out by the medical engineering department at a local NHS trust for all electrical equipment the department owned. The hospital also provided copies of servicing records for all remaining equipment serviced by other third party providers. This provided evidence of servicing and maintenance in the year before our inspection. This meant the service had assurances all equipment was maintained to keep it working safely.
- We reviewed the theatre implant registers for orthopaedics and breast implants. These contained batch numbers for the implants used for each patient, and details of the operating surgeon. We saw that all registers were completed up to the date of our visit. This allowed traceability of implants for national data collection to help identify any issues with a particular batch.

Medicines

- We saw that all controlled drugs in theatres were stored securely in a locked cabinet. Controlled drugs were medicines liable for misuse that required special management, therefore secure storage was vital to prevent unauthorised access to controlled drugs. The theatre controlled drugs register showed two members of staff had signed for all controlled drugs. This was in line with national standards for medicines management.
- The hospital pharmacist carried out quarterly medicines management audits to provide assurances around medicines management. We reviewed the last two

controlled drugs audits, which took place in August and November 2017. Both audits demonstrated controlled drugs were within their use-by dates, physical checks of controlled drugs matched the details in the controlled drugs register and entries in the controlled drugs registers were on the correct page for all theatres and wards. The audits also showed evidence staff in each area had carried out daily controlled drugs checks when each clinical area was open, and controlled drug cupboard keys were held securely with authorised staff in theatres and on the wards.

- However, the August and November 2017 controlled drugs audits also found some areas for improvement relating to the completion of controlled drugs registers. Both audits found staff in theatres had not always written the time of all entries in the controlled drugs registers, and that the volume used and any wastage was not always recorded. There were also issues with inappropriate crossings-out of any errors in the register, where staff had crossed through errors. This was not in line with hospital policy, which required that errors should be bracketed, asterisked with “entered in error”, signed and dated. There was also a missing anaesthetist signature in the controlled drugs registers for theatres one and two on both audits we reviewed.
- We saw that the pharmacist had given feedback for improvement and produced a list of actions to improve the issues identified relating to the controlled drugs registers in theatres. This included training sessions for theatre practitioners on completing documentation and error management and raising documentation issues at the next anaesthetic group meeting. At the time of our visit, a further controlled drugs audit had not yet been undertaken as this was due in February 2018. Therefore, we were unable to fully assess any improvements in this area.
- The pharmacist carried out monthly medicines reconciliations audits within 24 hours of admission for surgical inpatients. The aim of medicines reconciliation was to ensure that medicines patients were taking at home corresponded with those prescribed on admission. Medicines reconciliation audits therefore provided assurances patients were taking the correct medicine, at the correct dose via the correct route.
- We reviewed medicines reconciliation audit results for July to September 2017. Overall, this demonstrated

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patients were getting the correct medicine, at the correct dose and route, and at the correct time, although the patient numbers involved were small. The audits showed reconciliation was completed for two out of three patients in July 2017. In August and September 2017, reconciliation was completed for 100% of patients. For all three months, 100% of patients had their allergy status recorded on their medicines administration chart. This was important to prevent staff from giving medicine that may provoke an allergic reaction. In July and August 2017, 100% of patients received all medicines on time, with no missed doses. In September 2017, the audit found one out of five patients had missed one dose of a laxative without a reason for omission. Although the audit stated this had not caused any problems, any omitted doses should have a reason recorded on the patient's medicines administration chart in line with best practice.

- The resident medical officer prescribed medicines for patients to take-out, which the on-site pharmacy dispensed. To take-out medicines are medicines given to patient on discharge from hospital stay. We saw that nurses counselled patients on to take-out drugs at discharge to help ensure they took their medication as prescribed.

Records

- We reviewed five patient records and saw evidence of clear documentation and a high standard of record keeping. Staff had signed and dated all entries. This was in-line with guidance from the General Medical Council. All five patients had care plans that identified all their care needs. We saw staff had fully completed all five care plans.
- All patients had a pre-operative assessment in advance of surgery. Staff completed a comprehensive pre-assessment record as part of the patient's inpatient or day surgery pathway. We saw completed pre-assessment records in all five sets of notes we reviewed.
- Staff stored patient records securely in locked cabinets on the wards. This prevented unauthorised access to confidential patient data. After discharge, the hospital held patient records in its secure records storage facility on site. This allowed hospital staff to easily access patient records, for example following readmission, to

assist with clinical decision-making. We saw that operation notes were integrated into patients' hospital records in line with best practice. This was important so that all clinical information was immediately accessible in a single integrated record to facilitate safe clinical decision-making.

Safeguarding

- Hospital data showed 100% of staff in theatres had up-to-date training in safeguarding adults levels one and two, and safeguarding children levels one and two. As the hospital did not accept children under the age of 18 for surgery, this meant all theatre staff had an appropriate level of safeguarding children training in line with national guidance.
- Hospital data showed 100% of ward staff had up-to-date training in safeguarding adults levels one and two, and safeguarding children level one. The completion rate for ward staff for safeguarding children level two was 88% at the time of our visit. This was worse than the hospital target of 95%.
- All staff we asked could identify the hospital's safeguarding lead and could describe the process for reporting safeguarding concerns. The safeguarding lead and deputy safeguarding lead held safeguarding vulnerable adults level three and four training, and safeguarding children level three children in line with national guidance. We saw safeguarding flow charts available to remind staff of the processes for reporting concerns displayed on the wall in the theatre staff room.
- The safeguarding lead gave us an example of a safeguarding concern reported in relation to surgery. This related to a patient who developed concerns about going home following surgery. The safeguarding lead made a referral to the local safeguarding authority and allowed the patient to stay at the hospital for longer until they were fully mobile and a safe place for discharge had been arranged. A member of administrative staff also described an example of a safeguarding concern they identified and escalated to the safeguarding lead. This demonstrated staff were able to recognise and report safeguarding concerns in line with the hospital's safeguarding policies.
- We reviewed the hospital's safeguarding adults and safeguarding children's policies. We saw that both policies were recently reviewed and reflected up-to-date

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national guidance. For example, we saw that the safeguarding adults policy reflected national guidance relating to female genital mutilation (FGM) and human trafficking. Staff knew how to access the policies on the hospital's shared electronic drive. We also saw hard copies of safeguarding policies available in the theatre staff room to allow easy access to consultants with practising privileges.

Mandatory training (if this is the main core service report all information on the ward(s) here.

- Hospital data showed 100% of theatre staff had up-to-date mandatory training in all areas at the time of our visit. This was better than the hospital target of 95% and meant the hospital had assurances all staff had completed all the relevant training to allow them to safely do their jobs. Mandatory training covered the following areas: Infection prevention and control, information governance, consent, medical gases, fire safety, health, safety and welfare, safeguarding (see safeguarding section of this report for full details); and equality, diversity and human rights.
- Hospital data showed 97% of ward staff had up-to-date mandatory training at the time of our visit, which was better than the hospital target of 95%. Ward staff completed the same areas of mandatory training as theatre staff. Ward staff met the hospital's mandatory training target of 95% for nine out of 13 mandatory training modules. The modules where ward staff compliance was worse than the 95% target were moving and handling (92%), information governance (92%), medical gases (92%), and safeguarding children level two (88%).

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- We reviewed five sets of notes for surgical patients, and saw evidence of thorough pre-assessment for surgery in all five files. This included risk assessments for falls, VTE, pressure ulcers, and anaesthesia. These assessments were vital to assess a patient's suitability for surgery and to enable staff to make any necessary adjustments to ensure safe care, such as VTE prophylaxis.
- We saw staff in theatres confirming that any female patients aged between 18 and 55 had a negative urine pregnancy test on the morning of surgery. Ward staff checked pregnancy status of female patients of

childbearing age using a urine pregnancy test with the patient's consent. We reviewed the hospital's quality dashboard for October and November 2017, which showed 100% of female patients between the ages of 18 and 55, had documentation of pregnancy test results recorded in their notes. This was in line with NICE guideline NG45: "Routine preoperative tests for elective surgery".

- We observed theatre staff carrying out the World Health Organisation (WHO) Surgical Safety Checklist for six patients. The WHO checklist is a national core set of safety checks for use in any operating theatre environment. The checklist consists of five steps to safer surgery. These are team briefing, sign in (before anaesthesia), time out (before surgery starts), sign out (before any member of staff left the theatre) and debrief. We saw that staff fully completed and documented all the required checks. We also saw copies of completed pre-operative team briefing checklists and completed debrief checklists. This provided written records of the team brief and debrief at the start and end of each operating list.
- If the order of an operating list changed, we saw staff printed the new version of the list on red paper. We saw staff communicated the change as part of the team briefing at the start of each operating list. The different coloured paper alerted staff to use the correct list to ensure they collected patients for theatre in the correct order.
- The service audited staff compliance with the WHO checklist and calculated the percentage compliance each month. We reviewed the hospital's quality dashboard for October and November 2017, which showed 100% compliance with the WHO checklist. This reflected the high level of compliance with the checklist that we observed during our visit.
- The service used the National Early Warning System (NEWS) track and trigger flow charts. NEWS is a simple scoring system of physiological measurements (for example, blood pressure and pulse) for patient monitoring. This allowed staff to identify deteriorating patients and provide them with additional support. We reviewed five patients' NEWS charts. We saw staff had completed all five charts fully and calculated NEWS scores correctly. No patients whose records we reviewed had required escalation in line with the NEWS guidance.

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- The hospital audited NEWS chart completion every month. The hospital's quality dashboard showed staff completed 96% and 95% of NEWS charts fully and correctly in October and November 2017, respectively. This was worse than the hospital target of 100%. However, ward meeting minutes for October 2017 showed the service had achieved its target of 100% the previous month in September 2017. Meeting minutes demonstrated staff received feedback on NEWS chart completion to help drive improvement and compliance with the 100% target.
- Since our last inspection, the hospital had closed its critical care facility. However, there were three enhanced care bays on Nickleby Ward that the service used for any patients that needed a higher level of support after their operation. The service often allocated the enhanced care bays in advance for patients where a higher level of post-operative support was anticipated, such as bariatrics (patients with a high body mass index). The enhanced care bays were also used for any patients that deteriorated post-operatively and needed additional support. This was because the enhanced care bays had more space, as well as mobile monitoring equipment that could transfer with the patient in an ambulance. They were also close to the nurses' station to aid increased observation of patients that needed additional monitoring.
- Any patients who developed complications following discharge could contact the hospital nursing staff any time, day or night. We saw a copy of the discharge pack given to patients, and this included a 24-hour contact number direct to the ward. We also saw a nurse give this information to a patient they discharged.
- The hospital kept a stock of O negative blood on site for emergencies. O negative blood can be given to the majority of patients in an emergency, if they experience high blood loss. There was also an arrangement with a local trust called "code red". This meant that six units of blood and six units of frozen plasma would be immediately sent to KIMS Hospital, if requested.
- The hospital did not have any level two or three critical care beds. To mitigate this risk, we saw in theatres that the hospital routinely operated on patients pre-assessed as grade one or two under The American Society of Anaesthesiologists (ASA) grading system. Grade one patients were normal healthy patients, and

grade two patients had mild disease, for example well controlled mild asthma. We saw that the hospital occasionally accepted grade three patients (patients with severe systemic disease that is not incapacitating). The service operated on one grade three patient during our visit.

- The hospital pre-assessed patients on an individual basis. Following a nursing pre-assessment, a consultant anaesthetist reviewed the patient's medical history and observations and assessed the patient's ASA grade and suitability for surgery. If the anaesthetist had any concerns, the patient had a face-to-face assessment with them, as well as any other testing as clinically indicated such as electrocardiogram (ECG) monitoring. The hospital's exclusion criteria for private surgery stated the hospital would not accept "acutely unwell" patients. Other than detailing certain communicable infections such as tuberculosis as exclusions, the criteria did not give specific guidance on particular medical conditions or ASA grades that should be excluded. This meant the service could not be assured all consultant anaesthetists were consistent in determining a patient's suitability for surgery at the hospital.
- We saw a copy of the hospital's service-level agreement (SLA) for critical care services with a local NHS hospital. This enabled the service to transfer any patients who became acutely unwell after surgery and needed critical care support.
- We saw the hospital's "policy for transfer of the deteriorating patient", which the service reviewed in November 2017. This provided clear guidance to staff on the procedures for arranging transfers out. This included details of all the necessary equipment and medicines that should go with the patient.

Nursing and support staffing

- Hospital data showed the theatre department had 16.4 full-time equivalent registered nurses in post on 1 October 2017. On the same date, there were 17.9 full time equivalent registered operating department practitioners and healthcare assistants in post. At the time of our visit, the theatre manager reported there were no registered nursing or operating department practitioner vacancies and two healthcare assistant vacancies in theatres.

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- We saw theatre staff rotas, which showed there were two scrub practitioners, one scrub assistant, one anaesthetic assistant, one healthcare assistant and 0.5 recovery staff for each theatre. This reflected the staffing levels we observed in theatres throughout our visit. This met with the Association for Perioperative Practice (AfPP) guidance for safe theatre staffing.
- Hospital data showed the ratio of bank to agency staff in theatres was 14:1 for theatre nurses and 63:1 for operating department practitioners and healthcare assistants. This meant the hospital almost always used bank rather than agency staff to fill shifts in theatres. The theatre manager confirmed agency staff usage in theatres was 0% in October to December 2017. This meant shifts were filled by bank staff who worked regular shifts at the hospital that were more likely to be familiar with the service's policies, processes and ways of working than agency staff.
- Hospital data showed the rate of bank and agency theatre nurse use varied between 9% and 23% in the reporting period November 2016 to October 2017. The rate of bank and agency operating department practitioner and healthcare assistant use in theatres ranged from 12% to 27% during the same period. There was no national benchmarking data available for other independent hospitals during this period.
- The theatre department had a 24-hour on-call rota with a minimum of two scrub practitioners, an anaesthetic practitioner and a support worker to ensure sufficient staff were available for any out-of-hours returns to theatres. We saw on-call rotas, which reflected these staffing arrangements. The hospital required staff to be within 30 minutes of the hospital while on-call.
- The service used an in-house staffing planner tool to ensure a sufficient number and skill mix of nursing staff on the wards depending on patient numbers and acuity. The service planned nursing cover in advance and reviewed the tool on a daily basis. During our visit, we saw that the actual numbers of nurses and healthcare assistants on the ward met with the planned numbers.
- Hospital data showed the wards had 25.8 full time equivalent registered nurses and 9.2 full time equivalent healthcare assistants in post on 1 October 2017. There were five full time equivalent registered nurse vacancies on the wards on 1 October 2017, giving a nursing vacancy rate of 16%. The wards had no healthcare assistant vacancies at this time.
- The rate of bank and agency nurse use on the wards varied between 2% and 11% in the reporting period November 2016 to October 2017. The rate of bank and agency healthcare assistant use on the wards ranged from 4% to 22% during the same period. Hospital data showed there were no unfilled shifts on the wards between August and October 2017. This meant the service had never worked with less than the planned number of staff on shift during this period.
- Hospital data showed the ratio of bank to agency nurses on the wards was 3:1 during the reporting period. The service did not use any agency healthcare assistants during the reporting period. This meant most shifts on the wards were filled by bank staff who worked regular shifts at the hospital. These staff were more likely to be familiar with the service's policies, processes and ways of working than agency staff.
- We observed a nursing handover on Nickleby Ward. We saw that nurses handed over important safety information such as falls risk. The whiteboard in the nurses' office, which detailed patients currently on the ward, had different magnets, which nurses used to alert colleagues of additional needs or concerns such as falls risk or VTE prophylaxis. This allowed for continuity of safe care.

