

# King Edward VII's Hospital







## Quality Report

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Date of inspection visit: 11 - 13 December 2018  
Date of publication: 09/04/2019

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

## Letter from the Chief Inspector of Hospitals

King Edward VII's Hospital is operated by King Edward VII's Hospital Sister Agnes. The hospital has 50 beds. Facilities include three operating theatres, a four-bed level three critical care unit, and X-ray, outpatient and diagnostic facilities.

The hospital provides surgery, medical care, critical care, outpatient services and diagnostic imaging. We inspected all core services.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection between 11 and 13 December 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, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery service level report.

### Services we rate

Our rating of this hospital improved. We rated it as **Good** overall.

We found mainly good practice in all the key questions for all the five services we inspected.

The hospital had made significant improvements in the services of surgery and outpatients; both of these services had previously been rated as requires improvement.

We found the following areas of good practice across all services:

- The service had improved the systems in place for reporting, investigating and learning from incidents.
- The service had improved the systems of outpatient record keeping.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- The hospital used current evidence-based guidance and quality standards to plan the delivery of care and treatment to patients. There were effective processes and systems in place to ensure guidelines and policies were updated and reflected national guidance and improvement in practice.
- We observed staff treated patients and their families with compassion and care to meet their holistic needs.
- The hospital planned, developed and provided services in a way that met and supported the needs of the population that accessed the service, including those with complex or additional needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- Managers had implemented systems to strengthen governance, performance and risk management arrangements across the hospital since the last inspection.
- Managers across the services promoted a positive culture that supported and valued staff. The majority of staff told us they felt listened to and well supported by managers and colleagues and were confident to raise any concerns they had.
- The hospital engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- We found the following areas of outstanding practice:

# Summary of findings

- The Veteran's Centre provided a tailored pain management programme for veterans. A multidisciplinary team of consultants in pain medicine and clinical psychology, clinical nurse specialists and physiotherapists, worked together to treat patients suffering from chronic pain (often in association with post-traumatic stress disorder). Objectives of the programme were to help veterans to improve their mood, to develop a better understanding of their pain and to increase levels of meaningful activity, self-management skills and general quality of life.
- The breast unit was designed and organised around patients' individual needs, taking emotional effects into consideration and valuing patients' time. It was well managed and staff were enthusiastic and compassionate.

However, we also found the following issues that the service provider needs to improve in surgery, critical care, outpatients and diagnostic imaging:






- In surgical services, the hospital did not have an emergency anaesthetic consultant rota.
- Managers did not always monitor the effectiveness of care and treatment in all areas.
- Staff and patient survey results showed response rates below expectations.
- In the diagnostic imaging department, not all staff complied with infection control procedures. Staff did not consistently clean ultrasound probes according to hospital procedures and national guidance, sharps bins were not always stored safely, all staff were not bare below the elbows and equipment cleaning checks were not consistently completed.
- The safety barrier to prevent unauthorised access to the MRI room was not always pulled across when it should have been. The waiting area did not promote privacy and dignity.
- Staff did not always log out of computers to ensure security of patient data.
- There was a lack of health promotion material available across the diagnostic department.
- There was not full dietetic support over the weekend for patients requiring specialist input or those with total parenteral nutrition (TPN) prescriptions.
- Patient records were not always complete. We found some issues with completion of the WHO checklist, patient observation charts and tissue viability assessments.
- Not all medicines stored on the critical care unit were clearly labelled with expiry dates.
- There were high levels of bank staff in the outpatient department.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements. We also issued the provider with a requirement notice. Details are at the end of the report.

**Dr Nigel Acheson**  
**Deputy Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good 	<p>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.</p> <p>We rated this service as good because it was safe, effective, caring and responsive and well-led.</p>
Surgery	Good 	<p>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.</p> <p>Staffing was managed jointly with medical care.</p> <p>We rated this service as good because it was safe, effective, caring, responsive and well-led.</p>
Critical care	Good 	<p>Critical 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.</p> <p>The hospital has a four-bed level three critical care unit.</p> <p>We rated this service as good because it was safe, effective, caring, responsive and well-led.</p>
Outpatients	Good 	<p>Outpatients were a large proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.</p> <p>We rated this service as good because it was safe, caring, responsive and well-led. We do not rate effective in outpatients.</p>
Diagnostic imaging	Good 	<p>Diagnostic imaging was a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.</p> <p>We rated this service as good because it was caring, responsive and well-led. We rated safe requires improvement. We do not rate effective in diagnostic imaging.</p>

# Summary of findings

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Good 

# Location name here

**Services we looked at:**

Medical care; Surgery; Critical care; Outpatients; Diagnostic imaging.

# Summary of this inspection

## Background to King Edward VII's Hospital

King Edward VII's Hospital is operated by King Edward VII's Hospital Sister Agnes. The hospital opened in 1899. It is a private hospital in London. The hospital primarily serves a national patient population. It also accepts patient referrals from overseas patients.

The hospital has had a registered manager in post since October 2010. At the time of the inspection, a new manager had recently been appointed and was registered with the CQC in March 2018.

## Our inspection team

The team that inspected the service comprised a CQC inspection manager, Michelle Gibney, CQC lead inspector,

five other CQC inspectors, and specialist advisors with expertise in surgery, medicine, critical care, outpatients and diagnostic services. The inspection team was overseen by Terri Salt, Head of Hospital Inspection.

## Information about King Edward VII's Hospital

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

- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder and injury

During the inspection, we visited all wards and areas. We spoke with 25 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 15 patients and two relatives. During our inspection, we reviewed 28 sets of patient records.

The hospital has been inspected once before. This inspection took place in August 2017.

Activity (September 2017 to August 2018)

- In the reporting period, there were 2156 inpatient and 2252 day-case episodes of care recorded at the hospital; of these 100% were privately funded.
- There were 18884 outpatient total attendances in the reporting period; of these 100% were privately funded.

- There were 300 doctors who worked at the hospital under practising privileges including surgeons, anaesthetists, physicians and radiologists. In addition, 14 regular resident medical officers (RMOs) worked on a weekly rota. The hospital employed 158 other staff, including 63 registered nurses and 19 care assistants, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- Two Never events
- Two serious injuries
- Six inpatients deaths, of these one was unexpected.
- No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA)
- No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (C.Diff)
- No incidences of hospital acquired E-Coli
- Seven complaints

# 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?

Our rating of safe improved. We rated it as **Good** because:

**Good**



- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service had suitable premises and equipment and looked after them well.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.
- The service followed best practice when prescribing, giving and storing medicines. Patients received the right medication at the right dose at the right time.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

However:

- The hospital did not have an emergency anaesthetic consultant rota.
- The provider had systems to prevent and control the spread of infection. However, not all staff in the diagnostic imaging department complied with infection control procedures. Staff did not consistently clean ultrasound probes according to hospital procedures and national guidance, sharps bins were not always stored safely, all staff were not bare below the elbows and equipment cleaning checks were not consistently completed.



# Summary of this inspection

- The safety barrier to prevent unauthorised access to the MRI room was not always pulled across when it should have been.
- The medicines stored on the critical care unit were not always clearly labelled with expiry dates.
- Staff did not always log out of computers to ensure security of patient data.
- Patient records were not always complete. We found some issues with completion of the WHO checklist, patient observation charts and tissue viability assessments.

## Are services effective?

Our rating of effective stayed the same. We rated it as **Good** because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

However:

- Managers did not always monitor the effectiveness of care and treatment in all areas.

**Good**



# Summary of this inspection

- There was a lack of health promotion material available across the diagnostic department.
- There was not full dietetic support over the weekend for patients requiring specialist input or with total parenteral nutrition (TPN) prescriptions.

## Are services caring?

Our rating of caring stayed the same. We rated it as **Good** because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.

**Good**



## Are services responsive?

Our rating of responsive stayed the same. We rated it as **Good** because:

- The service planned and provided services in a way that met the needs of the people that accessed the service.
- The service took account of patients' individual needs.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

**Good**



## Are services well-led?

Our rating of well-led improved. We rated it as **Good** because:

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.

**Good**



# Summary of this inspection

- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

However:

- Staff and patient survey results showed response rates below expectations.

# 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
Critical care	Good	Good	Good	Good	Good	Good
Outpatients	Good	Good	Good	Good	Good	Good
Diagnostic imaging	Requires improvement	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

# Medical care

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

## Are medical care services safe?

Good 

Our rating of safe stayed the same. We rated it as **good**.

### Mandatory training

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

- Staff received mandatory training on a rolling annual programme which was provided through a mix of classroom based sessions and e-learning. Topics included: medical gases, incidents, clinical updates, pressure areas/nutrition, intravenous (IV) medication, personal safety and conflict, risk assessment, bullying & harassment, equality & diversity and stress management. Of all staff, 98% of staff were up to date with mandatory training. Please see surgery report for more information.
- There was a sepsis protocol in place at the time of the inspection. Staff also received education days on sepsis awareness and all staff we spoke with were aware of how to spot the signs of sepsis.
- At the time of our last inspection, staff received no formal or informal training regarding learning disabilities or dementia. Since our last inspection, the service had introduced dementia leads and launched dementia awareness weeks. Staff were also due to receive training on learning disabilities and the service was training up senior nursing staff who would provide the training on an ongoing basis.

- All appropriate staff in the critical care department received haemofiltration training from a neighbouring NHS trust. We reviewed training protocols for staff and found they were up to date with all training.

### Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.**

- Staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk of, or had been exposed to, abuse. There was an up-to-date safeguarding policy which also gave regard to the safeguarding of children (although the service did not treat children). Safeguarding was part of the hospital's mandatory training, with data indicating that 93% of ward staff and 100% of resident medical officers (RMOs) were compliant with level 2 safeguarding children and adults training. The services target for training compliance was 90%.
- Staff we spoke with were aware of the Mental Health Act s5(2) doctor's holding powers and s5(4) nurse's holding powers, although they explained that they rarely had reason to use these powers. The service did not have any examples of treating patients at risk of suicide or self-harm.
- Patients had access to a chaperone on request. We saw several "Would you feel comfortable with a chaperone" posters around the service. If a patient required a chaperone at their consultation, they could inform a doctor or nurse who would be happy to accommodate this request.