Medical staffing

- The hospital's resident medical officers provided on-site doctor cover 24 hours a day, seven days a week. This ensured nurses could always quickly escalate any issues concerning a deteriorating patient. The resident medical officer also informed the patient's consultant in an emergency so that they could provide consultant-level care.
- The resident medical officers worked a rota of one week on duty followed by one week off. Resident medical officers told us they had a handover at the start of the week. However, we were unable to observe a resident medical officer handover because the changeover day did not coincide with our visit. During busy periods, the

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hospital used a second resident medical officer to ensure that the resident medical officers had sufficient opportunities for rest. We saw that there were two resident medical officers in the hospital during our visit.

- The hospital required all surgeons to be on-call 24 hours a day for their own patients until discharge. Each consultant had a named “buddy” from the same specialty, who covered any emergencies with a patient if the primary consultant was not available, for example, due to annual leave. Staff reported there were no difficulties in contacting consultants when needed, and the theatre manager described consultants attending the hospital quickly in the event of returns to theatre.
- The hospital had a 24 hour anaesthetic on-call rota to ensure an anaesthetist was always available should a patient need to return to theatre in an emergency. The hospital’s practising privileges policy required consultant anaesthetists to be “immediately available, free of other commitments and resident within 30 minutes’ drive of the hospital” while on-call. For patients having planned post-operative enhanced care, the treating anaesthetist was also required to be available for the first 36 hours after surgery to provide support and advice. After this timeframe, staff could contact the on-call anaesthetist if needed.

Emergency awareness and training

- In the theatre department, we saw business continuity and emergency planning flowcharts displayed in the corridors. This gave clear guidance to staff in the event of a business continuity incident. We also saw action cards with additional guidance for staff with specific command roles relating to business continuity.
- We saw a current version of the hospital’s business continuity policy (December 2017). This contained information about the roles and responsibilities of key people, what to do in the event of any major incidents and key contact details.
- The hospital carried out regular resuscitation exercises to ensure staff kept their skills up-to-date in this area. We saw theatre team meeting minutes for October 2017, which demonstrated staff received feedback and learning following a recent resuscitation scenario.
- All hospital staff received fire safety training as part of their annual mandatory training. Hospital data showed

100% of theatre staff and 96% of ward staff held up-to-date fire safety training at the time of our inspection. This was better than the hospital target of 95%. The hospital tested its fire alarms weekly to provide ongoing assurances the alarms worked. Staff could describe where the fire evacuation points were located.

- We saw the hospital’s generator testing records. These provided evidence of monthly generator testing and six-monthly generator servicing. This meant the service had assurances around the functioning of the back-up generator to maintain an uninterrupted power supply in the event of mains power failure.

Are surgery services effective?

Good 

We rated effective as **good**.

At our last inspection, there was insufficient evidence to rate effective for surgery. Following this inspection, we now rate effective as good.

Evidence-based care and treatment

- We reviewed policies and standard operating procedures relating to surgery. All policies we saw were within their review dates and referenced relevant national guidance. This included National Institute for Health and Care Excellence (NICE) and the Association for Perioperative Practice (AfPP).
- The service audited staff compliance with hospital policies and national guidance in several areas and reported the results monthly. For example, we saw the results of monthly audits on the WHO surgical safety checklist, national early warning scores (NEWS), pre-operative pregnancy testing and effective discharge on the hospital’s quality dashboard. We reviewed staff meeting minutes, which demonstrated staff received feedback on local audit results and areas for improvement. For example, we saw the theatre team received feedback on WHO checklist audits and ward staff received feedback on NEWS audits at monthly team meetings. This helped drive high levels of compliance with the service’s policies.

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- In theatres, we observed staff following national guidance and hospital policies. For example, staff monitored patient temperatures before induction of anaesthesia and then at least every 30 minutes until the end of surgery. This was in line with NICE guideline CG65- Hypothermia: prevention and management in adults having surgery. We reviewed completed “recovery checklists” for December 2017, which also provided evidence of patient temperature monitoring in line with NICE guideline CG65.
- We reviewed five patient records, which all showed, evidence of regular observations, for example, blood pressure and oxygen saturation, to monitor the patients’ health post-surgery. Staff had completed all observation charts in line with NICE guideline CG50: Acutely ill patients in hospital- recognising and responding to deterioration.
- We saw that the service followed NICE clinical guideline CG74- Surgical site infections: prevention and treatment. This included only allowing staff wearing designated theatre clothing into theatres to minimise the risk of infection to patients. The service also followed the post-operative phase of this guidance, such as by treating patients that had a suspected surgical site infection with antibiotics.
- The service encouraged enhanced recovery for patients recovering from surgery. A physiotherapist we spoke with described how the team encouraged orthopaedic patients to mobilise four hours after surgery. Evidence-based studies suggest that early mobilisation can help speed patients’ recovery and reduce the length of hospital stay following elective surgery.

Pain relief

- The service used a numerical pain assessment scale to monitor patients’ pain levels. During routine observations, staff asked patients to rate their pain between zero and 10 (with zero meaning no pain and 10 being extreme pain). We saw pain scores recorded in all five sets of notes we reviewed. Monthly pain score audits for October and November 2017 showed staff had recorded pain scores on 100% of patients’ NEWS charts. This demonstrated staff consistently monitored and recorded patients’ pain.
- The hospital carried out monthly pain score audits and twice-yearly pain management audits as part of its

ongoing audit schedule. We reviewed the previous two pain management audits, which took place in October and December 2017. Both audits showed 100% of patients rated their pain management or control as 95% or better. This meant all patients felt their pain was well controlled. We also spoke with a patient who told us staff had managed their post-operative pain “very well”. The patient also told us nurses responded promptly when they had requested additional pain relief.

- The hospital’s pain management audit for October 2017 showed only 65% of patients had a fully completed pain management plan on admission detailing the plan to manage post-operative pain. We saw ward meeting minutes for October 2017, which showed staff received feedback on this area to drive improvement. The following pain management audit in December 2017 showed an improvement in this area to 75%. However, this was worse than the hospital target of 100%, which meant further improvement was necessary.
- The hospital had a lead pain nurse who had allocated time to complete pain compliance audits, training, patient assessment and actions. Consultant anaesthetists with an interest in pain relief could review patients if needed and give advice on pain management.

Nutrition and hydration

- The service followed the Royal College of Anaesthetists guidance on fasting prior to surgery. The guidance suggested patients could eat food up to six hours and drink clear fluids up to two hours before surgery. We saw written information that pre-assessment nurses gave to patients in advance of their surgery date, which reflected the Royal College of Anaesthetists guidance. A patient we spoke with confirmed they had received this information at their pre-operative assessment. The patient also told us they received a telephone call the day before their operation to remind them of the fasting guidance. This helped ensure patients followed the fasting guidance to prevent any delays to surgery due to inappropriate fasting and were kept nil by mouth for minimal time.
- We reviewed five sets of patient records and saw evidence of pre-operative nutritional screening for all patients. This helped the service identify patients with any additional nutrition needs in advance of surgery.

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- We reviewed patient menus and saw a variety of hot and cold choices. The hospital provided in-house catering services and cooked all meals on the premises. The chefs were able to cater for specific nutrition needs such as diabetic diets by substituting certain ingredients on request. Patients and relatives we spoke with were positive about the quality of the hospital food.

Patient outcomes

- The hospital provided data to national Patient Reportable Outcomes Measures (PROMS). PROMS used patient questionnaires to assess the quality of care and outcome measures following surgery. The hospital provided PROMS data relating to three types of operations: primary hip replacement, primary knee replacement and groin hernia repair. All PROMS data reported below relates to the period April 2016 to March 2017. This was the most recent available data at the time of our inspection.
- Overall, the PROMS data showed outcomes for patients that had knee or hip surgery at KIMS Hospital were about the same as other English hospitals. Patients that had groin hernia repair at KIMS Hospital had better outcomes than the national average during the reporting period.
- PROMS data for April 2016 to March 2017 showed 58% of KIMS Hospital patients reported a health improvement, 15% reported no change to their health and 27.3% reported worsened health following groin hernia repair according to the EQ VAS index. The EQ VAS index was a simple “thermometer-style” PROMS self-scoring tool that measured patients’ general health on the day they completed their questionnaire. The hospital’s results were better than the England average results of 39% improvement, 19% with no change and 42% with worsened health for the same period. The hospital’s adjusted average health gain for groin hernia surgery was 2.8. This was better than the England average adjusted health gain of -0.2 for the same period. KIMS Hospital contributed data from 33 eligible patients to the study during this period.
- PROMS data for April 2016 to March 2017 showed 55% of KIMS Hospital patients reported their health had improved and 25% reported their health was unchanged following groin hernia repair according to the EQ5D index. The EQ5D index was a PROMS scoring tool that collated patient responses in five broad areas (mobility, self-care, usual activities, pain/discomfort, and anxiety/depression) and combined them into a single value. This hospital’s results were about the same as the England average results of 51% and 31%, respectively, for the same period. The hospital contributed data from 40 eligible patients to the PROMS study during this period. The adjusted average health gain for groin hernia repair for KIMS Hospital patients was 0.093. This was about the same as the England average of 0.087. This meant the hospital achieved similar patient outcomes to other English hospitals.
- Following primary hip replacement between April 2016 and March 2017, 92% of KIMS Hospital patients reported an improvement in their health. A further 6.4% reported their health was unchanged according to the EQ5D index. This was about the same as the England average results of 90% and 5% for the same period. The average adjusted health gain for KIMS Hospital patients was 0.481, which was about the same as the England average of 0.444. The hospital submitted data for 78 patients during this period.
- According to the EQ VAS index, 62% of patients reported a health improvement and 12.2% reported their health was unchanged following primary hip replacement. This was about the same as the England average results of 68% and 10%, respectively, for the same period. The average adjusted health gain for KIMS Hospital patients was 14.4, which was about the same as the England average of 13.4.
- The hospital’s average adjusted health gain for primary hip replacement according to the Oxford Hip Score was 22.4. This was about the same as the England average of 21.8 for the same period.
- For primary knee replacement, 88% of patients reported an improvement in health and 7% reported no health change according to the EQ5D index. This was about the same as the England average results of 81% and 10%, respectively. The adjusted average health gain following surgery was 0.35, which was about the same as the England average of 0.32.
- According to the EQ VAS index, the adjusted average health gain following primary knee replacement was 7.7. This was about the same as the England average of 7.0. For the Oxford Knee Score, the adjusted average health

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gain was 17.3. This was about the same as the England average of 16.5. These meant patients at KIMS Hospital have similar outcomes following primary knee replacement to patients at other English hospitals.

- Hospital data showed there were nine unplanned transfers to hospitals with level two and three critical care facilities between November 2016 and October 2017. The rate of unplanned transfers was 0.4 for every 100 patients during this period. No national benchmarking data against other independent hospitals was available for the reporting period. We reviewed the root cause analysis (RCA) investigation for one unplanned transfer during this period. We saw that the patient was transferred in line with the hospital's transfer policy and recovered well.
- Hospital data showed there were 17 unplanned returns to the operating theatre between November 2016 and October 2017. There was no national benchmarking data against other independent hospitals available for the reporting period. The theatre manager described a recent return to theatre due to post-operative bleeding on the ward. The surgeon immediately returned to the hospital and the team acted quickly to get the patient into theatre to address the bleeding. The patient recovered well and went home from the hospital two days later.
- Hospital data showed there were 24 unplanned readmissions to hospital within 28 days of discharge between October 2016 and November 2017. There was no national benchmarking data against other independent hospitals available for the reporting period.
- The hospital has reported data to the Private Healthcare Information Network (PHIN) since September 2016. PHIN allowed independent hospitals to share performance data in accordance with legal requirements regulated by the Competition Markets Authority. The hospital submitted monthly data and covered the full range of PHIN requirements, including PROMS, adverse events and patient feedback to maintain ongoing compliance.

Competent staff

- Since our last inspection in September 2015, the hospital had strengthened its processes to ensure that consultants only carried out procedures within their

scope of practice. All consultant scope of practice forms were available on the hospital's shared drive. This allowed the reservations team to carry out checks when provisionally scheduling operations to ensure that consultants worked within their scope of practice. The theatre team subsequently carried out a second check at the daily "booking meeting".

- We attended a daily booking meeting and saw the theatre manager checking provisional operations against the relevant surgeon's scope of practice. We saw that the team only proceeded to book a theatre slot for patients when the planned operation fitted with the consultant's scope of practice. We saw that the proposed operation on one patient's booking form was not covered within the consultant's scope of practice. The team did not book the operation, and the theatre manager emailed the consultant to request evidence of their competency to carry out the planned surgery. The theatre manager told us that if any consultant was unable to provide evidence of experience and competency in a procedure not listed in their scope of practice, then the hospital would not book the surgery. This process provided assurances that surgeons only carried out operations they were experienced and competent to perform, in line with the hospital's practising privileges policy.
- The hospital required all consultants requesting practising privileges to submit an initial application form and CV. The medical director and /or chief executive subsequently interviewed applicants. The medical director discussed with the lead for consultant business development as to whether the consultant's service was needed and whether their scope of practice fitted with KIMS Hospital's business plan. The hospital subsequently requested proof of identity and other documentation to provide evidence of their competencies and scope of practice. This included evidence of registration with the General Medical Council (GMC), copies of professional qualification certificates, a full up-to-date appraisal and appropriate indemnity insurance. The medical advisory committee (MAC) subsequently reviewed the application and made a decision whether to grant practising privileges.
- We reviewed five consultant folders to check whether consultants had the correct documentation to support practising privileges at the hospital. The hospital

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required the following documents in line with its “practising privileges policy” (last reviewed in November 2017): A scope of practice form; a named consultant to provide “buddy” cover; names of two references; registration with the information commissioner’s office (ICO); evidence of medical indemnity insurance; an full, up-to-date appraisal; evidence of GMC registration; an interview form; an enhanced Disclosure and Barring Service (DBS) check; copies of professional qualifications; a CV; an occupational health check, including evidence of Hepatitis B vaccination; and photographic identification.

- Overall, we found an acceptable standard of documentation in consultant folders to support the granting of practising privileges in line with the hospital’s practising privileges policy. Apart from one file missing a completed interview form and another missing copies of qualifications and a CV, all other documentation was in place for all five folders we reviewed. We saw that although consultants had supplied details of two referees in line with the policy, the hospital had not written to referees to obtain written references. However, at the time the hospital granted practising privileges to the five consultants whose folders we reviewed, the policy was to obtain the names of referees but not to take up references. This meant the hospital had followed their practising privileges policy at the time these consultants were granted practising privileges. The hospital’s practising privileges policy had since changed, and the hospital now took up references rather than just requesting the names of referees. All five files we reviewed contained a full up-to-date appraisal, which provided the hospital with assurances around consultants’ competencies, scope and fitness to practice.
- The hospital required consultants to re-apply for their practising privileges a minimum of every two years. The medical director led the processes for the management of practising privileges. This included monthly consultant review meetings to monitor on-going activity and quarterly revalidation meetings where practising privileges were discussed. We saw meeting minutes from a monthly consultant practising privileges review meeting in October 2017. This demonstrated evidence of review of consultants’ activity levels and caseloads. This helped ensure all consultants operated in the

hospital at appropriate levels. We reviewed medical advisory committee meeting minutes for August 2017 and saw practising privileges were a standard agenda item as part of the medical director’s report.

- We saw an electronic database to track consultant documentation and appraisal dates. This was complete and provided up-to-date assurances that all consultants had the required evidence to support the continuation of their practising privileges. This included evidence of annual appraisal and up-to-date indemnity insurance. The hospital told us they contacted consultants to request documentation before it was due to expire. This was in line with the hospital’s practising privileges policy, which stated the hospital contacted consultants one month before any of their documentation expired. Consultants received a reminder one week before expiry if they had not submitted the required documentation.
- The hospital suspended any consultants that failed to submit requested documentation by the expiry date. Hospital data showed the hospital withdrew practising privileges for 21 consultants for failure to provide up-to-date documentation between November 2016 and October 2017. This demonstrated the hospital took action to ensure all consultants had up-to-date evidence of their competencies and fitness to practice in line with the practising privileges policy.
- In the same period, the hospital withdrew practising privileges for 28 consultants due to lack of activity at the hospital. This was important to help ensure that only consultants that regularly worked at the hospital and were therefore more likely to be familiar with the service’s staff, equipment, policies and procedures continued to hold practising privileges.
- We reviewed competency folders for two theatre staff. In both folders, we saw evidence of induction in key areas including incident reporting, equipment, fire safety and uniform. We also saw evidence of competency assessment in specific areas relevant to staff role, such as epidural analgesia. We saw that both staff member and supervisor had signed and dated all areas to provide assurances of staff competency. We also saw an anaesthetic practitioner logbook, which provided assurances of training and competencies for an anaesthetic practitioner.

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- Hospital data showed 89% of registered theatre nurses and 84% of operating department practitioners and healthcare assistants in theatres had completed an appraisal in the current year. The appraisal year ran from 1 May to 30 April. This meant the theatre department was on-target to ensure 100% of staff received an annual appraisal by 30 April 2018.
- Hospital data showed 87% of registered nurses, 88% of healthcare assistants and 85% of other ward staff had completed an appraisal in the current year. This meant the wards were on-target to ensure 100% of staff received an annual appraisal by 30 April 2018.
- Nursing staff on the wards received training in enhanced care. This allowed them to provide additional support to deteriorating patients before transfer out, as well as caring for post-operative patients with higher acuity needs. Hospital data showed 100% of ward nurses had received some enhanced care training specific to their role at the time of our inspection. The data showed 87% of ward nurses had completed all enhanced care training modules the hospital required. This included advanced life support, sepsis, cardiac monitoring and neurological observations. This was better than the hospital target of 85% to ensure the ward had a sufficient number of trained staff to provide enhanced care.
- Hospital data showed 23 members of ward staff had recently attended a training session on sepsis. We saw the hospital's sepsis policy, which provided clear guidance to staff on identifying and escalating suspected sepsis for immediate medical review. The policy also contained "sepsis six" forms to complete as they followed the sepsis six pathway. The sepsis six pathway involved three treatments and three tests for the diagnosis and management of sepsis in line with national guidance.

Multidisciplinary working

- We attended a daily booking meeting, where staff from a range of areas met to plan forthcoming patient bookings for surgery. We observed effective multidisciplinary communication and representation from areas including theatres, ward, pre-assessment, infection prevention and control, and reservations.
- We observed positive multidisciplinary working between surgeons, anaesthetists, operating department

practitioners, nurses and healthcare assistants in theatres throughout our visit. For example, we saw a consultant supervising a trainee theatre practitioner to insert an intravenous cannula in a supportive and empowering manner.

- All staff we spoke with reported positive multidisciplinary working relationships with colleagues. One member of staff told us there was "no segregation" across departments. Another described how colleagues from other teams always helped each other by providing the relevant specialist input to answer specific patient questions.
- Entries in the five patient records we reviewed demonstrated a range of professional input into patients' care. This included physiotherapy and pharmacy.

Seven-day services

- Orthopaedic patients recovering from surgery received daily physiotherapy on the ward. We saw physiotherapists on the ward treating patients post-surgery. The physiotherapy team provided seven-day cover. This meant patients recovering from surgery at the weekends had the same access to physiotherapy services as those recovering during the week. A physiotherapist we spoke with described how the team aimed to help patients mobilise within four hours of surgery to help their recovery. The physiotherapy team had a 24-hour on-call rota so that patients had immediate access to physiotherapy if required.
- The diagnostic imaging department provided a 24-hour a day and seven day a week on-call service for urgent imaging requests out of hours. The hospital had on-site facilities for x-ray, magnetic-resonance imaging (MRI), computerised tomography (CT), and ultrasound. Radiology consultants were on-site during clinic hours to manage urgent work and the reporting requirements for the hospital. They also had an on-call rota for outside clinic hours and staff told us they could easily reach a radiology consultant if required. This meant the service had 24-hour, seven days a week access for urgent diagnostic imaging requests to support clinical decision making.

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- The hospital had an on-site pharmacy. The hospital pharmacist team provided a daily service Monday to Friday between 8.30am and 5pm. Outside these hours, there was an on-call rota for urgent pharmacy advice.
- The hospital's practising privileges policy stated, "Patients must be visited at least once daily by the admitting consultant or their nominated deputy". In all five sets of patient records we looked at, we saw evidence of daily medical review in line with the policy.

Access to information

- Staff could access policies and procedures electronically through the shared drive and knew how to do this. We also saw paper copies of current policies available to staff in the theatre staff room for easy access such as in the event of computer failure. Staff could access national guidance via the internet, and we saw computers available in staff areas to enable them to do this.
- The hospital held integrated patient records on-site. As well as keeping confidential patient data safe, this ensured timely access to all the information needed for patient care. We reviewed five sets of notes for surgical patients. All five contained sufficient information to enable staff to provide appropriate patient care. This included diagnostic test results and care plans.
- We observed a discharge on Nickleby Ward and saw staff gave the patient comprehensive written and verbal information about their ongoing care. This included wound care, physiotherapy exercises, follow-up appointments, medication and VTE prophylaxis. This helped patients understand how to care for themselves and recognise any post-operative complications while they continued recovering at home. However, the patient said some of the discharge advice conflicted with verbal information given by their consultant and the physiotherapy team. We saw that the nurse promptly followed-up with colleagues so they could ensure that patient had all the correct information they needed before going home.
- We saw that nurses gave patients details of a 24-hour contact number for the ward as part of their discharge pack. We saw a nurse advising a patient to call the ward if they had any concerns or became unwell after discharge.

- Nurses on the wards printed discharge letters for patients' GPs. We saw that discharge letters included all relevant information to allow continuity of care. This included operation notes, prescribed medications and wound care. Discharge letters contained details of the treating consultant so that the patient's GP could contact them if needed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed five consent forms for surgery. On all five forms, we saw patients and consultants had signed consent forms before the day of surgery. This was in line with guidance from the Royal College of Surgeons "Good Surgical Practice 2014", which states staff should "Obtain the patient's consent prior to surgery and ensure that the patient has sufficient time and information to make an informed decision". Consultants then provided an additional signature on the day of surgery to confirm the patient's consent to proceed in line with the RCS guidance.
- The theatre manager told us theatre staff never brought a patient from the ward to theatres if the consultant surgeon had not re-signed confirmation of consent. The theatre manager said some consultants had previously felt any member of registered staff could confirm the consent. However, the theatre manager had challenged consultants on this issue. This was because consent must be taken by someone who "has clear knowledge of the procedure and the potential risks and complications" as specified in the Royal College of Surgeons guidance. The service empowered theatre staff to challenge consultants and only bring patients to theatres once the operating consultant had signed confirmation of consent. Therefore, the service always followed the Royal College of Surgeons guidance, "Good Surgical Practice 2014" guidance regarding consent for surgery.
- Staff received training in consent as part of their annual mandatory training. Hospital data showed 100% of theatre staff and 96% of ward staff had up-to-date consent training at the time of our inspection. This was better than the hospital target of 95% and meant the hospital had assurances staff had up-to-date knowledge around the requirements for consent.

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- We saw the hospital's "mental capacity and deprivation of liberty policy". The hospital had recently reviewed the policy, and it was within its review date. The policy provided clear guidance to staff where there were concerns about a patient's mental capacity. The policy included flowchart guidance, a capacity assessment form and a best interests' decision form. We asked two members of staff about how the service cared for patients that lacked capacity. Both demonstrated awareness around the Mental Capacity Act 2005, capacity assessment and best interests decision-making for patients that lacked capacity to provide consent. This meant staff had access to appropriate guidance on the MCA and knew how to apply it.
- We reviewed the minutes for a best interests' meeting that took place within six months before our visit. This demonstrated multidisciplinary involvement, including the patient's consultant, the deputy chief nurse, a ward sister, a pre-assessment nurse and the theatre manager. We saw that the patient attended the meeting with a relative. Involvement of patients and their relatives in the best interests' decision-making process was in line with best practice guidance. The consultant had assessed the patient's capacity to consent for their operation and signed a "Consent form four- statement of healthcare professional for adults who are unable to consent to investigation or treatment" because the patient lacked capacity to consent for surgery. This was in line with the Mental Capacity Act 2005.
- Hospital data showed 100% of patients that had cosmetic surgery at the hospital between November 2016 and October 2017 had 14 days or more between their consultation where they provided consent to surgery and the date of their cosmetic procedure. This was in line with the Royal College of Surgeons "Professional Standards for Cosmetic Surgery". It meant all patients had a minimum of a 14-day "cooling off period" when they could change their mind about proceeding with cosmetic surgery if they so wished.

Are surgery services caring?

Good 

We rated caring as **good**.

At our last inspection, we rated caring as good. On this inspection, we found the service had maintained the rating of good for caring.

Compassionate care

- The hospital participated in the NHS friends and family test for NHS-funded patients. Data for May to October 2017 showed between 94% and 96% of patients would recommend the hospital to their family and friends. Between 18% and 30% of patients responded to the survey during this period. This meant most patients that completed the survey were satisfied with the care they received.
- The hospital used its own "inpatient/day case patient questionnaires" to monitor patient satisfaction for all surgical patients. An external third party company collated and analysed the results every month. We reviewed the results for September to December 2017. Response rates to the survey varied between 16% and 31% during this period. In November 2017, 99% of patients that responded to the survey said they would be likely or extremely likely to recommend the service to family and friends. In the remaining three months we reviewed, 100% of patients surveyed said they would be likely or extremely likely to recommend the service to family and friends. This meant almost all patients that responded to the survey would recommend the service to their family and friends.
- We received 19 patient comment cards from surgical patients. All patients were positive about the compassionate care they received from hospital staff. Comments included, "I could not have been treated better", "Fantastic care throughout", and "Every member of staff I encountered showed genuine care and treated me with utter respect".
- We spoke with two patients, who were happy with the care they received from staff. One patient described the theatre team as "lovely" and "so friendly". They also commended the care they received from ward staff and a physiotherapist. They described how a nurse on the ward recognised them from a previous hospital stay and helped them feel at ease. This reflected the positive feedback we saw in patient comment cards and satisfaction surveys.
- We saw staff on Nickleby Ward respecting patients' privacy by knocking on the door before entering patient

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rooms. Patient comment cards we reviewed reflected that staff respected patients' privacy and dignity. Comments included, "Staff treated me with dignity and respect", and "Dignity and respect at all times". We also saw a poster of "Dignity Do's" displayed on Copperfield Ward to promote patient dignity and respect at all times.

Understanding and involvement of patients and those close to them

- In theatres, we observed a patient-centred approach, with staff keeping patients comfortable and informed at all times. For example, we saw staff taking extra care to prevent any discomfort to a patient with an injured arm when transferring them onto and off the operating table.
- Patients undergoing orthopaedic surgery attended a pre-operative "joint school". This was an information session run by physiotherapists to help patients feel fully informed about their planned surgery and the subsequent recovery period. Physiotherapists demonstrated exercises and started patients on their exercise programmes pre-operatively with the aim of helping them recover more quickly after surgery. We spoke with a patient who had attended joint school. The patient said the session was very informative, and that they found it particularly interesting to see examples of prosthetic joints. A patient comment card we reviewed also described joint school as "very informative" and said staff gave "very important responses to questions". This demonstrated the service actively involved orthopaedic patients in their treatment before they attended for surgery.
- A physiotherapist we spoke with described how the physiotherapy team aimed to help patients' mobilise within four hours of surgery. As well as helping patients recover more quickly, early mobilisation can help maximise patients' independence while in hospital.
- The hospital's inpatient/day case patient questionnaires asked patients whether they were involved as much as they wanted to be in their care and treatment. Results for September to December 2017 showed between 95% and 98% of patients felt as involved as they wanted to be during this period. This meant almost all patients that responded to the survey felt as involved as they wanted to be in decisions about their care and treatment.
- Patients we spoke with said they felt staff listened to them and invited them to ask any questions they had. One patient and their relative told us their surgeon was "lovely" and said, "He informs you of everything. They described how the surgeon always asked if they had any questions and answered them. However, another patient felt that although staff listened to them and responded to questions, "some points were conflicting and confusing". This meant the patient might not have felt fully informed of all aspects of their care and treatment.
- For self-funding patients, the hospital provided guide prices for all procedures on their website. The hospital subsequently confirmed the final price for a procedure following the patient's initial consultation and pre-operative assessment. This was because it was not known whether the patient would need any additional tests or procedures until after they had seen a consultant and been pre-assessed for surgery.
- We saw in the "consultant connect" newsletter for quarter three, 2017 that the hospital reminded consultants to discuss the additional costs of any pre-operative tests in advance with patients. This was following complaints from patients who felt their consultant had not fully informed them in advance about the hospital charges, in addition to the consultant fees, associated with these procedures. This demonstrated the hospital took action to ensure patients received complete and accurate information about treatment costs in advance.

Emotional support

- The hospital had a team of six volunteers called "KIMS angels" who were available to provide emotional support to patients if needed. Each volunteer worked a half-day shift each week, covering Monday to Friday. We spoke with a KIMS angel, who described how they helped lessen patients' anxieties by listening, talking and providing distraction. Staff told us the KIMS angels sometimes spent time on the wards providing company to older patients who did not have family close by to visit them. This helped reduce the loneliness sometimes experienced by this group of patients.
- A KIMS angel we spoke with described a time when a nurse asked them to spend time with a patient on the ward who had recently lost their spouse. The patient

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stayed in the hospital for a week, and received a daily visit from the KIMS angels during this time. The patient's mood had significantly improved by the time they were discharged home following the emotional support they received from the volunteers and ward staff.

- The hospital's inpatient/day case patient questionnaires asked patients whether they found anyone in the hospital to talk to about any worries or fears. The results for October to December 2017 showed 94% of patients found someone to talk to when they needed emotional support. The results for September 2017 showed 93% of patients found someone to talk to. This demonstrated most patients accessed emotional support when they needed it.
- The wards had open visiting for patients' friends and relatives. A patient's partner described how they had been able to visit their loved one at any time throughout their hospital stay. For an additional charge, visitors could eat a meal on the ward with their relative or friend. A patient's partner described how they had eaten meals with their partner throughout their stay. These measures allowed patients to receive emotional support from family and friends at any time while they were in hospital.
- The hospital had three specialists with expertise in counselling, health psychology and psychiatry that held practising privileges. Patients or relatives experiencing anxiety or stress could book an appointment for counselling at the hospital. Alternatively, hospital staff could refer them for counselling services on request.