# Medical care

- In the year prior to our inspection, the service did not report any safeguarding concerns to the local authority. Both medical and nursing staff were aware of who to contact if they had any safeguarding concerns.

## Cleanliness, infection control and hygiene

### The service controlled infection risk well.

- The hospital had an infection prevention and control (IPC) policy and all staff received mandatory training relating to this as part of their rolling training requirements. At the time of the inspection, 93% of inpatient nurses had received IPC training. Both wards had an IPC link nurse. Link nurses act as a link between the ward and the infection control team. Their role was to increase awareness of infection control issues and motivate staff to improve practice. There was a hospital-wide IPC nurse who staff were aware of and knew how to contact.
- The wards and endoscopy suite were visibly clean and tidy. The main entrances were clean and free from clutter. Personal Protective Equipment (PPE) was available for staff to use. All clinical areas had antibacterial gel dispensers throughout corridors and in patient rooms.
- Green 'I am clean' stickers were in use throughout the wards to let colleagues know at a glance which equipment's and surfaces were ready to use.
- At the time of our last inspection, we found that not all staff adhered to Bare Below Elbow (BBE) dress code. At the time of this inspection, we found that all staff adhered to the BBE dress code.
- All the inpatient rooms were single occupancy on the wards we visited and therefore additional isolation areas were not required. There was appropriate signage on doors to indicate risk of infection. Staff of all levels knew of measures they should take to reduce the risk of healthcare-associated infections.
- Patients were screened for communicable diseases pre-admission. Between November 2017 and December 2018, the hospital did not report any cases of hospital-acquired MRSA in medical patients. Methicillin-resistant *Staphylococcus aureus* (MRSA) is a bacterium that can be present on the skin and can cause serious infection. In the same period, there were no cases of *E. coli* or *Clostridium difficile* infection in medical patients (a bacterium that can infect the bowel and cause diarrhoea, most commonly affecting people who have recently been treated with antibiotics). There were no incidents of Methicillin Sensitive *Staphylococcus Aureus* (MSSA) in medical patients. MSSA is a type of bacterium that can live on the skin and develop into an infection, or even cause blood poisoning.
- In the Patient-Led Assessments of the Care Environment (PLACE) assessment in 2018, the hospital scored 99.6% for cleanliness, against a national average of 98.4%. The assessment of cleanliness covered all items commonly found in the healthcare premises including patient equipment, baths, toilets and showers, furniture, floors and other fixtures and fittings.
- The hospital audited the use of sharps bins to ensure that any issues were addressed. In the audit dated October 2018 we observed that no sharps bins were overfull with protruding sharps. We found no issues with the disposal of sharps on inspection.
- The hospital was following the guidance outlined in the management and decontamination of flexible endoscopes as per the Health Technical Memorandum 01-06: Decontamination of flexible endoscopes. All endoscopes were cleaned on site and then sent off for external decontamination. The service could fast-track the cleaning of endoscopes if needed for an emergency.

## Environment and equipment

### The service had suitable premises and equipment and looked after them well.

- We saw that adult inpatient and clinical facilities were designed in keeping with the Department of Health guidance in HBN-04-1 and HBN 03-02. Throughout our visit, we found the wards to be clean and well-lit with appropriate equipment. In 2018, the hospital received a PLACE score of 99% for condition, appearance and maintenance, against a national average of 94%. This assessment included various aspects of the general environment, such as decoration, condition, tidiness, signage, lighting (including access to natural light), linen, access to car parking, waste management, and the external appearance of buildings and maintenance of grounds. Patient satisfaction results from October 2018 found that 95% of the patients had a 'very good' or 'excellent' impression of the accommodation.

# Medical care

- Resuscitation equipment was available on all the wards we visited and tamper seals were in place. Emergency drugs were available and within the use-by date. Nursing staff carried out daily and weekly checks to demonstrate that equipment was safe and fit for use, with appropriate actions recorded to report any missing or expired items. When checks were missed, senior staff followed this up directly with the staff involved.
- All haemofiltration was undertaken in the critical care unit who managed one haemofiltration machine. The staff on the unit maintained their competence by training with a neighbouring NHS trust. The machine logs were up to date and showed that it had been maintained appropriately. If the service required another machine or the machine became faulty, they were aware of who to contact. At the time of our inspection, there were no patients requiring haemofiltration.
- Arrangements were in place for the safe handling of endoscopes and the segregation, decontamination and storage of endoscopes. Endoscopes were sent to a neighbouring NHS trust for decontamination.
- Patients clinical observations such as pulse, oxygen levels, blood pressure and temperature were monitored in line with National Institute for Health Care Excellence (NICE) guidance CG50 'Acutely ill-Patients in Hospital'. A scoring system based upon these observations, known as a national early warning score (NEWS) system, was used to identify patients whose condition was at risk of deteriorating. All staff received training on recognising sepsis and knew who to contact in the early stages of sepsis. Both junior and senior staff were aware of the stages of 'sepsis 6' and we saw that this was in use in paper policy bundles. For more information, please see the surgery report.
- The hospital had an outreach team staffed with critical care staff available 24 hours a day, who visited deteriorating patients on the wards to assess the patient and allow for timely intervention if required. There was a daily resuscitation team meeting to agree team responsibilities and identify potential patients of concern.
- The hospital performed case scenarios for various clinical risks. We saw the minutes for the recognition and initial treatment of acute coronary syndrome case scenario. The scenario would outline the immediate equipment needed for the condition as well as the necessary clinical observations. We saw resuscitation committee meeting minutes and found that they discussed incidents, resuscitation trolley audit results and the ongoing review of mock arrests.
- At the time of our last inspection, endoscopy took place in the main theatres. Since our last inspection, the service had refurbished part of the ward to create a dedicated endoscopy unit. The World Health Organisation (WHO) safety checklist was used in the endoscopy theatres and involved briefing, sign-in, timeout, sign-out and debriefing. The use of the WHO safety checklist ensures patient safety throughout the perioperative journey. The National Patient Safety Agency (NPSA) advocates it for all patients in England and Wales undergoing surgical procedures to reduce errors and adverse events, and increase teamwork and communication in surgery.
- Pathways were in place for the referral and transfer of patients to neighbouring NHS hospitals if this was required.

## Assessing and responding to patient risk

### Staff completed and updated risk assessments for each patient.

- We saw the hospital admissions policy, which had clear exclusion and inclusion criteria. Patients with a known terminal illness, severe psychiatric illness or women past 16 weeks of pregnancy were excluded. Patients who were grossly obese, with suspected acute heart conditions or with multiple traumas or head injury, required a risk assessment by the relevant consultant prior to admission.
- All patients were assessed on admission using national risk assessment tools in nutrition, falls risks, manual handling needs and skin integrity. We saw evidence that initial assessments were completed within 24 hours of admission, with the aim to identify any factor which the patient may need support with and to identify a baseline condition. We observed from the records that consultants reviewed all patients within 12 hours of admission, which was in line with agreed national standards.

# Medical care

## Nurse staffing

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

- Planned staffing levels were appropriate for the acuity and dependency of patients. The service used a tool recommended by NICE to plan daily staffing levels. The hospital's staffing standard was one qualified nurse for every four patients. In addition, there was one healthcare assistant (HCA) per shift, as well as the nurse in charge who did not take patients. During our inspection, we saw that ward areas followed the above ratios. Staffing was monitored and reviewed on a day-to-day basis. Agency and bank staff were used as required.
- Between September 2017 and August 2018, the rate for bank and agency usage in nursing staff was between 6% and 19%. The service only utilised the higher end of this range, 19% bank/agency staff, in one month, which was July 2018. The use of bank and agency healthcare assistants (HCAs) was higher on average. In the same reporting period, the rate for bank and agency healthcare assistants varied between 6% and 32%. The reason for the high usage in the summer months was due to staff sickness. In the same reporting period, staff sickness levels were between 0% and 6%. At the time of our inspection, there was a 7% vacancy rate for nursing staff and no HCA vacancies.
- Staffing skill mix was reviewed four times a day against patient numbers, patient level acuity and dependency across the hospital at the bed management meeting. Since our last inspection, the service had recruited clinical nurse specialists in colorectal, gynaecology, breast and orthopaedics to support nurses on the wards and provide support to consultants.
- We attended nursing handovers on both wards and found that they were well structured. Each patient was discussed, as were any additional needs across the service. Staffing and patient levels were discussed.

## Medical staffing

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

- Consultants worked under a practising privileges agreement. At the time of our inspection there were 300 doctors working at the hospital under practising privileges. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. Consultants were invited to join the staff at the hospital following identification of suitability via the consultant selection and review committee (CSRC). Approval was required at the medical committee before the medical director sent a formal letter of invitation.
- All patients were admitted under the care of a named consultant. All patients were reviewed by their consultant within 12 hours of admission. The consultant communicated any changes in care plans or concerns with the resident medical officer (RMO).
- At the time of our inspection there were 14 RMOs who worked throughout the hospital. Of these 14, four were permanent and all took turns to ensure that the hospital was staffed with an RMO 24 hours a day, seven days a week. We observed an RMO handover and found that it was thorough. RMOs were confident that they could get immediate guidance from a named consultant if needed. RMOs oversaw both medical and surgical patients and relied on the 24-hour support from the intensive treatment unit (ITU) fellow in the event of an emergency. All RMOs were at least grade ST3 (specialty trainee year three).