- In the reporting period November 2016 to October 2017, there were 6,936 visits to theatre. Of these, 4,867 patients (70%) had day-case procedures and 2,069 (30%) stayed overnight.
- The service provided a diverse range of elective surgery to meet the needs of the local population. This included orthopaedic surgery, gynaecology surgery, ear, nose and throat surgery and eye surgery. Hospital data showed the most common types of surgery between November 2016 and October 2017 were joint injections (583 procedures), knee replacement (428 procedures) and hip replacement (301 procedures).
- The hospital accepted different types of funding for treatment. These were self-paying, private medical insurance and NHS-funding. Hospital data showed 58% of surgical and inpatients had NHS-funded treatment between November 2016 and October 2017. The remaining 42% of patients either paid for their own treatment or used private medical insurance. This meant more than half of patients were able to use NHS-funding to cover the costs of their treatment.
- The hospital regularly met with local NHS commissioners to plan services and review their performance. Representatives from a local clinical commissioning group (CCG) visited the hospital to carry out annual quality reviews. We saw a copy of the most recent available report from October 2016.
- All admissions for surgery planned in advance were elective procedures. We attended a multidisciplinary daily booking meeting and saw staff book patient theatre slots and rooms on the ward. The booking meetings allowed staff to make arrangements for any specific patient needs in advance. For example, we saw a ward sister confirming availability for post-operative enhanced care for a bariatric patient. We also saw the theatre manager alert the orthopaedic lead to order a specific device ready for a patient's operation.
- Staff told us that as well as ensuring the availability of facilities and equipment, the booking meetings allowed the service to plan staffing rotas accordingly. For example, a ward sister told us they increased the planned number of nurses on days when they had patients in enhanced care to meet the acuity needs of these patients.

Are surgery services responsive?

Good 

We rated responsive as **good**.

At our last inspection, we rated responsive as good. On this inspection, we found the service had maintained the rating of good for responsive.

Service planning and delivery to meet the needs of local people

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- The hospital did not book any patients for planned elective surgery less than four days in advance. This was to ensure plenty of time for the return of any pre-operative screening results following blood tests and Methicillin-resistant Staphylococcus aureus (MRSA) swabs. We saw staff followed this policy during the booking meeting we observed.
- During our visit, we observed that nursing staff on Nickleby Ward answered call bells promptly within one minute. We asked a patient whether nurses responded quickly when they used their call bell. The patient told us the nursing staff were very responsive. This demonstrated nursing staff responded promptly to calls for assistance to meet patients' needs.

Access and flow

- Hospital data showed the hospital cancelled 12 NHS-funded patients' operations for non-clinical reasons between November 2016 and October 2017. We saw that two cancellations were due to patient choice. This was because one patient was unavailable on the day of their operation and the other decided not to proceed with surgery. There were different reasons for operations cancelled by the hospital, including consultant and anaesthetist sickness. The data showed 100% of patients who wished to continue with surgery at KIMS Hospital had their operation within 28 days of cancellation. This was in line with the NHS Constitution pledge and meant patients did not experience lengthy waits for an alternative surgery date.
- The hospital reported waiting times for NHS-funded patients on 18-week referral to treatment pathways to all local CCGs each month. At the time of our visit, the hospital was developing a waiting time report to allow the monitoring of trends.
- Hospital data showed 92.5% of NHS-funded patients had surgery within 18 weeks of referral between November 2016 and October 2017. This was better than the 90% target agreed with local commissioners. The data showed the hospital's performance was better than the 90% target in all months during this period, with the exception of July 2017, when the service achieved 89.9%. This was only 0.1% below the target. The hospital told us patient numbers were low in July due to the summer holiday period. This meant a slight increase in pathway times had a larger impact on the percentage

because the hospital admitted fewer patients in total. The hospital reported commissioners were satisfied with their performance in relation to referral to treatment times for surgery.

- The theatre team had an on-call rota to cover any unplanned returns to theatre outside of normal operating hours. Anaesthetists also participated in an on-call anaesthetic rota to ensure 24-hour anaesthetic cover. The hospital required all consultant surgeons or their nominated "buddy" from the same specialty to be on-call 24 hours a day for their own patients until discharge. These arrangements ensured patients had access to surgery at all times should the need for an unplanned return to theatre arise.
- On the day of surgery, staff collected patients from the hospital reception and showed them to their rooms on the ward. Patients changed into theatre gowns and had any necessary assessments, such as pre-operative pregnancy testing for women of childbearing age. After the patient's surgeon documented their confirmation of consent, a member of theatre staff escorted patients to the theatre suite for their operation.
- Immediately after surgery, theatre staff cared for patients in the recovery room. Once patients were stable and their pain was controlled, staff took them back to the ward to continue their recovery.

Meeting people's individual needs

- Patients had access to telephone and face-to-face interpreting services if needed. Staff we spoke with could describe the process for booking an interpreter. Staff gave examples of times surgical patients had used the interpreting service, including a British sign language interpreter in pre-assessment the week before our visit. A pre-assessment nurse told us the service booked longer appointment slots for patients using interpreters so they did not feel rushed. Hospital accounts data showed the hospital had used interpreters in 10 different languages between April 2016 and March 2017. This was the most recent annual data available at the time of our visit. This demonstrated the service used interpreters when required to meet patients' needs.
- The hospital was developing its dementia strategy at the time of our visit. The service saw a small number of patients with mild cognitive impairment, and a member

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of ward staff was the nominated dementia champion. We saw blue flower magnets for the nursing whiteboard on Nickleby Ward. Staff used these to easily and discreetly identify patients living with dementia for additional support. The service had links with a specialist dementia nurse at a local hospice, who reviewed patients and provided resources to help meet their individual needs.

- Nurses we spoke with on Nickleby Ward described an occasion when a patient showed signs of confusion and early dementia post-surgery. The service contacted the specialist dementia nurse from the local hospice, who came to KIMS Hospital and reviewed the patient. Staff described how the dementia nurse completed a “this is me” dementia passport with the patient and their partner. Dementia passports provided person-centred information about the patient. This enabled staff to recognise and respond to the patient’s individual needs. They also provided “twiddlemuffs” for the patient. Twiddlemuffs were knitted bands with various different textures. They were specifically designed for patients living with dementia to help occupy their hands and lessen any anxieties. Staff subsequently signposted the patient and their partner to community services for patients living with dementia for continuation of support after discharge.
- The theatre manager described an occasion when a patient living with dementia identified as feeling anxious about surgery. The theatre manager arranged for the patient and a relative to visit the theatre department before the day of their operation. This allowed the patient to familiarise themselves with the theatre environment and meet some of the staff that would care for them. Visiting the theatre department helped lessen the patient’s anxieties about their operation. This further demonstrated the service took appropriate action to meet the needs of patients living with dementia.
- The hospital’s catering team was able to cater for a range of preferences and cultural needs, such as vegetarian diets. We spoke with a host on Copperfield Ward, who told us their team visited every patient on the wards to take their orders and discuss any individual requirements. A chef we spoke with gave an example of a time when a patient specifically requested beef stroganoff, which was not on the menu that day. The

chef prepared the patient’s requested meal. The chef received positive feedback because the patient enjoyed their meal having not eaten well for the previous few days. This demonstrated the catering team were responsive to patients’ individual needs.

- We saw that patient rooms on the wards had ensuite bathrooms with level-access showers. We also saw additional aids to support patients with limited mobility such as shower chairs. We saw wheelchair-accessible toilets in Dover Clinic, where patients attended for pre-assessment. This meant wheelchair-users could access the service on an equal basis to others.
- The hospital had suitable facilities to treat bariatric patients. The hospital accepted admissions from bariatric patients with a body mass index (BMI) of 40 and above for certain operations. This was subject to a pre-operative risk assessment with an anaesthetist, who agreed it was safe for the individual patient to proceed with surgery. The service allocated bariatric patients an enhanced care bay on Nickleby Ward to allow additional monitoring after surgery. Bariatric beds, commodes and chairs were available to meet the needs of this group of patients.

Learning from complaints and concerns

- Hospital data showed there were 113 patient complaints relating to surgery between November 2016 and October 2017. The hospital received 272 complaints in total during the same period. No patients escalated a complaint relating to surgery to the ombudsman or the Independent Healthcare Sector Complaints Adjudication Service during this period. This suggested the service was able to satisfactorily resolve all complaints relating to surgery during the reporting period.
- We reviewed the hospital’s complaints log for the six months before our visit. This showed the hospital recorded all complaints or negative feedback on the electronic reporting system. This included informal complaints made verbally, and any negative feedback from patient questionnaires or via the hospital’s social media site. This demonstrated the hospital monitored all feedback to help the service improve, and not just formal complaints.
- The chief nurse was responsible for overseeing complaints, supported by the medical director. The

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deputy chief nurse also supported with clinical complaints. The quality and governance team managed the administration of complaints under the direction of the chief nurse.

- The hospital acknowledged all formal complaints within two days of receipt. The hospital invited all complainants to a face-to-face meeting with the appropriate staff to help resolve their concerns promptly. The hospital complaints log showed the service met the two-day acknowledgement target for complaints relating to surgery.
- If a complaint required further investigation, the target timescale for completion was 20-days in line with the hospital complaint's policy. The hospital's complaint log showed the hospital met this target for almost all complaints relating to surgery in the six months before our visit. For any investigations that took longer than 20 days, the hospital sent a holding letter apologising and explaining the reasons for the delay in line with its complaints policy.
- We reviewed three patient complaints relating to surgery received within the reporting period November 2016 to October 2017 and the hospital's responses. We saw evidence staff met with patients and provided opportunities for a face-to-face discussion about their concerns in line with the hospital's complaints policy. We saw evidence of investigation, explanation and apology. We saw the hospital was open and honest in its responses, for example, if staff had made mistakes or should have done things differently.
- In complaint responses we reviewed, we saw the service made changes to practice and implemented learning from complaints to help drive improvement. Ward meeting minutes also demonstrated staff received feedback and learning from complaints at monthly staff meetings. This helped the service improve the care and treatment it provided to patients.

At our last inspection, we rated well-led as requires improvement. On this inspection we have changed the rating to good because we saw significant improvements to the overall leadership, culture and governance of the service.

Leadership / culture of service related to this core service

- The hospital had a structured senior management team led by the chief executive. The medical director, chief nurse and chief operating officer reported to the chief executive. The ward sisters reported to the deputy chief nurse, who subsequently reported to the chief nurse. The theatre manager reported directly to the chief nurse. Staff in sterile services as well as theatres reported to the theatre manager.
- Staff said leadership had significantly improved since the new executive team arrived around the time of our previous inspection. Leaders had an inspiring shared purpose, to strive to deliver and to motivate staff to succeed. All staff spoke positively about their relationships with both their line manager and the senior management team. Staff felt able to escalate any issues to the senior management team if needed and gave examples of action the senior management team had taken to address concerns. This included a staff member who raised concerns about a consultant's behaviour, which the chief nurse promptly addressed.
- Staff described the senior management team as being visible and approachable, with an "open door policy". Staff told us the chief executive knew everyone by name. A volunteer told us they regularly ate lunch in the staff bistro with the chief executive officer. This demonstrated the open and accessible culture we observed throughout our visit.
- There was a strong culture of openness, transparency and learning. For example, the service encouraged staff to record any negative feedback, regardless of whether they received information informally, on the hospital's electronic reporting system. This allowed the service to continually learn and improve. All staff we asked knew what duty of candour meant and could describe their responsibilities relating to it. The senior management team also modelled open, transparent and welcoming behaviour with us.

Are surgery services well-led?

Good 

We rated well-led as **good**.

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- Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff described the culture of the service as “friendly”, “caring”, “welcoming” and “one big family”. This reflected the positive and supportive culture we observed throughout our visit.
- The theatre manager described how theatre staff had challenged consultants to ensure they documented confirmation of patient consent on the day of surgery. Theatre staff refused to bring patients to theatre until the patient’s surgeon documented confirmation of consent in line with the Royal College of Surgeons guidance. The senior management team supported the theatre team to do this to ensure all consultants followed national guidance regarding patient consent. This demonstrated the service empowered all staff to challenge behaviour that was inconsistent with the hospital values, regardless of seniority.

Vision and strategy for this core service

- The strategy for surgical services had been fully embedded since our last inspection. The new strategy, introduced by the current senior management team who were new in post around the time of our last inspection, focused on “getting the basics right”. This involved developing clear governance processes and creating a strong safety culture for low-risk, elective surgery. The safety improvements we identified in this inspection, such as incident learning and infection prevention and control, along with improved governance processes demonstrated the service had met this strategic goal.
- The service had a clear strategy going forwards. This was to continue to grow the hospital’s core surgery area of orthopaedics before broadening the surgical specialty portfolio. The hospital was also working to increase insurer engagement to allow more patients with private medical insurance to have surgery at KIMS Hospital.
- The service followed the hospital’s vision and values. The hospital’s mission was “to provide the highest quality of care in a world-class clinical environment for the people of Kent”. The values were caring, confident, dynamic, respecting people, and operating and communicating with integrity as a team to bring quality and value.
- Staff we spoke with knew the hospital values and had them printed on the back of their identity cards to serve

as a constant reminder. Staff described how they brought the values to life in their day-to-day work. For example, staff described how different areas of the hospital worked as one team. One person said, “There’s no segregation across departments”. Another told us colleagues in other departments were “never too busy to help”. Regarding the “respecting people” value, one person said, “I witness respect on a day-to-day-basis”. Another staff member said they felt senior staff always listened and respected their contributions if they wanted to raise suggestions in meetings. This demonstrated staff at all levels of the service followed the hospital values on a daily basis.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- The hospital’s quality and governance committee, chaired by the chief nurse, met monthly and provided assurances around quality and safety to the hospital management board. The hospital management board consisted of the executive chair, the chief executive, the chief operating officer, the chief nurse, the medical director, the human resources director, the finance director and the sales and marketing director. A range of different sub-committees including clinical effectiveness and audit, medicines management and infection prevention and control fed into the hospital clinical governance committee. The theatre manager, clinical manager and the sub-committee chairs sat on the quality and governance committee, which provided assurances to the board.
- Since our last inspection, the hospital had introduced an additional quality and governance sub-committee. The sub-committee was independent to the hospital quality and governance committee and provided independent assurances direct to the board. Independent representatives with expertise in governance and quality sat on the quality and governance sub-committee, whose chair was an external consultant. The executive team explained that the purpose of the sub-committee was to provide external scrutiny. This enabled external benchmarking, which was important because the provider was a single-location hospital rather than part of a group of

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hospitals that could benchmark performance against each other. External scrutiny therefore meant the board had greater assurances around the hospital's performance.

- The hospital's medical advisory committee provided the formal organisational structure through which consultants communicated. The medical director chaired the medical advisory committee, which met quarterly. The chief executive and chief nurse also sat on the medical advisory committee. A consultant surgeon from each surgical specialty represented surgery on the medical advisory committee. The medical advisory committee provided assurances around consultant and clinical matters to the hospital management board.
- We saw the hospital's audit schedule. This included audits in a range of key areas such as infection prevention and control, medicines management and record keeping. The hospital's clinical effectiveness and audit committee met monthly to review audit performance and provided a quarterly report to the hospital quality and governance committee.
- The hospital had a comprehensive quality dashboard, which monitored monthly performance in an extensive range of key areas relating to surgery. These included monthly WHO five steps to safer surgery audits, NEWS chart completion, surgical site infections, VTE screening compliance and unplanned returns to theatre. The hospital had targets for each key performance indicator. Targets were set in line with national standards where applicable and external input from the independent quality and governance sub-committee. Meeting minutes we reviewed showed the hospital quality and governance committee meeting reviewed dashboard performance each month.
- Theatres and wards held monthly team meetings. The theatre manager or senior escalated any risks or areas of concern to the hospital quality and governance committee. We saw copies of team meeting minutes, which showed staff received feedback on incidents and complaints. Staff also received feedback from other relevant meetings such as senior nurses' meetings. We saw departmental leads shared feedback from the quality and governance committee on relevant key performance indicators at monthly departmental meetings. For example, ward meeting minutes showed

staff received feedback on NEWS chart completion. Theatre team minutes showed evidence of feedback from monthly WHO checklist audits. This meant the service addressed any deterioration in performance and celebrated positive practice. The leadership drove continuous improvement and held staff accountable for delivering change.

- We saw the hospital risk register as well as the local risk register for theatres. The service used a risk matrix to assess the likelihood and severity of possible risks. Senior staff could describe key risks, such as the management of hard copies of policies. Staff could explain the potential impact of risks and we saw evidence of mitigation. For example, the service was introducing a new electronic quality management system. This required staff to provide an electronic signature as assurance they had read and understood any new or revised policies. The hospital's biggest risk on the risk register was nurse recruitment. We saw the hospital took action to mitigate this risk such as developing links with a university, which resulted in the successful recruitment of newly qualified nurses in theatres and on the wards. This showed the service took action to reduce risks.

Public and staff engagement (local and service level if this is the main core service)

- The service had consistently high levels of constructive engagement with staff. The hospital had a staff forum called "KIMS voice" run by staff, for staff. KIMS' voice met monthly and staff invited the chief executive or chief nurse to attend to listen to staff ideas for improvement. Staff spoke positively of the forum and told us about suggestions they made that the senior management team subsequently implemented. This included a suggestion for all staff to have an extra day's annual leave each year on their birthday. Staff felt listened to and valued when the senior management team implemented this incentive.
- The hospital also had staff suggestion boxes where staff could submit suggestions for improvement. Staff described contributions the hospital had implemented, such as introducing "grab and go" breakfast boxes and putting curry sauce on the bistro menu.
- The hospital had a "values champion" scheme, where staff could nominate colleagues whose behaviours went

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“above and beyond” the hospital values. The winning values champion each month received a shopping voucher. This helped staff feel valued by colleagues and the senior management team, as well as incentivising behaviour that exceeded the values.

- Staff received strategy briefings led by the chief executive every six months. Staff told us the hospital encouraged everyone to attend and said they valued these communications.
- The hospital ran an annual staff survey. We reviewed the results from the 2016 survey, as the 2017 results were not yet available at the time of our visit. The survey had an 80% response rate, which reflected the high levels of staff engagement we observed throughout our visit. There were high levels of staff satisfaction relating to surgery. The results for theatres and sterile services were very positive about service leadership and culture. For example, 98% of staff said they were proud to work for the hospital and 91% said they would recommend the hospital as a place to work. Ninety-five per cent of staff felt the hospital communicated a clear vision of where the organisation was heading and how it was getting there. Ninety-eight per cent said their line manager motivated them to be more effective in their job. These results reflected the strong leadership and culture of confidence in leaders that we observed throughout our visit.
- To engage with the local community, the hospital had a nominated local charity that they raised funds for each year. Staff described fundraising events they had attended, such as a family fun day and the London to Brighton bike ride. As well as promoting engagement in the local community, fundraising events increased staff engagement and team building within the hospital. The hospital also had a staff choir, and staff described singing in Christmas concerts with colleagues.
- The hospital held quarterly patient forums to seek patient feedback. A member of the hospital management board and other key staff attended. All patients and their relatives were welcome to attend. This meant the hospital could discuss suggestions for service improvement with those who used the service.
- The hospital also provided multiple avenues for obtaining written feedback from patients. These were day case/inpatient questionnaires, NHS friends, family test surveys, and a social media page.
- To engage with consultants, the hospital produced quarterly consultant newsletters. The hospital also ran an annual consultant survey to seek consultant feedback. The response rate to the 2017 consultant survey was 41.5%. However, survey data showed a further 48.7% of consultants had “clicked through” the electronic survey without responding to any questions. This meant 90.2% of consultants had acknowledged the survey, even though almost half had chosen not to respond to it.
- We saw the results of the 2017 consultant survey, which showed 52% of consultants that responded felt the theatre department at KIMS Hospital was better than other independent hospitals they had worked at in the last year. A further 33% felt the theatres were comparable to other independent hospitals they had worked in. This meant 85% of consultants were satisfied or very satisfied with theatres. We also saw an action plan to address areas of improvement highlighted in the survey. This included improved communication through the consultant newsletter and a dedicated email address for pre-assessment. This demonstrated the hospital listened to consultants’ views when identifying areas for improvement.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- The hospital had made improvements in many areas since our last inspection in September 2015, which are reflected throughout this report. Patient safety and governance were at the centre of these improvements.
- The hospital had developed links with three local universities to help boost staff recruitment. The hospital recently held an open day attended by approximately 20 newly qualified nurses. This event led to the successful recruitment of three new nurses under the preceptorship programme. One nurse had a post in theatres and the others on the wards.
- The hospital had ongoing projects to drive continuous improvement. We saw the hospital’s project tracker, which showed evidence of weekly monitoring against

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project targets. Ongoing improvement projects relevant to surgery included the preceptorship programme and the recently introduced three-point checking system to monitor consultant scope of practice.

Outpatients and diagnostic imaging

Safe	Good 
Effective	
Caring	Good 
Responsive	Good 
Well-led	Good 

Are outpatients and diagnostic imaging services safe?

Good 

We rated safe as **good**.

At our last inspection, we rated safe as requires improvement. On this inspection we have changed the rating to good because we have seen improvements in key areas such as incident reporting and learning from incidents, management of medicines and records, waiting times from referral to first appointments and leadership.

Incidents

- The hospital reported no never events in this service in the reporting period from November 2016 to October 2017. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The hospital implemented an electronic computer system for reporting incidents in January 2016. This replaced the paper based system which was in place during the previous inspection in 2015.
- October 2016 and September 2017, the hospital reported 977 clinical incidents and 465 non-clinical incidents. There were 246 of the 977 clinical incidents and 93 of the 465 non-clinical incidents related to outpatient and diagnostic imaging service. Of the 339 clinical and non-clinical incidents, 284 were reported as no harm, 52 as low harm, three were

moderate harm and none were severe harm. Of these, three incidents were related to children and young people; one was clinical and two were non-clinical incidents which were reported as no harm. We reviewed the incident log and this did not identify any common themes. Incidents had occurred across different clinical specialities. We saw an incident involved hot drink spillage on a patient, and that following an investigation the managers fed back to the relevant staff with lessons learnt. There was no harm to the patient.

- Managers and staff we spoke with were comfortable reporting incidents and felt the open and honest culture was supported by the hospital governance committee. This together with the change from paper to electronic based system had increased staff awareness and resulted in increased reporting.
- Staff demonstrated how they would access and use the electronic incident reporting system which showed they were confident in using the system. We saw incidents discussed as a standing agenda item in the minutes of the quality governance and medical advisory committee (MAC), and heads of department meetings.
- Staff were able to describe the outcomes of investigations from reported incidents and recalled the lessons learnt. We were provided with two examples.
- In one outpatient area, staff described an example of a doctor who frequently ran late in seeing their patients. We saw this reported as an incident. Staff told us this had improved following a thorough review and investigation of this incident, and patients were no longer kept waiting.
- Staff explained they received feedback about key learning outcomes from incidents at departmental

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meetings and information related to these was accessible to all relevant staff from the hospital electronic system. We saw this documented in the staff and heads of department meeting notes.

- Radiology staff told us they could discuss incidents relating to radiation with the radiation protection supervisor available on-site. In addition to this, staff told us the radiation protection advisor although not on-site, was easily contactable should advice be required for reportable incidents required under the Ionising Radiation (Medical Exposure) Regulations IR(ME)R 2000. Some IR(ME)R incidents require notification to the Care Quality Commission under regulation 4(5).
- There were no IR(ME)R notifications made by the radiology department in the last year in the information provided to us prior to this inspection.
- At the start of this inspection, the chief nurse and diagnostics and cardiology services manager told us that one reportable IR(ME)R incident took place the day before this inspection started. The chief nurse told us that initial investigations demonstrated an agency staff member had not followed the hospital standard operational procedure even though they had been working in the hospital for a few months; they had spoken with the individual and said the hospital would not use them again. The diagnostics and cardiology services manager told us the two patients involved did not come to any harm, had apologised to the patients and provided them with an explanation of what went wrong. Staff told us this incident will be fully investigated which was in line with the hospital policy.
- We saw radiology staff completed an adaptation of the World Health Organisation safety questionnaire and verbal safety checks prior to patients undergoing scans and magnetic resonance imaging (MRI) procedures. This helped to assure that potential risks were identified and acted upon.
- Duty of Candour (DoC) is a statutory requirement under the Health and Social Care Act (Regulated Activities Regulations) 2014 for healthcare providers to disclose safety incidents that result in moderate or severe harm or death to patients or any other relevant person. Staff we spoke with understood that the legislation is about being open and honest. Staff gave an example of an information recording error. Even though the patient did

not experience harm, staff apologised and explained to the patient what went wrong. We saw the hospital training records indicated DoC was included in mandatory training for all staff. We saw a poster displayed on the staff notice board describing the process to follow should DoC apply.

Cleanliness, infection control and hygiene

- We found that overall the outpatient and diagnostic imaging services complied with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (updated 2015). There were systems in place to reduce the risk and spread of infections. In addition to this there was a named nurse for infection prevention and control.
- The hospital reported no cases of methicillin-resistant staphylococcus aureus (MRSA), methicillin sensitive staphylococcus aureus (MSSA), clostridium difficile (C. diff) or escherichia coli (E.coli) within the outpatient and diagnostic imaging services in the last year.
- We saw consulting and treatment rooms were clean, tidy and well presented. We looked at cleaning checklists for the period of three months before our visit. These were completed each day in the areas of the departments which were open. There was no dust visible on high and low dusting levels in all the areas we visited. Our findings were consistent with the department's infection prevention and control environmental audit compliance rate, which showed 96% for cleanliness in August 2017. This was better than the hospital compliance target of 90%.
- We saw staff using personal protective equipment (PPE) such as disposable gloves and aprons and PPE was available in all the clinical areas visited. PPE including all sizes of gloves were readily available in each clinical area. We also saw radiation protection equipment such as lead aprons and glasses were available in the radiology department.
- We saw hand washbasins and hand gel was available in all clinical and waiting areas, and we saw staff using the product. Posters were displayed over handwash basins which explained '5 steps in hand hygiene' in line with the World Health Organisation guidance. The posters acted as a reminder to staff of the need for hand

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hygiene. We saw staff in clean uniforms, were bare below the elbow and washing their hands in line with this guidance before and after patient interactions. This meant the spreading of infections was reduced.

- The outpatient manager told us that hand hygiene compliance was monitored weekly, and the hand hygiene audits scored 100% for the assessment of individuals from August 2017 to December 2017. We saw hand hygiene was discussed in the minutes of the infection prevention control committee meeting in September 2017 which recorded that “staff had challenged two consultants who failed hand hygiene; one was not bare below the elbow and the other had painted nails”. This demonstrated good practice.
- We saw containers for the safe disposal of sharp objects were available in areas where medical sharps were used. Staff signed a label on each sharps container which indicated the date it had been constructed and by whom. All the bins we saw were closed with temporary lids, clearly marked and placed close to work areas where medical sharps were used. This was in line with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, which requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw the department’s sharps audit completed in August 2017 showed 96% compliance which was better than the hospital’s target of 90%.
- Disposable curtains were fitted in the outpatient consulting rooms and clinical areas. We saw all the curtains had a label which indicated the curtains were changed within the last three months. According to the Department of Health’s Health Building Note (HBN) 00-09: infection control in the built environment, using disposable curtains that are routinely changed helps to reduce bacterial cross contamination.
- HBN 00-09 states, “There needs to be a clear demarcation between clean/unused equipment and soiled/dirty equipment. Clean and dirty areas should be kept separate and the workflow patterns of each area should be clearly defined”. We saw clean and dirty equipment separated and stored appropriately in the clean and dirty utility rooms.
- Waste in outpatient and diagnostic imaging areas was separated and in different coloured bags to identify the different waste categories. This meant the hospital could safely handle biological or hazardous waste which was in line with Health Technical Memorandum (HTM) 07-01: management and disposal of healthcare waste, Control of Substance Hazardous to Health (COSHH) and Health and Safety at Work Regulations. The most recent waste handling audit demonstrated compliance with the hospital’s policy.
- We reviewed the toys cleaning checklists for the three months before our inspection, which indicated staff had cleaned the toys daily and each time after they were used. We saw toys in the dedicated children’s waiting room were visibly clean. This showed staff had cleaned the toys and followed hospital policy.
- Staff completed infection prevention and control training as part of their annual mandatory training programme. As at April 2017, data provided to us showed 100% completion rate for all clinical and non-clinical staff for this service.
- The outpatient manager told us some clinical procedures occurred in all 14 consulting rooms in the main outpatient area. At the previous inspection, we saw carpets in all the rooms compared with nine of the 14 rooms at this inspection. The outpatient area remained not compliant with the Health Building Note 00-09 (HBN 00-09): Infection control in the built environment (Department of Health, March 2013) which states that carpets should not be used as this area has a high probability of body fluid contamination. This meant the hospital could not be assured of effective cleaning and removal of body fluid spillages. However, we saw a carpet replacement programme for those areas to be completed in the year 2019-2020, and a carpet cleaning programme showed the carpets were cleaned every three months and a deep clean for heavy decontamination or spillages when required.
- Patient-led assessments of the care environment (PLACE) are an annual appraisal for assessing the non-clinical quality aspects of the patient environment in NHS and independent/private healthcare settings; undertaken by teams made up of staff and a minimum of 50% patients’ representatives who go into hospitals. They assess how the environment supports patients’ privacy and dignity, food and hydration provision, cleanliness, the building condition, appearance and maintenance, and whether the premises are equipped

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to meet the needs of people living with dementia or with a disability. In August 2017, the hospital PLACE assessment for cleanliness was 99%, which was better than the England national average of 98%. The assessment of cleanliness covers areas such as patient equipment, baths, showers, toilets, floors and other fixtures and fittings.