## Records

**Staff kept detailed records of patients' care and treatment.**

- Hospital staff used paper-based patient records to record patients' needs and care plans, medical decision-making and reviews, and risk assessments. Nursing records and medical records were kept together in a lockable cupboard by the nursing station.
- We reviewed 15 sets of medical notes and found that 13 of these complied with The General Medical Councils (GMC) and Nursing & Midwifery Council (NMC) standards for documentation. Two records were signed but no



# Medical care

name was written against the signature. In all 15 records, we observed both allergies and Venous Thromboembolism (VTE) assessments were clearly documented.

- Information governance was part of the mandatory training programme, which all staff were required to attend. We saw that 100% of inpatient staff had attended this training, against a target of 100%.
- Since our last inspection, the service had produced implemented governance structures and policies to capture and monitor hidden disabilities such as learning disabilities, autism and dementia. The service identified whether a patient had a hidden disability at admission via the consultant's office. This information was then placed with medical records and collated by the ward clerks, who would provide the nurses with the information before the patient was admitted to the ward. If a patient had a dementia diagnosis or was identified as pre-dementia, they would have a sticker placed both in their notes and discreetly on the front of their doors to ensure all staff were aware.
- Upon discharge, patients were provided with a typed-up letter explaining the procedure/care they had received that they could share with their GP.

## Medicines

### The service followed best practice when prescribing, giving, recording and storing medicines.

- Medicines were managed and stored appropriately on most of the wards. Staff kept medicines and intravenous (IV) fluids in locked cupboards or rooms with restricted access to ensure security. All drugs that we checked were within date, with stickers used to indicate those nearing expiry.
- The service stored, monitored and administered controlled drugs (CDs) in line with the Nursing and Midwifery Council (NMC) Standards for Medicine Management. At the time of our last inspection, CDs were stored in a locked cupboard in the medicines room, which the nurse in charge held keys for. The CDs were still stored in a locked cupboard at the time of our inspection, but any registered general nurse could hold the keys for the cupboard. To increase efficiency and keep an audit of where the keys were, the service had introduced an electronic key tracker system that required a personalised key code to enter. Once the keys were taken out, they were electronically held against that member of staff's name. In the event of another member of staff requiring the keys, they would check the system to see who held the keys and ask the member of staff to return them before they could log them out. This system ensured there was a clear audit of who held the keys at what time.
- We noted that both wards stored CDs in the same way. We saw that the CD cupboard contained two log books: one for the checking of CDs that belonged to the service, and the other check book to record CDs that were brought in by patients. Both logs contained checks both in the morning and evening. An audit of the drugs within the cabinet showed that none were out of date or approaching their use-by date.
- Medication fridge temperatures were monitored electronically, with the pharmacist and senior nurses receiving alerts if these were out of range. Records of the three months prior to inspection were provided and appropriate actions were taken when these were out of normal range. The ambient room temperatures of each treatment room were also monitored centrally to ensure temperatures did not exceed recommendations for the safe storage of medicines. We observed the ambient room temperature audits for the year prior to our inspection and found that the temperatures never went out of range.
- The hospital had an adult antimicrobial guideline for the use of antibiotics, which was due for review in March 2019. This was in line with national guidance. We saw evidence in notes that patients prescribed an antimicrobial had microbiological samples taken.
- On the rare occasion that a patient was receiving palliative care, the Resident Medical Officer (RMO) would prescribe anticipatory medications along with the palliative care consultant.
- Staff had access to copies of the British National Formulary (BNF), in addition to policies and training relating to medicines management (including the antimicrobial formulary), via the trust intranet.
- In all records we checked we found that all medicines administration records were completed accurately and contained a record of any allergies if necessary.

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## Incidents

### The service managed patient safety incidents well.

- In the 12 months prior to our inspection, there were no 'never events' reported within the medical division. A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. 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.
- At the time of our last inspection we saw that 671 incidents had not been marked as complete on the hospital incident reporting system. Since our last inspection, we saw that the service had made positive strides to investigate and close incidents within a reasonable timeframe. The service had implemented additional governance processes in the recording, investigating and closing of incidents.
- In the 12 months prior to our inspection, the hospital reported 169 clinic incidents across the inpatient setting. Of these, 126 were classed as 'no harm', 15 were classed as 'near misses', 27 were classed as 'low harm' and one was classed as 'moderate harm'. There were no incidents that resulted in 'serious harm/death'. The main themes of these incidents were medication issues and falls.
- There were no serious incidents (SIs) reported across the medicine service in the 12 months prior to our inspection. Senior ward staff informed us of the processes if a serious incident occurred. This included a full root cause analysis (RCA) investigation, with action plans being developed. The senior ward staff attended the monthly senior clinical team meetings (SCTM). The SCTM meetings would discuss incidents, falls, nutrition and other patient safety issues. The information shared at these meetings would be disseminated to staff at daily huddles and more formally at monthly ward meetings.
- A low number of deaths occurred at the service as it did not accept purely palliative patients. The service did however conduct mortality review meetings to discuss any deaths as they occurred.

## Safety Thermometer

### The service used safety monitoring results well.

- The service was not required to use the NHS Safety Thermometer as they are an independent healthcare provider. This is a tool which measures harm to patients which may be associated with their care. At the time of our last inspection, there were 'hot boards' on each ward that displayed the data relating to performance in these key areas. At the time of this inspection, we found that the service had refurbished the 'hot boards' to include infection rates and patient feedback boxes.
- Between April 2018 and November 2018, 99% of inpatients were risk assessed for VTE on admission. The service had a compliance target of 98%.
- Between December 2017 and November 2018, there were three hospital acquired pressure ulcers. All three of these pressure ulcers were either 'grade one' or 'grade two' in severity. In the same period, 80% of inpatients were assessed for risk of pressure ulcers on admission. We confirmed that these risk assessments were mostly completed and regularly reviewed in the 15 patient records we looked at. The service had plans to ensure that at least 50% of nursing staff attended training sessions to reduce the overall number of avoidable hospital acquired pressure ulcers.
- Between December 2017 and November 2018, there were nine reported falls. In the same reporting period, 85% of patients were assessed for their risk of falls. We confirmed that risk assessments were mostly completed and regularly reviewed in the 15 records that we looked at. The service used non-slip socks and had a 'Call Don't Fall' drive in place across inpatient rooms. Patients informed us that they were encouraged to call for help if required.

## Are medical care services effective?

Good 

Our rating of effective stayed the same. We rated it as **good**.

## Evidence-based care and treatment

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## **The service provided care and treatment based on national guidance and evidence of its effectiveness.**

- Hospital policies were current and referenced according to national guidelines and recommendations. These were accessible electronically for all staff that had access. All policies sampled were up to date.
- The hospital did not routinely admit patients for end of life care but recognised that patients may deteriorate whilst an inpatient and require end of life care. The service had appropriate guidelines for prescribing anticipatory medications that was used as guidance alongside the formalised End of Life Policy.
- Sepsis screening and management was done effectively, in line with national guidance. We observed 'sepsis 6' guidance based on guidance from the Sepsis Trust and NICE guidance.
- Endoscopy procedures were carried out in line with guidance from the British Society of Gastroenterology.

## **Nutrition and hydration**

### **Staff gave patients enough food and drink to meet their needs and improve their health.**

- All patients were screened on admission to ensure they were not at risk of malnutrition. A tool based on the malnutrition universal screening tool (MUST) was used to identify the risk level of each patient and this was documented in each set of notes we reviewed. Nursing staff could refer patients to dietitians or speech and language therapists (SALTs), who were employed by the hospital through a service-level agreement.
- Fluid balance charts were only in use for patients where clinically indicated. For example, patients receiving IV fluids would receive a fluid chart. We reviewed 15 nurse's notes and found that of those 15 patients, only four were on fluid charts. All charts were fully complete.
- Lack of dietetics support over the weekend could result in total parenteral nutrition (TPN) prescriptions running out and not being re-started until the Monday. We saw evidence of this for an elderly patient on the ward. We were assured that this was an isolated incident and we saw no evidence that suggested that this happened frequently.
- In the Patient-Led Assessments of the Care Environment (PLACE) assessment in 2018, the hospital scored 97%

overall for food and hydration on the ward, against a national average of 90%. Food and Hydration includes a range of organisational questions relating to the catering service, such as: the choice of food, 24-hour availability, meal times and access to menus. An assessment of food services at ward level and the taste and temperature of food was also completed.

- The service held quarterly nutrition working group meetings. There were set agenda items for discussion each month, which included: the menu, nutrition and hygiene training, policies, nutrition risk assessment policy and patient feedback. The meetings also discussed the results of the nutrition and hydration audit. Between April 2018 and June 2018, the service scored between 91% and 98% in terms of compliance rates.

## **Pain relief**

### **Staff assessed and monitored patients regularly to see if they were in pain.**

- The hospital used a variety of tools to assess pain, depending on the needs of the patient. The numeric rating scale (NRS) was most commonly used, with patients asked to score their pain from zero to 10 each time their vital signs were taken. In this scale, zero meant no pain and 10 was extreme pain. An adapted pain scoring tool was available for those who did not speak English, or had communication difficulties.
- We saw consistent pain assessment tools used across recovery and the wards. We saw that nurses routinely asked patients about pain and patients told us that their pain had been managed appropriately during their stay. We reviewed 15 patients notes and medicines charts that showed that appropriate actions were taken when a patient experienced pain.
- There was a pain specialist nurse who was available Monday to Friday. Outside of these times staff could access advice and support from the CCU fellows.

## **Patient outcomes**

### **Managers monitored the effectiveness of care and treatment and used the findings to improve them.**

- The service did not participate in any national audits related to medical care or end of life care as the numbers of patients who would be eligible to be

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included was very small. However, the hospital aimed to review national audit reports for recommendations and incorporate best practice into their policies and procedures.

- Between December 2017 and November 2018, there were five unplanned readmissions within 28 days of discharge. This was down from 24 at the time of our last inspection. These readmissions were due to various reasons, from pain to patients being generally unwell.
- The service had very few deaths per year but when palliative patients were treated, the service ensured it met all the needs of the patient. We observed the end of life audit for a palliative patient who died on the ward. This found that all the patient's wishes were addressed and the preferred place of death was achieved.
- The endoscopy service was working towards Joint Advisory Group (JAG) accreditation and hoped to be fully accredited within the next year.
- The numbers of patients receiving haemofiltration were too low per year for the service to input into the UK renal registry.

## Competent staff

### The service made sure staff were competent for their roles.

- The hospital reported that 100% of nursing staff and health care assistants had an annual appraisal in the current year and staff we talked with confirmed this. Staff reported they were generally happy with the appraisal system and process, which allowed them to identify their continuing professional development (CPD) needs.
- There were reliable arrangements in place for supporting and managing new nurses, including a comprehensive induction and a supernumerary period during which senior staff assessed their clinical competencies.
- The nurse in charge of each shift checked the skill mix and competencies of their team before allocating work at handover. We observed this at the two handovers we attended. Agency nurses worked under the supervision of unit staff and received an orientation on their first shift.

- Nursing revalidation is the process by which registered nurses are required to demonstrate on a regular basis that they are up to date and fit to practice. The hospital had helped nursing staff through this process by offering workshops, guidance and support.
- The service facilitated diabetes study days, which were mandatory for all new members of nursing staff. The aim of the study day was to ensure safe practice standards for patients with diabetes receiving care. The day covered principles of blood glucose monitoring and acute complications including hypoglycaemia and ketoacidosis. The study day was provided by the diabetes nurse consultant.
- The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. Consultants were invited to join the staff at the hospital following identification of suitability via the consultant selection and review committee (CSRC). Approval was required at the medical committee, before the medical director sent a formal letter of invitation. All consultants with practising privileges at the hospital had their GMC registration checked on an annual basis as part of the clinical governance process. Consultants were appraised through their NHS Trust and had to provide a copy of this appraisal to the hospital each year. In the 12 months prior to our inspection, no staff members had been referred to the GMC or the NMC. Scope of practice was reviewed and managed by the medical director's office.

## Multidisciplinary working

### Staff of different kinds worked together as a team to benefit patients.

- Relevant professionals were involved in the assessment, planning and delivery of patient care. On the ward, staff were aware of which nurse took responsibility for each patient as their names were written on a board at the nurse's station. Multi-disciplinary team (MDTs) meetings took place monthly for different specialities.
- Since our last inspection, clinical nurse specialists (CNSs) had been introduced to support consultants and ensure seamless care for patients. During our inspection

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we met with all three CNSs in the specialties of colorectal, orthopaedic and gynaecology. All CNSs worked equally with consultants and nurses alike. Nurses told us their guidance was “invaluable”.

- The service had an service-level agreement (SLA) in place for patients requiring dietetics and speech and language therapist (SALT) support. In the event of a patient requiring this additional support, the staff knew how to access them. Staff informed us that whilst it was “easy” to gain access to dietitians, it was slightly more difficult to request assistance from SALTs.
- Psychiatric support worked on a referral basis. If staff had concerns about a patient, or if they required a mental capacity assessment, they would call up a psychiatrist that was known to them.
- We saw examples of referral letters from GPs and responses from the hospital, including previous discharge summaries.

## Seven-day services

### Essential services were available seven days a week to support care to be delivered.

- All patients were admitted under the care of a named consultant, who provided consultant level cover in case of absence. Consultants were supported by resident medical officers (RMOs) 24 hours a day, seven days a week. A consultant-led ward round took place every day.
- The service had access to diagnostic imaging and tests, 24 hours a day, seven days a week.
- Pharmacy services were available six days a week with a Saturday service operating between 9.30am and 5pm. Out of hours cover was provided by an on call service.

## Health promotion

### The service supported people supported to live healthier lives.

- The service had materials on smoking cessation and the importance of maintaining a healthy weight available for patients.

- The service provided patients with information both pre-admission and post-admission. The leaflets provided information on recovering after an inpatient stay and contact details if they had any questions.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

### Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

- At the time of our last inspection, we found that not all staff were able to give clear explanations of their roles and responsibilities under the Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards (DoLS). At this inspection, we found that staff could accurately provide clear guidelines for the threshold of referring a patient for a capacity assessment. In the 12 months prior to our inspection there had been no DoLS applications or authorisations.
- For patients requiring a DoLS assessment, staff would liaise directly with social workers in the community.
- At the time of our inspection only one patient had a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) order. We reviewed the patient’s DNACPR form and found that it was fully and legibly complete. The patient’s surgeon had gone through the form with them and had explained the process. The consultant had then signed and dated the form. We spoke with the patient with the DNACPR order and a member of their family and found that they had a thorough discussion with the consultant prior to completing the form. The reason not to resuscitate was filled out clearly and it was indicated that there had been a thorough conversation with both the patient and their family.
- At the time of our last inspection, the service did not audit DNACPR forms. At the time of this inspection, the service had carried out one audit with the expectation to carry out more. The audit of five DNACPR forms found that the DNACPR forms filled out in November 2018 had an 86% compliance rate with agreed standards. On two forms, the decisions for DNACPR were not documented in the patient notes within 48 hours of admission.

## Are medical care services caring?



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Good 

Our rating of caring stayed the same. We rated it as **good**.

## Compassionate care

### Staff cared for patients with compassion.

- The seven patients we spoke with all provided positive feedback about the treatment and care they received from the hospital staff. They were treated as individuals and spoken to with respect by staff at all levels. Patients felt listened to and that nursing staff were “patient” and “very helpful”, working as a team to provide compassionate care. Patients told us that nursing staff made sure they were comfortable and their needs were met.
- At the time of our last inspection, the service scored less than the national average for their Patient-Assessments of the Care Environment (PLACE) scores for the assessment of privacy, dignity and wellbeing. In the 2018 PLACE results the hospital scored 91% for privacy, dignity and wellbeing, against a national average of 84%. The assessment of privacy, dignity and wellbeing included: infrastructural/organisational aspects such as provision of outdoor/ recreation areas, changing and waiting facilities, access to television, radio, computers and telephones. It also included the practicality of male and female services, such as sleeping and bathroom/ toilet facilities, bedside curtains sufficient in size to create a private space around beds and ensuring patients were appropriately dressed to protect their dignity.
- The hospital had a privacy, dignity and respect policy that was due to be reviewed in November 2019. The policy was thorough and set out the scope of attitudes and behaviours staff should adopt with patients.
- Patients were asked to complete a questionnaire on discharge about their experience, either in paper form or via a ward-based tablet. The hospital used the Friends and Family Test (FFT) question to assess patients’ overall experience. Between January and October 2018, the hospital’s FFT score ranged between 95% and 99%, which was in line with the England average. The response rate was between 20% and 30%.

- Patient satisfaction survey results from October 2018 found that 95% of patients answered ‘yes’ to being asked if they felt they were treated with respect and dignity.

## Emotional support

### Staff provided emotional support to patients to minimise their distress.

- Patients had access to psychological support and counselling services via a service-level agreement (SLA) with a local hospital. Staff were clear how they could access these services if needed. Staff told us that psychological support was discussed at handover to ensure this was a key part of patients’ care and offered if needed.
- Patients informed us that they received a lot of easy to understand information on admission and that staff were very supportive.

## Understanding and involvement of patients and those close to them

### Staff involved patients and those close to them in decisions about their care and treatment.

- We saw staff involving patients and those close to them during assessments on the ward, giving them time to ask questions or clarify comments. Written information leaflets were available for patients about a range of treatments and procedures.
- The hospital provided information and support with the payment of fees through the admissions office, which patients could contact during office hours. There was written information available on how to pay for treatment.

## Are medical care services responsive?

Good 

Our rating of responsive stayed the same. We rated it as **good**.

## Service delivery to meet the needs of local people

### The service planned and provided services in a way that met the needs of people accessing the service.

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- New services were developed in line with the hospital's business plan, incorporating comments from patients and consultations with consultants and nurses.
- Facilities and premises were appropriate for the services that were delivered.

## Meeting people's individual needs

### The service took account of patients' individual needs.

- At the time of our last inspection, the service had no formal dementia training in place for staff. Since our last inspection, the service had introduced a dementia course to improve communication and care for people living with dementia across the patient journey. All staff (100%) had completed the dementia course and additional staff were trained as dementia champions. The dementia champions would have additional training provided by a local dementia charity and could disseminate learning across the ward as necessary.
- The service had continued to build on its dementia awareness. A discreet butterfly was placed on the door of patients with dementia to ensure that all staff were aware. The Integrated Care Pathway (ICP) was used for dementia patients and was produced in line with National Institute for Health and Care Excellence (NICE) guidance.
- In the Patient-Led Assessments of the Care Environment (PLACE) assessment in 2018, the hospital scored 94% overall for caring for those with a disability, against a national average of 84%. The disability assessment focussed on issues of access, including: wheelchair access, mobility aids (e.g. handrails), signage and provision of such things as visual/ audible appointment alert systems, hearing loops, and aspects relating to food and food service. The items included in the assessment focussed mainly on buildings/environment related aspects. We found environments to be suited to those in wheelchairs or with mobility issues. There were notices on patient rooms to alert staff to those with hearing difficulties or poor vision.
- In the PLACE assessment in 2018, the hospital scored 92% in the dementia assessment, against a national average of 78%. The dementia assessment focussed on flooring, decor and signage, but also included such things as availability of handrails and appropriate seating and, to a lesser extent, food. We found that the premises were suitable overall for those patients living with dementia. Clocks were available to place in patient rooms to keep people living with dementia oriented.
- Patients had access to both male and female chaperones at outpatient appointments and inpatient assessments. This was facilitated at pre-assessment where patients could also choose to have a pre-admission tour/familiarisation visit prior to inpatient stay.
- Patient satisfaction survey results from October 2018 found that 96% of the patients found the catering to be 'very good' or 'excellent'.
- The hospital had access to a recently refurbished multi-faith room. The room contained different religious texts, which were stored appropriately. Patients had access to multi-faith spiritual support. Staff could contact local spiritual leaders from Jewish, Muslim, Catholic and Church of England backgrounds.
- Translation services were readily available with access to support people speaking over 200 languages.
- At the time of our last inspection, we found that there was no link nurse for patients with disabilities and no specific training or policy on caring for these patients. Since our last inspection, the service had developed its policy of caring for patients with learning disabilities and identified learning opportunities for staff in this area.
- There was a learning disability link nurse. The learning disability link nurse visited patients with additional needs to help co-ordinate care and ensure the hospital passport was being used appropriately by staff. Link nurses also engaged with external agencies to ensure that best practice was maintained and offered formal training sessions to other staff.
- Face-to-face training was run by an external agency to train nine members of staff to be learning disability champions.