Environment and equipment

- We observed outpatient and diagnostic imaging waiting areas were spacious, well-lit and in good decorative order.
- There was a separate waiting room in the main outpatient area specifically designed and dedicated for children. We saw age appropriate toys, books, a table and chairs were available in the room. A separate waiting area for children ensured privacy for them and their parents, and access to a dedicated children's play area. In addition, there was easy access to the baby changing facilities situated adjacent to the waiting room.
- We saw a 'safety gate' installed at the doorway of the children's waiting room which had hazard tape markings on the floor indicating a raised bar to avoid trips. This procedure itself could create a trip hazard to patients, visitors and staff. The children lead nurse told us this was being investigated and was on the risk register.
- We saw all the consulting rooms were equipped with sufficient quantity of consumables held in covered trolleys and storage racks. We saw all consumables were within their expiry dates. This indicated staff had adequate supplies of in date consumables ready for use when required.
- Single use items of sterile equipment were readily available and stored appropriately in all areas checked. All items we saw were in date, such as syringes and dressing packs. The correct storage and stock rotation ensured the sterility of items was maintained and risks of cross contamination reduced. We saw examples of single use items being used once and safely discarded after use.
- Instruments used for minor procedures that required decontamination and sterilisation were handled through an external sterile supplies contractor.
- Outpatient and imaging staff had access to emergency equipment including oxygen and resuscitation items for adults. Staff also had access to paediatric resuscitation items including pulse oximeters and weighing scales. We saw records that staff had checked the defibrillator and suction daily and other equipment on the resuscitation trolley weekly. We saw all trolleys were tamper evident and the equipment on the trolleys was within their expiry dates. This demonstrated staff had regularly ensured equipment was not out of date.
- We saw a total of 51 items of equipment and service records, and all the equipment had regular service maintenance, calibration and safety checks. This followed the Medicines and Healthcare products Regulatory Agency (MHRA) Managing Medical Devices April 2015 guidance, which states the provider must "ensure that devices are regularly checked for functionality prior to use by the user in line with the manufacturer's instructions and throughout the expected lifetime of the device".
- In diagnostic imaging, we saw a number of installed features designed to prevent or minimise accidental exposure to ionising radiation or magnetic fields. Doors were fitted with electronic interlocks to prevent access when the equipment was operating. Emergency stop buttons were clearly positioned in the rooms and illuminated warning signs were fitted to doorways which lit automatically when the interlock was turned on. We saw key card access to computed tomography (CT), magnetic resonance imaging (MRI) and nuclear medicine rooms. Only authorised staff had a key card to prevent unauthorised access.
- There was prominent signage outside the MRI suite to warn patients with pacemakers or other surgical devices not to enter due to the powerful magnetic field generated. Signs advising women who may be pregnant to inform staff were clearly displayed in the x-ray area, in line with best practice. Pregnancy tests were completed to confirm status for relevant procedures. This helped the hospital prevent potentially harmful exposure to radiation to unborn babies.
- The diagnostic and imaging department was registered with the health and safety executive (HSE) and was audited annually by an HSE approved radiation protection adviser (RPA). We saw the most recent records which confirmed this.

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- In August 2017, the hospital patient-led assessments of the care environment (PLACE) for the building condition, appearance and maintenance was 97%, which was better than the England national average of 94%.

Medicines

- We saw the hospital had a medicines management policy (review date January 2018). Staff showed us how they could access a paper copy of the policy kept in a folder in the nurses' office and electronically from the hospital computer system.
- The hospital had a pharmacy dispensary on-site. Staff told us the hospital pharmacy team was readily available to offer support and advice to both staff and patients, maintained adequate stock levels, and dispensed prescriptions in a safe and timely manner.
- We observed there were adequate security procedures to ensure only approved staff could access medicines, and these arrangements were clearly communicated to relevant staff. Staff we spoke with had good knowledge of the security procedures and their description aligned with the hospital medicines management policy and our observation.
- Medicines in outpatients and imaging were stored in locked cupboards, and registered health professionals held the keys to access the cupboards. This prevented unauthorised access to medicines and was in line with standards for good medicines management and the hospital medicines management policy.
- Pharmacy staff described a comprehensive process of receiving Medicines and Healthcare Regulatory Agency (MHRA) and NHS Patient Safety Alerts. Staff described to us how these were actioned and cascaded appropriately. We saw meeting minutes showing these were discussed at clinical governance meetings.
- We saw systems implemented to check for date-expired medicines and unused contrast medium, and to rotate medicines with a shorter expiry date. All the medicines we looked at were within the expiry date.
- There was a paediatric resuscitation medicines bag in the resuscitation trolley in outpatients. We observed this was sealed and all medications were in date.
- The BNF is updated in book and electronic formats twice a year and the BNFC annually, and details all medicines that are generally prescribed in the UK, with information about indications, dosages, contraindications, cautions and side effects. It is considered an essential resource for safe prescribing and the availability of the latest copy indicated that an appropriate level of support was provided to the consultants in clinics.
- In the outpatient department, there were several copies of the British National Formulary (BNF) Issue 74 September 2017 to March 2018, which was the latest edition in print for adults. We also saw a printed copy of the British National Formulary for children (BNFC) September 2016 to 2017 although this was not the latest edition. We raised this with the children lead nurse who explained that doctors were encouraged to access this online and staff showed us how they could do this. This meant doctors could access the latest medicine information to provide safe patient care.
- Doctors hand wrote prescriptions on private prescription and NHS prescription (FP10) forms. We saw each prescription had a serial number on it. Doctors could request individual prescription forms during clinic sessions and a registered nurse would then issue the form. We noted unused prescriptions were checked and stored in a locked drawer at the end of clinic. This reduced the chance of prescription forms being lost or stolen.
- Patient group directions (PGDs) allow some registered health professionals (such as nurses) to give specified medicines such as painkillers, to a predefined group of patients without them having to see a doctor. The legislation for PGDs is included in the Human Medicines Regulations 2012. The outpatient manager told us that PGDs were not used in outpatient and imaging departments as the supply and administration of medicines were carried out only by doctors. This was in line with the local and national medicines requirements.
- We saw medicines that required storage in a temperature-controlled environment were held in designated fridges. These were locked and incorporated digital thermometers that allowed the pharmacy team to monitor the temperatures of all the fridges from a central system. The system instantly alerted staff to fluctuations in temperatures to help preserve medicine supplies. This ensured medicines were kept at optimum temperatures. Staff explained the process for dealing

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with out of range temperatures and would report any issues as an incident. The pharmacy team recorded daily temperature checks and the most recent records we saw were all within range.

- We saw keys to all lockable cupboards were labelled clearly and stored in a key safe in diagnostic imaging. The key to the safe was in a code access locked box. The department did not store controlled medicines.
- The nuclear medicine department stored medicines in a locked cupboard and the key was stored in an unlocked drawer. This area could only be accessed by key card where only authorised staff had access. This gave adequate security to the medicines cupboard.
- We saw certificates for staff issued by the administration of radioactive substances advisory committee (ASARC) in a folder within the nuclear medicine department. This indicated staff were safe to give medicine in this department.
- Radiopharmaceuticals were supplied by a unit holding a manufacturer's licence from the medicines healthcare products regulatory authority (MHRA) in the nuclear medicine department. This gave independent assurance of nuclear medicines used at this hospital.
- The diagnostic imaging service followed the hospital policy designed to detect and prevent contrast-induced nephropathy (CIN), which is kidney injury in susceptible individuals caused by the use of contrast media in imaging. We saw staff used safety questionnaires which enabled the doctors to check for CIN. Imaging staff we spoke with described appropriate actions they would take in the event of any allergic reactions. This followed the Royal College of Radiologists Standards for Intravascular contrast agent when given to patients.
- For our detailed findings on medicines please see the Safe section in the surgery service report.

Records

- The hospital had a medical records policy which was current (review date September 2020). Staff we spoke with told us the reservations team prepared medical records for each clinic list every day. The medical records were transferred to the outpatient area where

they were kept in the nurses' office. We saw medical records were stored in a lockable cabinet which was locked at the time of our inspection. This indicated records were being kept securely in this area.

- Staff told us medical records were always available with the exception of one occasion. Staff described they noted this before the clinic started and had contacted the reservations team who successfully helped with locating them. Staff explained they would make every effort to ensure medical records were available in order not to cancel an appointment.
- We reviewed five medical records of adults who had minor procedures. We saw all records had key clinical information such as allergies and medical history, and staff had followed specific procedure pathways and all the pathway checklists had legible entries, were signed and dated in line with General Medical Council (GMC) and Nursing and Midwifery Council (NMC) guidance.
- We saw all five patient medical records for adults also contained evidence of the doctor's treatment notes and consent forms were filed. All entries were legible, signed and dated. This meant that patient medical records were complete and contemporaneous. This was in line with the completion of accurate and contemporaneous medical records, which formed part of the practising privileges agreement for all consultants. Consultants were also registered data controllers with the Information Commissioning Office (ICO) as part of this agreement.
- In the diagnostic imaging department, we saw staff kept all patient paperwork stored in a locked cupboard. We saw confidential waste was stored in a separate room in a locked office and was shredded on-site. This provided assurance that records were kept safe and secure.
- The children lead nurse told us they registered all children and young people who attended outpatients. We saw a register that contained their attendance details such as names, dates seen and the consultants they had seen. This matched the outpatient appointment list of children and young people who attended for the two-week period prior to our inspection. This gave assurance that every child and young person was accounted for at each outpatient attendance.

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- We saw three medical records of children and young people who attended outpatient clinics. All the records had referral letters and all entries were legible, signed and dated. Overall, we saw an appropriate standard of documentation for children and young people patient records. We saw staff had signed and dated all entries in line with General Medical Council (GMC) and Nursing and Midwifery Council (NMC) guidance.
- We observed staff used individual account details to log into computer systems and saw individuals logged out of the system when they left the computer terminal. This indicated secure access which complied with the Data Protection Act 1998.

Safeguarding

- The chief nurse was the hospital safeguarding lead and the deputy chief nurse was the hospital deputy safeguarding lead for children and adults. They had completed level four safeguarding training in adults at risk and children and young people. Staff we spoke could name the children's and adult's safeguarding leads and demonstrated a good awareness of what to do if they had safeguarding concerns.
- We saw the hospital had introduced separate safeguarding policies for children and young people in October 2017 and adults at risk in December 2017. Staff could access the policies in the safeguarding folders in all outpatient and diagnostic imaging areas and they showed us how they could also access the policy from the hospital electronic system. We saw staff signature sheets completed with signatures and dates which indicated staff had read the policy. The safeguarding policies were detailed and included clear processes for staff to follow if they had safeguarding concerns. We saw clear flow charts were displayed in suitable areas and contained key contact details.
- We saw information provided by the hospital showed 100% of outpatient and diagnostic imaging staff had completed safeguarding adults at risk levels one and two training, and 97% at levels three and four. This was better than the hospital compliance target rate of 95%. This indicated staff had the knowledge to identify vulnerable adults and appropriately report concerns when required. This followed the hospital safeguarding adults at risk policy.
- The hospital information showed that all staff who were involved in treating children were 100% compliant at levels one and two training, and 97% compliant at level three. This was better than the hospital compliance target rate of 95%. The chief nurse told us the remaining 3% for children level three training had started their training and due to complete the rest of the modules within level three. This demonstrated the hospital was working towards all staff involved in treating children to have had level three training in line with national guidance from the intercollegiate document "Safeguarding Children and Young People: Role and Competencies for Health Care Staff" (March 2014).
- Staff told us that a children trained nurse always accompanied a child or young person who attended outpatient, imaging and physiotherapy appointments. This service held dedicated clinic days for children to ensure appointments for children were only booked when children's nurses were available to attend. We did not see this as there were no children's clinics held during our inspection. The hospital only allowed consultants with practising privileges to care for children and young people if they provided evidence of level three safeguarding children training.
- We saw a hospital chaperone policy for older children or adolescents who attended outpatient and diagnostic imaging appointments without a parent or guardian. Staff knew how to access the policy and gave examples of circumstances in which they may need to apply it. However, staff told us most children attended with their parents. In all the children's medical records we reviewed, we saw that a parent or guardian had accompanied their child. We saw posters with information about the chaperone process were displayed in all of the consulting rooms we visited.

Mandatory training

- All required staff had completed paediatric basic life support training for the outpatient children services.
- Staff we spoke with in the outpatient and diagnostic imaging departments told us they were up to date with mandatory training. All staff completed mandatory training using online learning and face-to-face training. This included modules in life support including children,

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fire safety, infection prevention and control, safeguarding children and adults at risk, moving and handling, information governance, and equality and diversity.

- We saw information which indicated outpatient staff achieved 98% compliance with completion of mandatory training which was better than the hospital target of 90%. Compliance rates were monitored and we saw future training dates planned for staff that needed to complete their mandatory training. Staff were also advised to attend refresher training when necessary. We saw training compliance was reviewed regularly as part of appraisals and in heads of department meetings and was recorded in the minutes between June and October 2017.
- Staff we spoke with were positive about the training provided and were confident they would be supported to attend additional training if required. Staff told us there were no barriers to completing training and they were given protected time to complete training.

Assessing and responding to patient risk

- Immediate or emergency assistance from the hospital resuscitation team could be summoned by the use of the "crash call". Medical assistance was provided by the resident medical officer (RMO) and the senior nurses.
- Staff told us patients who required specialist emergency care were transferred to the local NHS hospital by ambulance. We saw clear protocols for this which was in line with the hospital policy.
- We saw a hospital "outpatient procedure pathway checklist" based on the World Health Organisation (WHO) Surgical Safety checklist used for minor procedures in the outpatients department. This included 'sign in' checks where the patient identity and minor operative site was confirmed and 'sign out' checks where the instruments used were counted back and any specimens were labelled and sent to the laboratory. The outpatient manager told us they carried out frequent documentation audits to ensure good practice. However, we saw an audit in December 2017 showed 40% compliance of the checklists being completed in full although these were mainly sections

which were not applicable and were left blank. We saw this was discussed in the minutes of the December staff meeting and an action for managers to raise this with the individual staff was recorded.

- Staff in the imaging and diagnostic department told us a patient MRI safety questionnaire was completed on the telephone prior to offering an appointment. Staff would then repeat this at the patient's attendance to a diagnostic test and before the scan was performed. This indicated good practice as they managed the risk to patients.
- Staff in radiology told us they would first check with a patient if they had previous scans and x-rays. They told us they could access any scans that enabled them to ensure a patient was not over irradiated, which was in line with IR(ME)R regulations. We saw the hospital's standard procedure which confirmed this was the process.
- Staff told us they would not book patients for a CT or MRI scan if they required a contrast media without having blood test results available. This was to minimise the risk of contrast induced nephropathy. We saw the hospital's standard procedure which was in line with the Royal College of Radiographers' standards of prevention of contrast induced acute kidney injury in adult patients.
- The radiographer told us patients injected with a radioactive substance whilst in the nuclear medicine department were isolated in a separate waiting area with a dedicated toilet which demonstrated good practice. This prevented others from being exposed to radiation. In addition, the radiographer checked the toilet for traces of radiation at the end of each day and there was a process to deal with high levels. This gave assurance this was being regularly monitored.
- We saw measures in place for reducing exposure to radiation in the diagnostic imaging department. For example, up-to-date local rules were available in every imaging area we visited and signed by all members of staff, which indicated they had read the rules and understood their responsibilities. We also noted imaging protocols and policies stored in folders in each room and staff demonstrated a clear understanding of these protocols.
- We observed good radiation compliance during our visit. The department displayed clear warning notices,

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doors were shut during examinations and warning lights were illuminated. We saw radiographers referring to the Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R for patient's examinations. A radiation protection supervisor was on site for each diagnostic test and a radiation protection advisor was contactable if required, which complied with IR(ME)R.

- There were visible signs to inform women of childbearing age to consider whether they may be pregnant. This prompted patients to raise this with the diagnostic and imaging staff. Staff told us they questioned a female of child bearing age about the possibility of pregnancy and ensured they signed a form to confirm this which helped manage the risk in this patient group.
- Lead aprons limit exposure to radiation to keep patients safe. We saw lead aprons available in all appropriate areas of the imaging department. We saw evidence which showed checks of the effectiveness of their protection occurred regularly and equipment provided adequate protection as per regulations. The radiation protection advisor performed an annual quality assurance check on equipment in the diagnostic imaging department. Departmental staff also carried out regular checks. This helped to assure the hospital that imaging equipment was working correctly and these mandatory checks were in line with Ionising Regulations 1999 and the IR(ME)R 2000. We saw records of these checks during our visit.