## Access and flow

### People could access the service when they needed it.

- There were daily bed management meetings attended by senior staff to plan patient admissions, transfers and

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discharges. We attended one of these meetings and found it to be structured, with discussion of a range of topics, including staffing levels and activities planned to suit the needs of patients.

- There were no 'wait times' for treatments or services at the hospital, as such. We were told that the booking system was based on elective bookings and patient choice. Patients were usually offered treatment within two weeks of wanting or needing treatment.
- The discharge process was thorough. Both junior and senior staff informed us that they could usually discharge patients promptly if the patient did not require complex discharge arrangements. We observed a daily handover and found that discharge was discussed and planned for in advance. A discharge planning audit, conducted between May 2018 and October 2018, found between 93% and 96% overall compliance with agreed standards. Some issues were found, such as: there being no evidence that an escort was identified pre-admission, there being no evidence that a discharge plan was signed on the integrated care pathway and the discharge checklist being incomplete.

## Learning from complaints and concerns

**The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.**

- Information on how to make a complaint was available in the service information book, which was available in each patient's room. Patients were advised to make any complaints to the nurse in charge, who escalated these to the matron as appropriate. Nursing staff told us that the service would aim to resolve the complaint informally immediately.
- Formal complaints were handled by the director of governance and overseen by the chief executive officer. There was an up-to-date complaints policy available on the intranet. The hospital aimed to acknowledge all formal complaints within three working days. A target of 20 working days was set for a full response.
- In the 12 months prior to our inspection, there were 10 complaints attributable to medical services. The complaints varied from dissatisfaction with nursing staff,

to issues with catering requirements, but there were no general themes. All complaints were acknowledged via telephone within 48 hours and the complaint indicated if the full response was received within 20 working days.

- The service made efforts to change things in response to complaints. For example, the catering staff had increased options on the menu and catered to a variety of different diets because of a complaint.
- A complaints leaflet was available in all areas which described the process should a patient want to raise a concern. There was information about how to contact the independent sector complaints adjudication service (ISCAS) if patients were unhappy about the outcome of their complaint. Patients and relatives we spoke with were aware of the complaints process and said that staff were always there to resolve any concerns.

## Are medical care services well-led?

Good 

Our rating of well-led stayed the same. We rated it as **good**.

## Leadership

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

- There was a clear senior and ward management structure within the hospital. The hospital had a clinical nurse manager in place, who oversaw all the inpatients on both wards and day care ward. The clinical nurse manager line managed the day and night ward sisters. The director of nursing was commonly referred to as the matron and line managed the clinical nurse manager. The service was actively looking for a deputy director of nursing at the time of our inspection. The chief executive officer (CEO) managed the overall running of the hospital.
- Doctors reported to the medical director, who sat on the board and had oversight of the consultants and resident medical officers (RMOs). The medical director's office took the lead on consultant's scope of practice and managed the human resources files.



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- Senior staff were visible on the wards and staff at all levels knew who sat on the board. Senior staff on the ward spoke very positively of the executive team and stated that the changes since our last inspection had facilitated a more transparent mode of working. Senior staff informed us that the executive team were in touch with the needs of patients and put patients at the centre of care. Junior staff spoke highly of both their managers and the hospital.
- Due to small numbers of patients who were admitted with mental health issues per year, the service did not have a lead for mental health. The service did have a lead for dementia and hidden disabilities.
- We observed information leaflets on the unit encouraging staff to speak up (whistle blow) if they saw something was wrong. There was an up-to-date whistleblowing policy, which outlined how to escalate any concerns.
- The human resource (HR) files that we saw all contained the appropriate level of valid professional indemnity insurance for consultants with practising privileges. The Medical Director's office would ensure that these were up to date.
- We saw good team working amongst staff at all levels. Nursing staff spoke highly of both consultants and resident medical officers (RMOs), who they told us were always available to them.
- Staff spoke highly of the continued professional development that the hospital prioritised. Nurses informed us that their appraisals were very helpful in "deciding a course of action for further education" and that they were always supported to learn and train more.
- Staff of all levels sat with one another at lunch as meals were provided to staff free of charge.
- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents' and provide reasonable support to that person. Staff confirmed that a culture of candour was fully supported at all levels. Both junior and senior nurses, as well as other clinicians, confirmed there was an expectation of openness when care and treatment did not go according to plan. We saw duty of candour pamphlets available to both staff and patients that included the statutory steps the service had to take in the event of a notifiable incident taking place.
- In the 12 months prior to our inspection, there were no DoC notifications.

## Vision and strategy

**The medical service did not have a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.**

- The hospital's vision was to 'be the leading private hospital in the UK and to support an increased number of veterans through charitable work'. The vision was underpinned by the hospital's philosophy of care, which was a nine-bulleted point philosophy outlining how they aimed to deliver patient care.
- The medical service accounted for less than 10% of hospital work and did not see itself as distinct from the surgical service. To view more information on this, please see the surgery report.

## Culture

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

## Governance

**The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.**

- The Integrated Governance Meetings (IGM) were held every other month. IGMs discussed incidents, complaints and audit results. There was also monthly senior clinical team meeting (SCTM) that discussed incidents, complaints, risk and quality governance. Learning from these meetings was shared by providing verbal progress reports and minutes of meetings were sent to heads of department and other committees.
- The hospital had an audit calendar, which was used to monitor services and compliance against national and local standards, where possible. Nursing staff participated in local audits. There was an audit committee that met every month to oversee both

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external and internal audits. At the time of our last inspection, there were no audits taking place specifically relating to medical or end of life care. At the time of this inspection, the service had commenced audits for DNACPRs and end of life integrated care pathways.

- The service had various service-level agreements (SLAs) in place. For example, the hospital had SLAs for the provision of speech and language services and pathology. These were all managed well and the service had an appropriate SLA policy in place.

## Managing risks, issues and performance

**The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**

- The service had an audit calendar, which was used to monitor services and compliance against national and local standards, where possible. The calendar included audits on a variety of clinical issues such as sharps bins, cleaning of clinical areas and end of life care. The nursing staff took the lead on these audits and learned from other local hospitals to inform the range of audits they undertook.
- The service held weekly governance meetings to review incidents and discuss learning. These meetings were called Complaints, Legal, Incidents, Patient feedback and Audit (CLIPA) meetings. Both the integrated governance meeting (IGM) and the CLIPA meeting reviewed the audit schedule and the results of each audit.
- Whilst the service did not take part in any national audits, they did submit data to private healthcare information network (PHIN).
- The service had streamlined their risk register. Risks were now arranged by clinical area and were managed by a named individual (until closed after the implementation of an action plan). The risks were specific and the level of risk was recorded in all cases. There were seven active risks on the inpatient risk register. The risks included: staffing levels, managing patient falls and patients being at risk of developing deep vein thrombosis. We found that these identified risks correlated to those we saw whilst on inspection and were known to junior and senior staff.

- The service had a contingency business plans in place in case of an emergency. Staff had awareness of what actions they would take in the event of a major incident, including a fire.

## Managing information

**The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**

- Do not attempt coronary pulmonary resuscitation (DNACPR) forms were located at the front of the paper patient records for all patients with an active order.
- Staff were happy with the electronic systems and the paper based systems worked well.
- The service had future plans for rolling out electronic patient records.

## Engagement

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

- The service held monthly patient experience groups for previous patients to gain additional feedback. A variety of staff were present at the monthly meetings including: the director of nursing, the estates team, head of IT, the head chef and members of the outpatient and imaging team. Senior staff informed us that actions resulting from this meeting had practical implications for the service. An example of this was the 'hot boards' we observed on each ward. The 'hot boards' had pictures of staff members explaining what grade of staff wore which uniform. This initiative was launched after a patient at the patient experience group stated that they were unsure what the different uniforms meant.
- We observed minutes from a patient experience group and found that it was well attended by patients and staff alike. The discussion at the meeting ranged from refurbishments due around the service, to what the service should do about noisy call bells.

## Medical care

- Patients were provided with a patient survey on discharge from the wards to gather their feedback. Survey results were collected and considered by the service to improve patient experience across the hospital.
- We reviewed the patient satisfaction survey results from October 2018. The service had a 23% response rate to patient feedback on discharge. We saw that 96% of patients said they would recommend the service, and 98% of patients said that the overall quality of care was 'good', 'very good' or 'excellent'.

### Learning, continuous improvement and innovation

#### **The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.**

- Since our last inspection the service had opened the endoscopy suite. The endoscopy service was working towards Joint Advisory Group (JAG) accreditation.
- The service showed that it had undertaken considerable learning from the last inspection. The governance processes had been streamlined and incidents were now managed with more oversight.

# Surgery

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

## Are surgery services safe?

Good 

Our rating of safe improved. We rated it as **good**.