Nursing and radiology staffing

- As at 1 October 2017, hospital data showed there were 6.3 whole time equivalent registered nurses and 4.6 healthcare assistants who staffed the outpatient clinics. The outpatient manager told us there was one vacancy and one member of staff on maternity leave at the time of our visit. They told us that either overtime was paid or an in-house bank nurse called in when required.
- Managers we spoke with told us they calculated nursing staffing levels dependent on the number of clinics and the numbers of patients attending clinics, as well as other factors such as procedure support and chaperoning. We saw sufficient staff present during our inspection.
- Hospital data from August 2017 to October 2017 showed the sickness rates for outpatient registered nurses varied

between 0% and 3%, and between 6% and 13% for healthcare assistants. The hospital reported no unfilled shifts in the same reporting period. This meant the service had sufficient nursing staff on all shifts to provide appropriate care and support. There was no comparable data with other independent acute hospitals we hold this type of data for in the same reporting period.

- The staff turnover rate for outpatient registered nurses was 13%, and 18% for health care assistants from November 2016 to October 2017. This meant the team was stable and experienced. The outpatient manager told us that nursing retention was due to positive factors such as professional development and internal promotion opportunities. There was no comparable data with other independent acute hospitals that we hold this type of data for in the same reporting period.
- In the reporting period from November 2016 to October 2017, the rates of bank and agency nurse usage varied between 15% and 46%, and the healthcare assistant rates was 0% for all months with the exception of 1% for July 2017 in the outpatient department. The hospital reported no use of agency staff from August 2017 to September 2017. We were told the reasons for use of bank nurses was due to staff annual leave entitlement and other unplanned absences.
- The diagnostics and cardiology services manager told us they had a full complement of staff in radiology. This had improved since the previous inspection when the department was short of six whole time equivalents. We were told that there was very little use of agency staff to cover annual leave or sickness.

Medical staffing

- The outpatient manager told us registered medical officers (RMOs) were not usually required for outpatient clinics. The clinics were timetabled to suit each consultant's availability and obligation as part of the consultant's practising privileges contract. Staff told us consultants in clinics were assisted by the RMO if required, in cases where urgent or additional medical support was required. During our inspection we did not observe this as it was not required.
- RMOs working at the hospital had advanced children life support (APLS) training. This ensured the hospital always had a member of staff with APLS training on the

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premises to respond to any emergencies involving children if required. We also saw training records, which provided evidence of in-date children advanced life support (EPALS) training for the children's lead nurse.

- Radiology consultants were on-site during clinic hours to manage urgent work and the reporting requirements for the hospital. They also had an on-call rota for outside clinic hours and staff told us they could easily reach a radiology consultant if required. The service used image-sharing computer software to access results. This meant patients could get their results without delay.

Emergency awareness and training

- We saw a current version of the hospital business continuity policy which was issued in December 2017. This contained information about the roles and responsibilities of key people, what to do in the event of any major incidents and key contact details.
- Staff described participating in regular medical emergency simulations, for example cardiac arrest and reported the learning experience in positive terms.
- Staff showed us action cards they would use in the event such as a flood, fire or electrical failure. We saw the action cards were linked into the hospital business continuity policy. This showed clear processes for staff to follow in the event of a flood or fire.
- We saw an in-date version of the policy for managing radiation incidents. This demonstrated that the hospital had considered potential risks to safety and had prepared responses for any such eventuality.

Are outpatients and diagnostic imaging services effective?

We inspected, but did not rate, effective just as the previous inspection.

Evidence-based care and treatment

- The hospital regularly updated policy documents and issued them for implementation. These were available on the hospital electronic system as well as in the policy folders located in the outpatient and diagnostic imaging offices.
- We saw local policies and standard operating procedures such as consent, management of medicines

and emergency evacuation. We saw how policies were disseminated to staff to read, sign and implement using tracker documents to confirm understanding and their compliance. Staff we spoke with had a good awareness of the policies. We saw copies of signed sheets which indicated staff had read the policies recently. The hospital governance team disseminated new national guidance to staff through head of departments. The medical advisory committee (MAC), including consultants, assessed their relevance before dissemination. This meant that staff had evidence-based and clear instructions to follow to provide safe care.

- The hospital MAC met quarterly to review clinical performance, incidents and complaints. We saw minutes of a MAC meeting held in August 2017 where feedback was obtained from the consultant body on new developments and initiatives from within the various specialities.
- Staff followed the National Institute for Health and Care Excellence (NICE) and Royal College of Radiologists standards in the speciality areas we visited. We saw evidence of checks and audits demonstrating the department monitored compliance with these guidelines which meant that staff provided safe care to patients.
- We saw audits undertaken which included radiation dose, environmental, medicines management, hand washing and infection control checks and the results of these were shared among staff. We observed examples shared on staff notice boards and in departmental meeting notes.

Pain relief

- The on-site pharmacy stocked and dispensed prescription only pain relieving medicines. Staff told us medicines requiring prescription were prescribed by doctors only.
- We saw a pain assessment tool staff would use where adult patients were asked to score discomfort based on a range from 0-10, when required. We did not see the tool used by staff at the time of our inspection as none of the patients reported or appeared to be in discomfort.

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- The children lead nurse showed us age-appropriate tools for the assessment of children's pain. The assessment chart had pictures of faces from smiles to frowns so that young children could easily report their level of pain. The use of a pain scoring system allowed doctors to establish the children's pain levels to provide medicines advice or support with alternative pain management techniques, and to review the effectiveness of the intervention.

Nutrition and hydration

- We saw water and hot drink dispensers were made available to patients in the outpatient and diagnostic imaging waiting areas while they waited for their appointment.
- A café was also on-site at the hospital main entrance which offered patients and visitors a choice of refreshments and baked goods while they waited.
- Staff told us they would offer a drink and snack to patients after a minor procedure, if required.

Patient outcomes

- The outpatient physiotherapy lead told us they recorded and monitored patient outcomes. For example, we saw staff used the musculoskeletal health questionnaire (MSK-HQ) to record patient outcomes such as pain, function, sleep, physical activity and psychological impact for patients with musculoskeletal conditions. MSK-HQ is a recognised NHS tool used for clinical practice to evaluate the health status and to monitor changes of patients, in order to establish the effectiveness of treatment.

Competent staff

- Staff told us all new staff had an induction package, which included core competencies and knowledge that was signed off by their manager. We reviewed examples of this in the staff files for nurses, radiographers and physiotherapists and saw they had completed competencies in the past 12 months. This meant that any new, bank and agency staff could integrate safely and efficiently into the workforce.

- Staff we spoke with were positive about the training provided and were confident they would be supported to attend additional training if required. Staff told us there were no barriers to completing training and they were given protected time to complete training.
- The staff appraisals period was from May to April annually. Information provided to us prior to the inspection showed 86% of registered nurses and 100% of healthcare assistants received a performance appraisal, as of January 2018. During our inspection we saw the remaining 14% of staff had dates booked to complete their appraisals within the appraisal period. We saw staff files contained records of regular performance meetings between appraisals. This meant the hospital could identify, monitor and support staff performance and personal development.
- We saw records of concerns about staff performance were initially dealt with through informal discussions in the staff file. If concerns continued, the formal process was triggered in consultation with the human resources lead. This indicated the hospital had a clearly defined performance management system in place.
- The medical director told us the process for managing practising privileges was reviewed and as a result this had improved to support thorough management of consultants working at the hospital. Consultants were offered practising privileges by the medical advisory committee (MAC) only after thorough interviews, and human resources team had received the necessary assurance documentation. There were processes in place for confirmation of practising privileges.
- All consultant appraisals were shared by the consultants following their appraisals with the NHS trust in which they worked. Where the hospital director provided information for NHS appraisals, this routinely included data related to that consultant's practice such as surgical site infections, complaints and morbidity and mortality. The data also included outcomes collected by the hospital as part of their regular practising privilege reviews.
- Hospital information provided to us before the inspection showed 100% validation of professional registration for doctors practising under the rules of

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privileges in the reporting period from November 2016 to October 2017. In the same reporting period, we saw information showed 100% validation of professional registration of nursing staff.

Multidisciplinary working

- We saw effective multi-disciplinary working between all staff groups across all staff grades. This included housekeeping and reception staff.
- There was consistent evidence of close collaboration across different services within outpatients and diagnostic imaging. We saw imaging staff discussing with the reservation team how they could arrange suitable radiology appointment times for patients to be seen straight after an outpatient appointment. Staff told us they felt fully supported by other staff groups and there was good communication within the teams. We saw an outpatient nurse communicated with a physiotherapist about a patient's treatment plan. We observed the housekeeping team liaise with outpatient staff about the day's cleaning plan.
- Staff at all grades gave us positive feedback about the good teamwork within the hospital generally.

Seven-day services

- The diagnostic imaging department provided a 24-hour a day and seven day a week service. They were open Monday to Friday from 8am to 8pm and as required on Saturday and Sunday. Outside these hours, the service was open for urgent examination requests.
- All other outpatient departments did not operate a seven day service, but were open Monday to Friday from 8am to 8pm and as required on Saturday.
- The hospital pharmacist team provided a daily service Monday to Friday between 8.30am and 5pm, and out of hours, staff were able to access the resident medical officer or senior nurse for pharmacy support and advice.

Access to information

- All staff we spoke with said they had access to policies, procedures, NICE and specialist guidance through a secure computer system and we were shown examples. Computer terminals were located in all consulting

rooms and offices to enable staff to do this. Staff were generally positive about the hospital's computer network and told us their managers communicated effectively with them via e-mail.

- We observed staff access patient information through a secure computer system by using their individual passcodes. Different staff groups and grades had specific access to different levels of patient information which ensured staff could only access information specific to their job roles.
- Staff showed us how they accessed electronic pathology test results. In addition, the pathology department sent paper copies to consultants. This meant staff could receive timely results and it enabled them to make appropriate decisions about a patient's care.
- The imaging department used picture archiving and communication system (PACS) technology. This enabled the hospital to quickly store, retrieve, distribute and view high-quality medical images. This meant the hospital was able to provide rapid electronic access to diagnostic results. For example, the department could access images from other hospitals to enable them to see previous scans or tests undertaken. This meant staff could ensure patients did not receive greater doses of radiation than required. Staff could also share images with radiologists at the local NHS hospital to help them make appropriate decisions about a patient's care, if needed.
- The imaging department had a system in place for radiologists to urgently communicate any unexpected findings with GPs. Radiology staff would contact GPs by telephone and staff we interviewed told us this system worked well.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a 'Consent to Investigations or Treatment Policy' (review date April 2019). We saw staff could access different consent to investigation or treatment forms for adults and children, parents or their legal guardians, including forms for patients who are unable to give consent.
- Staff explained they would always assume adults had capacity to consent and for patients who lacked capacity, staff would undertake a mental capacity

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assessment (MCA) before any investigations or treatment was carried out. We saw MCA forms were available in all the outpatient consulting rooms we visited. This ensured staff gained appropriate consent and this was in line with the hospital's policy and national guidelines.

- The children lead nurse told us that parents or legal guardians could sign consent forms on behalf of children who were not competent to provide consent. We saw these forms also had a space for children to sign as well as the parent to show their involvement in decisions about their treatment. This aligned with the hospital policy
- Staff told us when required consultants would seek consent and assess Gillick competence for children under the age of 16 to consent to his or her own medical treatment, if they chose not to involve their parents. Gillick competence is used to determine that children under 16 can consent if they have sufficient understanding and intelligence to fully understand what is involved in a proposed treatment, including its purpose, nature, likely effects and risks, chances of success and the availability of other options. This was in line with statutory guidelines for assessing children under the age of 16 who were competent to make decisions about their own care and treatment. Staff said this did not happen often but they knew the process to obtain appropriate consent which was in line with the local and national guidance.
- We reviewed five patient records for adults who had minor procedures. All five records contained fully completed consent forms. This meant there was record of a patient's agreement to the intervention and the discussions which led to that agreement. All entries were legible, signed and dated, and included the doctor explaining the benefits and risks of the procedure to the patient. This showed staff followed the hospital consent policy.
- We observed diagnostic staff used imaging checklists to gain verbal consent from patients undergoing diagnostic imaging in the department. This was in line with the professional and hospital guidance.
- The hospital had a policy to guide staff in the correct interpretation and implementation of the Mental Capacity Act 2005 (MCA) which included Deprivation of

Liberty Safeguards. We saw a copy of this in the policy folder kept in the outpatient staff office. Staff we spoke with demonstrated awareness of how the Mental Capacity Act 2005 related to their practice and were aware of who to contact if they required guidance.

Are outpatients and diagnostic imaging services caring?

Good 

We rated caring as **good**.

At our last inspection, we rated caring as good. On this inspection we have not changed the rating.

Compassionate care

- We saw staff treated patients with kindness, dignity and respect. Staff interacted with patients in a positive, professional and informative manner.
- The outpatient and diagnostic imaging service carried out a monthly internal survey that was an adapted version of the NHS Friends and Family Test. This was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give views after receiving care or treatment. An external contractor distributed the survey and analysed results. The outcome from the survey carried out from July to November 2017 showed the service received 356 responses. Of these, 90% of patients were extremely likely to recommend the hospital to family or friends for similar care or treatment, and 90% of patients rated the quality of the service as excellent. This was better than the hospital target of 85%.
- We received 26 'tell us about your care' comment cards from patients who attended the outpatient, imaging, physiotherapy and dermatology departments. The comments were positive and praised the staff, environment and facilities. Examples of some comments included "very friendly and helpful, caring and nothing was too much trouble for whoever I spoke to", "doctor and nurse were extremely polite, courteous and made an effort to make my daughter feel at ease and comfortable", "I was well informed and didn't feel

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rushed, I was treated with dignity and respect”, “I was treated with the greatest of care and dignity during my MRI scan today. Also very clean and safe environment, felt relaxed” and “the best service I have received”.

- We saw diagnostic imaging staff maintained patients’ dignity despite the need to wear examination gowns during the process. We saw the dermatology department had an individual ultraviolet B treatment room which provided patients privacy and dignity during their treatment.
- We saw posters displayed in appropriate areas throughout the outpatient and diagnostic imaging departments informing patients of their right to request a chaperone for any consultation, examination or treatment. Staff told us it was not frequent a chaperone was requested. However, when required they offered patients a chaperone before any examination or procedure and were able to anticipate requests based on the clinic schedule.
- We observed staff were friendly and professional when they spoke with patients. We observed all staff were approachable and greeted patients and visitors with “hello how are you, my name is”. We saw staff were polite and respectful of confidentiality. Patients were able to have conversations with staff without being overheard and minimal patient identifiable data was discussed.

Understanding and involvement of patients and those close to them

- We saw staff names and photographs were clearly and legibly displayed on noticeboards at the waiting areas in outpatient and diagnostic departments. This helped patients and visitors identify key staff they encountered during their visit.
- Patients told us they received clear and detailed information about their care and any procedures they may require. They described that staff and consultants were approachable and took the time to provide an explanation, and said this made them feel part of the decision-making process about their care and treatment.

- We saw patients had access to a variety of information leaflets in all the outpatient and diagnostic imaging areas. There was information specific to children, older people and those with learning difficulties.
- Patients we spoke with told us they were informed about the fees for their consultation before their appointment. We saw a pricing structure sheet available in all the consulting rooms. This meant patients received appropriate information in relation to costs to enable them to make an informed decision about their appointment.
- In August 2017, the hospital patient-led assessments of the care environment (PLACE) for privacy and dignity 95%, which was better than the England national average of 84%.