### Mandatory training

**The service provided mandatory training in key skills to all staff including bank staff and gave staff time and support to ensure everyone completed it.**

- Mandatory training was provided for the following subjects: basic life support, intermediate life support, advanced life support (operating staff and recovery staff only), medical gases, manual handling, health & safety, fire evacuation, infection control, governance, safeguarding, mental capacity act, consent, information governance, diversity, conflict resolution, dementia, fall prevention, cyber security and bullying & harassment.
- Mandatory training was provided annually to all staff, including bank staff, through a mix of both classroom and online sessions. Staff were given 30 days a year to fully complete mandatory training and were given time within their working day to complete this. Some training could be completed at home. Staff were paid over time if they completed mandatory training outside of their normal working hours.
- The completion of mandatory training within the surgical services had been a priority and we saw high levels of completion rates throughout the service. Data provided demonstrated 94% of nurses, 100% of resident medical officers, 94% of theatre practitioners and 100% of department managers had completed all mandatory training topics. We saw there were new starters on the

wards and two further new staff in theatres, who were currently completing training to improve compliance rates further. The hospital compliance standard was set at 90%.

- An online programme was used to manage training compliance and we saw that managers had easy access to staff completion rates via this system. In theatres we saw reminders to staff on staff room notice boards that mandatory training was due.
- In theatres we saw that all mandatory training for staff was up to date, including for bank staff. We reviewed that mandatory training compliance rates for all bank staff on shift that day and found there was 100% compliance for all staff.
- There were reliable arrangements in place for supporting new staff at the hospital, including an induction and supernumerary period during which clinical competencies were assessed.

### Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies and used national guidance to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

- The hospital had clear systems, processes and practices in place to safeguard patients from avoidable harm, abuse and neglect, that reflected relevant legislation and national requirements.
- Prior to inspection, we saw an updated safeguarding adult's policy which included appropriate reference to national guidelines and professional bodies. However, when we asked staff to locate the policy they were

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unable to find this on their intranet. We questioned this during inspection and saw evidence in the most recent staff newsletter that the policy had recently moved from the clinical folder to an organisational folder following a review.

- We saw a clear and updated safeguarding flowchart for staff to refer to if they had concerns about a patient. Staff were clear who to report concerns to and how to escalate their concerns. There was a safeguarding lead in the hospital and staff were clear how they would contact them when needed.
- Staff on the wards and in theatres were clear about different types of abuse and what they should look for to ensure patients were protected from harm.
- Data provided to us showed that compliance for safeguarding adult level 1 and 2 training was 96% and 93% respectively for ward nurses, 100% for ward assistants, 91% and 93% for theatre nurses, 83% for theatre assistants and 100% for resident medical officers.
- Staff had also received child safeguarding training levels 1 and 2, with the theatre manager also completing level 3. The hospital recognised that although they did not treat children, staff were likely to meet children who were visiting patients in the hospital.
- Data provided to us showed compliance for safeguarding children level 1 and 2 training was in the range of 83% to 100% for the above-mentioned staffing groups. The hospital compliance standard was 90%.

## Cleanliness, infection control and hygiene

### The service controlled infection risk well. Staff kept themselves, equipment and the premises clean.

- The hospital recorded two unrelated episodes of clostridium difficile from September 2017 to August 2018.
- The hospital screened patients for meticillin-resistant Staphylococcus aureus (MRSA). The hospital's MRSA screening policy stated that all elective surgical patients should have pre-admission MRSA screening, in line with Department of Health guidelines. We saw in patients notes that patients were screened for MRSA during their pre-admission appointment.
- There were no reported MRSA bacteraemia, one episode of Meticillin Sensitive Staphylococcus Aureus (MSSA) and three episodes of E coli from September 2017 to August 2018.
- We saw hand hygiene audit results for October 2018, which demonstrated some poor compliance against the hospital policy. This included hands and wrists not always being free from watches and jewellery and alcohol rub being used inappropriately. We were informed that this related to one member of staff. Hand Hygiene audits took place bi-monthly. The hospital reported 100% compliance in April 2018, 99% compliance in June 2018 and 100% compliance in August 2018. On inspection, we observed that staff adhered to high standards of hand hygiene.
- We saw that all incident reports related to infection prevention and control were discussed at the infection prevention and control committee meeting. We saw examples in meeting minutes of where concerns had been reported and corrective actions had been put in place.
- Nurses on the wards were not aware what the hand hygiene audit results were for their own local area and were unable to tell us of any improvements introduced as a result of these audits.
- We saw there was access to hand washing facilities, hand sanitiser and supplies of personal protective equipment (PPE), which included sterile gloves, gowns and aprons in all areas.
- All staff in theatres and on the wards were bare below the elbows and used PPE when necessary. We saw nurses, doctors and allied health care professionals washing and decontaminating their hands before and after patient contact. Staff in theatres could tell us what precautions they would take to prevent the spread of infection.
- We saw surgical site infection (SSI) information was collected for different types of surgeries. Information provided demonstrated an overall SSI rate of 0.2%. This is below the national average. We saw the SSI rates for hip replacement, knee replacement and gynaecological surgery were all below the national average.
- We observed that the decontamination pathway in the theatres was clear and followed by all staff. If there was a

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last-minute list, the theatre staff could fast track the cleaning of equipment to be completed within 24 hours. Progress of this could be tracked on an online system.

## Environment and equipment

### The service had suitable premises and equipment and looked after them well.

- We saw that wards and theatres were clean and clutter-free and corridors were kept clear to ensure patient beds could be manoeuvred easily. All patients had single rooms with en suite bathroom facilities, which included a walk-in shower. Rooms were kept clean and tidy.
- Equipment decontamination and sterilisation was outsourced to an instrument decontamination company. We saw clear tracking and tracing of these by health care staff in theatres. Sterile equipment was stored appropriately in theatres.
- We reviewed equipment logs and saw that equipment used was serviced within appropriate time frames. There was an ongoing asset replacement program to replace older equipment which was beyond its recommended replacement year and still in use.
- Equipment we reviewed was safety tested within recommended dates. All equipment in theatres was neatly stored and well-maintained.
- We checked resuscitation trolley logs in theatres and on the wards and saw these were fully stocked. All equipment and medicines we checked inside the trolleys were in date. The hospital had recently upgraded all resuscitation trollies to ensure these were standardised across the hospital.
- We saw a difficult intubation trolley with disposable intubating scope in theatres. We saw this trolley was checked weekly and saw no gaps in completion of these checklists. At our last inspection, we saw that this trolley was shared with the critical care unit. During this inspection, we saw that each department had their own trolley.

- We saw new checklists in place for anaesthetic equipment and anaesthetic machines. These logs were fully completed. Senior operating department practitioners had oversight of this and responsibility for completion was shared amongst the team.
- The arrangements for the management of waste were appropriate and complied with waste management regulations. We saw that sharp bins were closed appropriately when not in use. We saw there were yearly external waste audits completed and saw evidence of an action plan implemented from recommendations.

## Assessing and responding to patient risk

### Staff completed and updated risk assessments for each patient.

- We saw the hospital admissions policy, which had clear exclusion and inclusion criteria. Patients with a known terminal illness, severe psychiatric illness or women past 16 weeks of pregnancy were excluded. Bariatric patients, those with suspected acute heart conditions or with multiple traumas or head injury, required a risk assessment by the relevant consultant prior to admission.
- The service had a pre-operative assessment team for all patients that provided advice and information to patients prior to their surgery. The service tested all patients for MRSA and offered patients the opportunity to clarify any details of their surgical journey. Patients who were not physically assessed would be assessed over the phone by a pre-assessment nurse.
- The service used the World Health Organisation (WHO) safety checklist for patients throughout the perioperative journey, to prevent or avoid serious patient harm. This was in line with national recommendations (NPSA Patient Safety Alert: WHO Surgical Safety Checklist).
- The hospital provided a WHO checklist audit report for the breast service which demonstrated 100% compliance in June, July, August and September 2018. However, the audit focused on the documentation of the 'sign in' and 'sign out' processes only. No observational audits took place and the five steps of the process were not audited.
- During the inspection, we observed the 'sign in' and 'time out' parts of the checklist and noticed that the



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checks were carried out efficiently, with all staff engaged in the process. We spoke with staff about the team brief process, who told us that all surgeons were present as the patient could not be sent for before the team brief had occurred.

- National Early Warning Score (NEWS) audits were completed on the ward each month, with practice reviewed in line with the hospital policy. Results showed compliance rates below 90% in June and July, no audit was completed in August and 95% compliance was achieved in September 2018. Action points from these audits included provision of training on the deteriorating patient and a study session on pain.
- During inspection, we reviewed 15 observation charts and saw that these were completed correctly. However, the patient escalation box on the checklist was not always completed by staff and we saw three examples where the patients NEWS meant they should have been escalated to be reviewed by a senior nurse or doctor. There was no evidence of such escalation.
- Staff had attended training days on management of the deteriorating patients, which included sepsis recognition and management. Staff we spoke with had a clear understanding of how to recognise the signs of sepsis and how to respond. Sepsis cards and posters were visible to staff on the wards.
- We saw that the service responded well following incidents that had occurred. For example, there was learning and improvement made after a patient fall and we saw new falls risk assessment paper work and training for staff.
- A falls safety awareness week had recently taken place at the hospital. The week focussed on reducing falls risk and introducing staff to the new falls risk assessment. During inspection, we saw the use of 'call don't fall' posters in patient rooms and saw that patients who had surgery were given information which explained why they may be at a greater risk of falls. We saw falls risk assessments fully completed in all patient notes we reviewed. However, we saw three examples where an action plan had been developed but no evidence of appropriate implementation.
- We saw risk assessments for tissue viability in all patient notes we reviewed. However, we saw examples where

the score for a patient was more than 12 and no action had been taken. For example, when patients were identified as needing a Safer Skin care bundle, this was not in place.