Emotional support

- We observed patients’ relatives were invited to accompany them into consultation rooms, which indicated that staff encouraged a partner or friend to attend the appointment in order to provide emotional and moral support.
- Staff told us they could access counselling services which provided confidential emotional support, if required.

Are outpatients and diagnostic imaging services responsive?

Good 

We rated responsive as **good**.

At our last inspection, we rated responsive as requires improvement. On this inspection we have changed the rating to good because of improvements to key areas such as waiting times to be seen from first referral and learning from complaints and concerns.

Service planning and delivery to meet the needs of local people

- A range of outpatient clinics were made available to meet the needs of the local population and according to the consultants’ availability. According to information the hospital provided, this included orthopaedics, gynaecology, general surgery, interventional cardiology,

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rheumatology, urology, neurology, ear, nose and throat (ENT), dermatology, gastroenterology, paediatrics and general medicine. Orthopaedics was the most attended clinic.

- These outpatient clinics were supported by diagnostic imaging services including Magnetic Resonance Imaging (MRI) scans, x-ray, nuclear medicine and ultrasound scans. These facilities supported consultants in clinical decision-making about a patient's treatment.
- We saw the environment was patient centred as the service had comfortable and sufficient seating, toilets, reading materials, Wi-Fi access, drinks machine and a separate waiting area for children. In addition, we observed many free car park spaces were available on-site to patients during our inspection. The hospital main entrance had bags for visitors to carry wet umbrellas during rainy days to prevent water drips onto surfaces within the hospital.
- The outpatient and diagnostic imaging departments were clearly signposted, which made it easy for patients and visitors to make their way to a specific area.
- Receptionists booked patients in, using a computer on their arrival, which enabled the team to track patients around the hospital. They also kept patients informed of any delays of more than 15 minutes.
- Even though the hospital only offered outpatient appointments for children, they had a children retrieval service arrangement with a local NHS hospital which meant that critically ill children could have immediate specialist transport to the trust, if required.

Access and flow

- GPs referred the majority of new NHS and private patients who used the service. We were told referrals were also received from physiotherapists and other registered healthcare practitioners. A patient we spoke with confirmed this.
- We saw information the hospital provided that showed the average wait time for an outpatient appointment was 3.5 weeks, which was consistent with what staff told us.
- Information the hospital provided showed 10,314 outpatient clinics were held in the last 12 months; of these 66 clinics were cancelled. This information was

not available at the last inspection in 2015. In addition, we saw 37 of the 66 clinics were cancelled with less than six weeks' notice in the same reporting period, compared with 62 clinics found at the 2015 inspection. This indicated the hospital had worked towards continuous improvement to reduce delay in patient care and treatment.

- Between January 2017 and January 2018, no patients waited six weeks or longer from referral to receive appointments for diagnostic imaging tests. Information provided to us showed the average wait time for a diagnostic imaging test was three weeks and there were no breaches in the same reporting period.
- Patients we spoke with said they had their first appointment within days of referral. They also reported that they did not wait long to see a nurse or a doctor when they attended for a clinic.
- Staff arranged follow up appointments according to consultants' availability and to patient needs.
- Opening hours for outpatient clinics varied. Specific clinics were held on different days and times to ensure there was provision to suit patients' preference and availability.
- Staff told us delays in outpatients did not happen often and we saw appointment lists that supported this. This was consistent with the examples we saw on audits of wait time on patients' arrival at outpatients for the past three months. Staff and managers expressed a strong commitment to the efficiency of the departments and gave examples of their responses when clinics ran late. Patients were kept informed and personal apologies made when there were delays.

Meeting people's individual needs

- Staff told us they would ensure patients living with dementia were seen as soon as they arrived for an appointment, or let them bypass queues at reception and when clinics ran late.
- Patients had a choice of a male or female staff who could act as a chaperone, if required. This indicated the individual preferences of patients were met.
- Evening and Saturday outpatient clinics were routinely offered, which provided additional choice and convenience to patients.

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- Hearing loops were available in the waiting area, which helped those who used hearing aids to access services on an equal basis to others.
 - We saw details of a translation service used by the hospital. Staff told us they had used the service but this was not very often. Staff who had not used the service described the process and knew who to contact, if required.
 - We observed the waiting room and clinic areas were accessible to all people including wheelchair users. This included level access and automatic doors from the car park and throughout the departments on the ground floor.
 - The outpatients department had toy boxes and books available in the dedicated waiting room for children and were made available in consulting rooms to provide distraction and comfort to children. We saw three different toy boxes and books for different age groups that were suitable for toddlers and slightly older children.
 - We saw adults and children had separate waiting areas, resulting in the provision of privacy and dignity for both groups. This arrangement minimised the risk of abuse as waiting areas were often left unsupervised. Staff we spoke with told us that they always encouraged adults to supervise their children. We saw posters displayed in the children waiting area to act as a reminder.
 - We observed all seats in the waiting area were suitable for bariatric patients. Bariatrics is the branch of medicine that deals with the causes, prevention, and treatment of obesity. This allowed bariatric patients to sit anywhere they chose.
- We saw a variety of literature and patient information leaflets produced by an external contractor with reference to professional healthcare organisations, throughout the outpatient, imaging and physiotherapy departments. These were available to help patients understand their condition and treatment, in larger print for people with visual impairment and in different languages as required.
- Staff told us that patients were given an opportunity to view the different hospital areas prior to an outpatient

appointment and / or admission to become more familiar with the surroundings and to meet staff who will be caring for them during their inpatient stay, if required.

Learning from complaints and concerns

- The chief nurse had responsibility for overseeing complaints, supported by the Medical Director. The deputy chief nurse provided support with clinical complaints. The quality and governance team managed the administration of complaints under the direction of the chief nurse.
- The hospital received 32 complaints from November 2016 to October 2017 related to outpatient and diagnostic imaging service. None of the complaints were related to children. All of the complaints were resolved at a local level and were not referred to the Ombudsman or Independent Healthcare Sector Complaints Adjudication Service (ISCAS). Staff at all levels described an open and honest culture and a willingness to accept responsibility to take action, if required.
- All written complaints were acknowledged within two days of receipt. The acknowledgement letters would confirm the chief nurse's understanding of the complaints and the complainants were invited to a face-to-face meeting with the appropriate staff to resolve matters quickly. If further investigation was required, this was within a 20-day timescale in line with the hospital complaint's policy. We reviewed five written complaints related to outpatient and imaging departments and all had acknowledgements and responses within the time scale set by the hospital policy.
- Managers we spoke with told us where complaints involved clinical care, a consultant not directly involved with the patient's care carried out the investigation. This aligned with the written complaints we reviewed to ensure the investigation was carried out independent of the consultant involved.
- Complaints along with lessons learnt were discussed at heads of department meetings and daily briefings, which were disseminated to departmental frontline staff. In addition, they were also monitored and reviewed at the quality and governance committee, the clinical effectiveness committee and at board level.

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Complaints were also discussed in detail at speciality meetings and any significant incidents were actioned. The numbers of complaints and compliments received were discussed weekly at the hospital management and operational group, and then more thoroughly at the quarterly medical advisory committee.

- The hospital monitored trends on a regular basis which allowed the service to identify any areas for improvement. A key theme was that patients were not aware of additional charges that may incur within an outpatient visit. We saw the hospital was working to address this, for example, clear pricing structures were displayed in all the consulting rooms.
- There was a robust system in place for capturing learning from complaints. The senior management team “signed off” every complaint, which was logged onto the incident reporting software. We saw all complaints were reported via the hospital reporting structure. This enabled all staff to learn from complaints within the hospital.
- There were no children specific feedback forms in the outpatients and imaging departments. However, the children lead nurse told us they were at the early stages of producing a children and young people feedback questionnaire. Information provided by the hospital before our visit confirmed that they were in the process of developing this. This meant the hospital could receive feedback from children on how they felt about this service, even though the hospital reported no complaints related to children in the last 12 months.

Are outpatients and diagnostic imaging services well-led?

Good 

We rated well-led as **good**.

At our last inspection, we rated well-led as requires improvement. On this inspection we have changed the rating to good because we saw improvements to the overall leadership and culture of the service.

Leadership and culture of service

- The hospital had a structured senior management team led by the chief executive officer. The medical director,

chief nurse, chief operating officer, head of consultant business development and directors of finance, human resource, sales and marketing reported to the chief executive officer. The nursing departments reported to the deputy chief nurse who reported to the chief nurse. The diagnostics and cardiology services manager reported directly to the chief nurse.

- Staff we spoke with described the improved culture and morale of the team unlike findings at the last inspection. They told us everyone now felt a part of team and worked really well with one another. We saw staff throughout the main outpatient areas including physiotherapy and dermatology smiling, greeting and supporting one another at this inspection.
- The diagnostic imaging staff had continued feeling positive. They felt involved in decision making and were part of the wider hospital team.
- Staff we spoke with felt managers and the hospital senior management team were open and approachable. They told us they felt more established at the hospital since the last inspection. They described the senior management team as very visible and they felt able to discuss any issues with them on a daily basis. The senior management team had an open door approach and during busy days, they visited clinical areas more than once daily to “ensure everyone was well and the day was going smoothly”. Staff told us the chief executive officer knew everyone by name.
- We saw good examples of local leadership in the nursing, diagnostic imaging and physiotherapy teams. For example, staff told us about the support they received when they escalated an issue with clinic delays. The manager intervened and escalated this to the senior management team. The issue was investigated and resolved in line with local and national guidance.
- Staff we spoke with told us they enjoyed coming to work and were passionate about the care they gave to patients. This was consistent with the data provided by the hospital of low staff sickness and turnover rates in the outpatient and imaging departments.
- There was safeguarding leadership and presence within and outside the hospital, for adults at risk and children. We saw safeguarding was discussed as a standard agenda item in the minutes of the medical advisory committee, quality governance committee and heads of

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department meetings minutes the hospital provided for the period between August to October 2017. We saw examples of discussions such as the hospital raising awareness of safeguarding and mental capacity and ratifying the safeguarding children policy. We saw this hospital's safeguarding lead and deputy participated in the regional safeguarding network for independent and NHS hospitals. This was documented in the minutes of the 'Safeguarding Kent and Medway' network meetings held in April, July and December 2017.

- The hospital had clear oversight of services for children and young people. There was a lead consultant paediatrician who could be contacted and was supported by a deputy paediatric consultant, when required and a named paediatric safeguarding doctor for the hospital.
- A working group to review services for children & young people across the hospital was set up in 2016, which initially met monthly and then bi-monthly. From November 2017, it had evolved into the children and young people committee. The children lead nurse told us this would be held quarterly to include discussions such as service developments, incidents and issues related to safeguarding. We saw the children and young people service discussed at the hospital's monthly quality governance meetings.

Vision and strategy for this core service

- The hospital had a written mission "to provide the highest quality of care in a world-class clinical environment for the people of Kent", underpinned by their values of being caring, confident, dynamic and respecting people, operating and communicating with integrity as a team to bring quality and value. Patients were at the heart of the hospital's strategic objectives.
- Staff understood the hospital's mission and values, when we saw them working together as a team to provide the best care for patients and they told us how they valued the caring nature of staff, from the senior management team to frontline staff. We saw the vision statement on computers as desktop wallpapers and posters displayed in appropriate areas.

Governance, risk management and quality measurement

- The hospital had a governance structure and a process for reporting against the governance framework for all staff. This allowed the hospital to be assured of the quality of the services and continuous service improvement.
- There was an electronic incident reporting system that fully linked complaints, incidents and risk reporting. This assisted managers in monitoring the quality of the services and addressing any issues, and to identify any developing trends or patterns.
- The senior management team monitored information on incidents monthly. We saw lessons learned were discussed and disseminated across the organisation.
- The senior management team shared information at the monthly heads of departments meetings. Once the senior management team had reviewed and considered the information, they produced a governance report that was fed upwards to the hospital's quality governance committee for review and feedback.
- The senior management team explained that updates to NICE guidance or safety alerts were shared via the monthly heads of department and departmental meetings. We saw examples of this in the minutes of the meetings we reviewed.
- Departmental managers we spoke with demonstrated a clear understanding of the risks within their areas. They provided an example such as structural damage to an adjoining wall to a scanning room which was consistent with the hospital's risk register we saw. Risks were broken down by departments and staff could identify clinical and non-clinical risks.

Public and staff engagement

- Staff of all grades we spoke with expressed pride in their team work and the services they provided. This was consistent with the feedback provided by patients who completed the "Tell us about your care" comment cards placed throughout the hospital prior to our inspection.
- The service had local patient experience questionnaires for adults. This meant the hospital could gain feedback from patients or service users for any improvements that needed to be made and compliments about staff who had provided quality care. We saw in the most recent patient survey results that this service overall had, from July to October 2017, consistently achieved

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above 90% where patients would recommend to family and friends if they needed similar care or treatment. The exception to this was November 2017 when they scored 88% but this was better than the hospital target of 85%.

- The children lead nurse told us they were working to develop a patient questionnaire for children. This aligned with the hospital information provided to us before our inspection. This meant the hospital could gain feedback from children using an age appropriate approach.
- Patient forums were held quarterly which were attended by a member of the health management board and other key staff. All NHS and non-NHS patients and their relatives were welcome. This meant the hospital could receive feedback directly from patients to allow continuous improvement of services or care provided.
- The hospital participated in the NHS Friends and Family Test. This was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. We saw the hospital scored an average of 95% between May and October 2017.
- The hospital had staff forums that were run by staff. Staff told us there was always good attendance with over 20

staff at a time. Staff said it gave them an opportunity to connect with one another, raise positive things and any concerns. They felt listened to and supported. This was consistent with the annual staff survey results. Out of 298 staff who participated in the survey in December 2016, 238 responded; 90% of these staff would recommend this hospital to family and friends as a good place to work. The hospital was awaiting the results for the survey carried out in November 2017 at the time of this inspection.

- The hospital carried out a consultant survey which meant feedback from consultants was used to provide continuous improvement to services and patient care. We saw an action plan contained feedback from the survey.

Innovation, improvement and sustainability

- The hospital had volunteers known as 'KIMS angels' who spent time in departments talking to patients. This was introduced to enhance patient care and support patients so that they felt listened to.
- Staff received a day off work on their birthdays. In addition, they received an additional day after three years' service at this hospital.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital had volunteers known as 'KIMS angels' who spent time in departments talking to patients. This was introduced to enhance patient care and support patients so that they felt listened to.
- The hospital's strong commitment to staff engagement through various routes, including staff forums, suggestion boxes, nomination schemes, team events and family fun days, was an area of outstanding practice.
- Staff had direct links to the board through 'KIMS Voice' so they could directly communicate their views, ideas and concerns. Out of 'KIMS' voice', the provider gave all staff a day off work on their birthday. In addition, they received an additional day after three years' service at this hospital.
- The cardiac catheterisation laboratory carried out comprehensive risk assessments for all patients. We saw a pre-assessment and discharge checklist and specific pathways for each procedure. Based on risk assessments, staff had included additional checks to the World Health Organisation 'five steps to safer surgery' checklist.

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should consider the doorway to the children's waiting room in the outpatients' department is free from any potential trips and/or falls.
- The provider should consider reviewing its exclusion/acceptance criteria for surgery to provide more specific guidance to consultants.
- The provider should continue replacing carpets in clinical areas in line with its carpet replacement programme until there are no carpets remaining.
- The provider should ensure that hand hygiene sinks are free from obstruction.
- The provider should ensure the application of clear documentation and the completion of reviews when prescribing antimicrobials.
- The provider should ensure that all bins are clearly labelled to identify the waste type within.