- The hospital reported four cases of hospital acquired pressure ulcers between January 2018 to December 2018. All pressure ulcers were category two or below. Staff were encouraged to report all incidents of patients being admitted with pressure ulcers and followed the Department of Health Safeguarding adults protocol to identify concerns with care of the patient at home.
- The hospital had a critical care outreach team made up of staff from critical care, who were available 24 hours a day. The team were available to support ward staff with deteriorating patients or when ward nurses had concerns.
- There was a daily resuscitation team meeting to agree team responsibilities during a cardiac arrest. This ensured staff were aware of their designated role to improve response rates if a cardiac arrest occurred.
- A pathway was in place for the referral and transfer of patients to a neighbouring NHS hospital, if specialised care was required which the hospital could not offer.

## Nursing and support staffing

### **The service had enough nursing staff, with the right mix of qualifications and skills, to keep patients safe and provide the right care and treatment.**

- Due to the size of the inpatient wards, the hospital could allocate staff in advance, based on demand. The hospital set a target nurse patient ratio of 1:4 on inpatient wards, 1:5 on day case wards and 1:5 on night duty. Healthcare assistants were allocated in addition to these ratios. During our inspection, we saw that ward areas followed these ratios. Staffing was monitored and reviewed on a day-to-day basis and agency and bank staff were used as required.
- Staffing levels in theatres complied with the Association for Perioperative Practice (AfPP) guidelines. However, the theatre department relied on agency and bank staff and staff in the department told us that permanent staffing numbers were low for some shifts. When we spoke with the theatre manager about staffing levels, he

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acknowledged this and told us that they were currently recruiting further permanent theatre staff. Whenever possible, the department tried to use the same bank and agency staff consistently.

- Since the last inspection, the service had recruited clinical nurse specialists in colorectal, gynaecology, breast and orthopaedics specialisms to support nurses on the wards and provide support to consultants.

## Medical staffing

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

- There was no emergency anaesthetic consultant rota for the hospital. Anaesthetists were aware they needed to be available if their patients needed to go back to theatres in an emergency and surgeons would ensure they had anaesthetic cover for these situations. We spoke with the theatre manager about this arrangement and he told us he felt assured that doctors ensured there was cover available if needed. We were told that there was a list of contact details of anaesthetists with practicing privileges who could be used if an anaesthetist was needed at short notice. The hospital reported there were two returns to theatre in the previous 12 months. Staff told us that anaesthetist availability had not been a concern.
- Consultant doctors worked under practicing privileges. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work with an independent hospital. We reviewed consultant files which demonstrated all relevant documentation was up to date and reviewed annually.
- All patients were admitted under the care of a named consultant. We saw that all patients were reviewed daily by consultants in the medical notes. The named consultant had a responsibility to be available 24 hours a day.
- Resident medical officers (RMOs) covered the day-to-day care of patients on the ward. We saw they worked 24-hour shifts. Rotas reviewed noted that RMOs worked from 9am to 9pm, then were on call from 9pm to

9am the following morning. This is not uncommon for independent hospitals and we were assured that arrangements were in place to support RMOs when required.

- RMOs were confident that they could get immediate guidance from a named consultant if needed. RMOs oversaw both medical and surgical patients and relied on the 24-hour support from the intensive treatment unit (ITU) fellow in the event of an emergency. All RMOs were at least grade ST3 (specialty trainee year three).

## Records

**Staff kept detailed records of patients care and treatment. Records we reviewed were up to date.**

- Nursing records and medical records were kept together in a lockable cupboard by the nursing station.
- New imaging software allowed consultants to view images while in the hospital, or externally on mobile devices. This improved flexibility when reviewing patient scans and x rays.
- The hospital attained a satisfactory compliance rating from NHS digital for information governance and there was a steering group which ensured these standards were maintained.
- We reviewed 15 sets of medical notes and found that 13 of these complied with General Medical Councils (GMC) standards for documentation. Two records were signed but no name was written against the signature.
- We reviewed 15 sets of patients notes and found multiple care plan and risk assessment documents used, some of which duplicated information. For example, we saw integrated care pathways in use, as well as surgical pathway documents. In some patient notes, we saw the new Venous thromboembolism (VTE) assessment documents alongside the old documents.
- Reviewed anaesthetist documentation clearly instructed staff on how to contact the consultant anaesthetist if necessary.
- Upon discharge, patients were provided with a typed-up letter explaining the procedure/care they had received that they could share with their GP.



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- All staff had access to information governance training. It was part of the mandatory training programme, which all staff were required to attend. Within the surgical service, all staff had attended this training, against a hospital target of 100%.

## Medicines

**The service followed best practice when prescribing, giving and recording medicines. Patients received the right medication at the right dose at the right time.**

**Nurses on the wards were supported by pharmacists and the storage of medicines was managed well.**

- The service had a good system in place for the management and reconciling of medicines in line with the national standards and guidelines. The service carried out several audits of medicines to identify and address safety issues and improve the service for patients.
- A medicines management audit report completed in July 2018 documented an overall compliance rate of 93% with agreed standards for the storage of medicines.
- Arrangements were in place to ensure that medicines incidents were reported, recorded and investigated. All medicine incidents were reviewed by the pharmacist. We saw incidents categorised as medication incidents, with lessons learned documented and saw these were shared in the staff governance newsletter. We saw 13 medicine incidents had been reported within the previous four months. There were no trends identified.
- The National Institute of Health Care Excellence (NICE) guidance states 100% of patients should have an accurate drug history taken and medicines reconciled within 24 hours of admission. We saw a medicines audit which monitored whether patients received medicine reconciliation within 24 hours of admission as recommended by NICE guidelines. Audit results demonstrated a compliance rate of 80% in April 2018 and 95% in July 2018.
- A quarterly controlled drug audit was completed, which assessed standards against NICE guidance for safe use and management of controlled drugs. The hospital reported an overall compliance rate of 99%. During inspection, we saw that controlled drugs were stored and checked in line with this standard.
- The hospital had adult antimicrobial guideline for the use of antibiotics, which was due for review in March 2019. This was in line with national guidance. We saw evidence in notes that patients prescribed an antimicrobial had microbiological samples taken.
- Staff had access to copies of the British National Formulary (BNF), in addition to policies and training relating to medicines management (including the antimicrobial formulary), via the trust intranet.
- In all records we checked we found that all medicines administration records were completed accurately and contained records of allergies if necessary.

## Incidents

**The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.**

- During our last inspection, we identified a lack of effective systems and processes to assess, monitor and improve patient safety. During this inspection, we found reliable systems in place which enabled staff to identify, report and learn from incidents. Staff across the wards and in theatres were aware how to report incidents. Staff told us that when they reported an incident, they received feedback and told us how learning was shared across the service. There had been an increase in the numbers of incidents reported since our last inspection which further evidenced that staff were engaged and felt confident to report incidents.
- A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. 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.
- There were three serious incidents (SIs) reported in the previous 12 months relating to surgery: one fall resulting in harm, one involving major haemorrhage (MH) in theatres where MH policy was not followed and one unexpected death of a patient. We saw detailed RCA investigations into each incident, with clear action

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plans. For each incident we saw that duty of candour requirements were followed. During the inspection we saw improvements made because of these incidents. For example, we saw updated sepsis guidance, which steered staff on when to contact consultants and an updated major haemorrhage procedure.

- We saw postcards with key messages to staff about changes that when an incident had occurred. These were in the staff break room and on notice boards. Staff we spoke with could recall in detail what messages had been distributed. In theatres, staff were able to demonstrate knowledge of how this related to their practice.
- Incident trends were reported to the board each month, along with identified trends and relevant learning points. Incidents themes included: inpatient falls, theatre equipment issues and blood product management.
- We looked at incident reporting in theatres and found there had been 45 incidents reported within the three months prior to inspection. All incidents had been reviewed within the expected time frame and there were currently nine incidents awaiting review. None of these incidents had occurred within the previous 20 days. This was an improvement from our previous inspection, when there was a backlog of 671 incidents waiting 'to be closed'.
- The service ran a staff survey to look at patient safety culture, which was completed in August 2018. It highlighted several concerns in relation to staff knowledge and their ability to report incidents. Fewer than half of the 84 respondents felt there was a clear understanding of the reporting processes. A further 89% thought that there would be fewer errors if processes changed. In October 2018, a project was launched which aimed to ensure all staff felt engaged in shaping and improving safety culture. During inspection, we saw evidence of improvement. Staff told us they felt more empowered to report incidents and that senior staff supported them when things went wrong.
- There was a total of 340 incidents reported over the previous 12 months within surgical services. Themes of these included: issues with equipment, pathology samples and medication errors.

- We saw that learning and actions from incidents were shared via a monthly staff newsletter. We saw copies of these located in staff rooms and on notice boards, which reflected the incident themes we had discussed with managers. Consultants were also updated via a quarterly consultant newsletter.
- A low number of deaths occurred at the service as it did not accept purely palliative patients. The service did however conduct mortality review meetings to discuss any deaths as they occurred.

## Safety Thermometer

### The service used safety monitoring results well.

- The NHS safety thermometer is an improvement tool to measure patient harms and harm-free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheter associated urinary tract infections. The hospital was not required to use the safety thermometer as it was a private healthcare provider. However, the hospital collected this information as part of the surgery dashboard.
- We saw that patient harms were recorded and that these were displayed on ward information boards. However, these results referred to hospital-wide reports and results and did not demonstrate the local level of harm to surgical patients.
- We spoke with staff on the wards about performance measures and staff were unable to tell us about performance results which related to their own environment. Senior staff could tell us about hospital-wide performance in relation to falls and pressure ulcers.

## Are surgery services effective?

Good 

Our rating of effective stayed the same. We rated it as **good**.

## Evidence-based care and treatment

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**The service provided care and treatment based on national guidance and evidence of its effectiveness. Policies and procedures, we reviewed had been updated. An annual audit program was in place to ensure staff followed the guidance.**

- We saw a detailed audit programme in place for the surgical services. However, nurses that we spoke to had little knowledge about audits and results within their own areas. Staff were aware that the matron undertook audits but were unsure how this related to their areas of work. Much of the audit feedback information we saw and staff told us about was hospital-wide.
- An internal hospital review, conducted in May 2018, noted that one in four policies and guidelines documents were out of date. Reasons highlighted for this included there being no central system to review each document. During the course of inspection, we saw that policies and procedures accessed online by staff had been reviewed, were in date and reflected national guidelines.
- A policy and guidelines ratification committee was in place and we saw evidence of progress being made to ensure all policies and guidelines were updated and revised to reflect national guidelines. For example, we saw a new dementia policy, a revised complaints policy, new acute kidney injury guidelines, revised thromboembolism prevention and a revised health and safety at work policy.
- The hospital told us that they expect all guidelines and procedures to be updated in line with NICE guidelines within nine months of new guidance being issued. We saw this included on the hospital risk register and saw on inspection that progress had been made.
- The hospital contributed to relevant national audits including the National Joint Registry (NJR), Patient Related Outcome Measures (PROMS), Public Health England (PHE) surgical site infection surveillance and Patient-led Assessment of Care Environment (PLACE). Audits such as PLACE are not mandatory for the hospital as they do not see NHS patients. However, the hospital used the audit to benchmark their service against other similar services.
- We saw audits were used to improve and ensure services were safe. For example, data from the NJR had alerted the hospital to performance which was below

the national average. The hospital responded appropriately and invited a review from the Royal College of Surgeons. We saw that recommendations had been put in place to improve patient outcomes as a result.

## Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs. Menus provided ensured patients with specific preferences were catered for. Staff recorded food and fluid intake after surgery however there was no standard procedure to discontinue the use of these.**

- Dietitian services were provided via a service-level agreement (SLA) with a nearby hospital. Senior nurses were aware how to access this service if required for a patient if necessary or if they had any specific concerns.
- We saw that all patients were assessed using a malnutrition universal screening tool (MUST) on admission.
- Patient records demonstrated that food and fluid intake was monitored after a patient's surgery. However, notes we reviewed did not demonstrate a clear and consistent way of discontinuing these tools and nurses told us they were simply discontinued when they were no longer required.
- Patients had good access to a range of different food and drinks and could order food from a menu as and when they required. Onsite chefs prepared the food for patients. Patients we spoke to were complimentary about the food.
- Nausea and vomiting was managed effectively within the recovery department. We saw patients were prescribed anti-sickness drugs if required and saw that nurses regularly checked that patients did not feel sick.
- There was a nil-by-mouth policy in place and patients we spoke with informed us that they had been provided guidance on fasting times pre-surgery.

## Pain relief

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**Staff assessed and monitored patients regularly using appropriate assessments to see if they were in pain. Patients told us their pain was managed well and we saw nurses administering additional pain relief when required.**

- We saw consistent pain assessment tools in use across recovery and the wards. We saw that nurses routinely asked patients about pain and patients told us that their pain had been managed appropriately during their stay. We reviewed 15 patients notes and medicines charts, which showed that appropriate actions were taken when a patient experienced pain.
- There was a pain specialist nurse who was available Monday to Friday. Outside of these times staff could access advice and support from the CCU fellows.

## Patient outcomes

**Effectiveness of care and treatment was monitored and results were used to improve and review services. The hospital collected key performance data to assess patient outcomes.**

- The hospital collected key performance data to assess patient outcomes. This included instances of unplanned return to theatres, readmissions within 28 days, unexpected admission to the critical care unit, surgical site infection information and mortality data. The hospital submitted this data to PHIN, in line with healthcare regulations. Currently this information was collected through an electronic reporting system and the hospital was considering new and more effective ways to capture this data.
- We saw there were 17 unplanned returns to theatres between December 2017 and November 2018, and one emergency transfer to another hospital where the patient required a pace maker.
- The hospital governance team told us that collecting patient outcomes data was a key priority for the coming year. We saw evidence of this in the hospital's stated values and future strategy. The hospital had identified that this was currently a weakness and had identified ways in which they could improve. This included developing IT capability to collect information and

outcomes measures. There was a clear deadline for this work to be completed. The team told us that the hospital aimed to be able to produce detailed outcome trends within the next four months.

- Patient reported outcomes measures (PROMs) assess the quality of care delivered from the patient's perspective. The hospital had started to collect PROMS data and were in the process of establishing ways they could improve levels of patient engagement in these surveys.
- The hospital reported information to the National Joint Registry (NJR), which collects information on all hip, knee, ankle, elbow and shoulder replacement operations to monitor performance. We saw that the most recent NJR report highlighted concerns where a surgeon's outcomes were worse than the national average. The hospital governance team had responded to this and referred the information to the relevant national professional bodies for review. While this was being reviewed, the surgeon's practicing privileges had been removed, meaning they could no longer practice at the hospital. This information was also shared with the surgeon's NHS employer.

## Competent staff

**The service ensured staff were competent for their roles through regular appraisal. Staff had access to professional development opportunities and were encouraged to progress.**

- Education was identified as a key theme in the hospital's annual plan. Their aim was to develop a thriving learning environment throughout the hospital, ensuring all staff had the highest levels of skills and knowledge, whilst retaining the best and most talented staff in all areas of the organisation. This would be achieved through a comprehensive internal and external development and education program.
- We saw an updated education, training and development policy to help deliver this aim and to create a continual learning culture.
- We saw that all theatre and ward nursing staff had received an appraisal within the previous 12 months.

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Staff we spoke with told us that the appraisal process was used to identify areas for development and found that the process encouraged them to progress within their role.

- We saw staff had access to multiple opportunities to learn and develop. Staff could access courses within areas of interest which related to their roles. We saw evidence of staff undertaking both clinical and non-clinical courses, such as leadership and management.
- Senior staff told us learning needs were identified during the yearly appraisal. However, staff told us that if they identified a course they were interested in they could go to their manager for approval at other times. There was a budget for staff training, but managers told us that they could approve most courses for staff.
- Nursing revalidation is the process by which registered nurses are required to demonstrate that they fulfil certain requirements to remain on the nursing register. Nurses told us that they had been helped through this process by the hospital and had been offered workshops, guidance and support.
- In the 12 months prior to our inspection, no staff members had been referred to the General Medical Council (GMC) or the Nursing and Midwifery Council (NMC).
- The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. Consultants were invited to join the staff at the hospital following identification of suitability via the consultant selection and review committee. Approval was required at the medical committee, before the medical director sent a formal letter of invitation. All consultants with practising privileges at the hospital had their GMC registration checked on an annual basis as part of the clinical governance process. Consultants were appraised through their NHS Trust and had to provide a copy of this to the hospital each year. Scope of practice was reviewed and managed by the medical director's office.

## Multidisciplinary working

**Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and allied health professionals worked well together to provide seamless patient care.**

- Since our last inspection, clinical nurse specialists had been introduced to support consultants and ensure better care for patients. During inspection, we met with the clinical nurse specialist for orthopaedics who had recently been appointed. The aim of the role was to ensure joined up care between the consultant and the multidisciplinary team.
- We saw physiotherapists working on the ward and saw that their care interventions were documented in the medical notes. We reviewed eight patients who had orthopaedic procedures within the previous 48 hours and saw that all patients had been reviewed at least once by a physiotherapist.
- Multidisciplinary team (MDT) meetings took place at lunch time on the wards. MDT meetings ensured patient needs were reviewed and planned for the next twenty-four hours.
- Formal MDT meetings did not occur on a regular basis due to the types of patients the hospital treated. However, we saw examples of MDT meetings which took place for complex patients prior to discharge with appropriate professionals who had been involved in patient care.

## Seven-day services

**Essential services were available seven days a week to support care to be delivered.**

- Patients were admitted under the care of named consultants, who were supported by registered medical officers 24 hours a day, seven days a week. There were also resident CCU fellows, who were senior level doctors in the hospital, available for advice and support should a ward patient become unwell.
- Pharmacy services were available six days a week, with a Saturday service operating between 9.30am and 5pm. Out of hours cover was provided by an on call service.
- Diagnostic imaging services were available 24 hours a day, seven days a week via an on-call radiographer.



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- Dietitian and speech and language services were available via service-level agreement with another local hospital. Nurses on the wards told us these arrangements were sufficient for the patients the hospital treated.
- We saw that the physiotherapy team offered inpatient physiotherapy treatment, 9am to 5pm seven days a week.

## Health promotion

### The service supported people supported to live healthier lives.

- The service had materials on smoking cessation and the importance of maintaining a healthy weight available for patients.
- On admission, patients were provided with materials they could read that would outline their procedure. On discharge, patients were provided with further information on how to look after themselves post-surgery.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

### Staff understood their roles and responsibilities under the Mental Health Act and the Mental Capacity Act. They knew how to support patients to make decisions and processes to follow when a patient lacked the capacity to make decisions about their care.

- We saw evidence that systems were in place to obtain consent from patients before carrying out procedures and treatments. We observed staff gaining consent from patients before providing care such as routine observations.
- We reviewed 15 sets of notes with completed consent forms for surgical procedures. We saw that consent forms were completed by the consultant undertaking the procedure and outlined risks and benefits, which had been discussed with the patient. We saw that consent forms were signed on the day of surgery. Patients we spoke with told us they were given time to ask questions and felt fully informed about their procedures.
- A yearly consent audit was completed and we saw practice was audited against relevant legislation such as

the Royal College of Nursing guidance, Royal College of Surgeons guidance and the King Edward VII's Hospital consent policy and procedure. Results from September 2018 demonstrated a 68% compliance against agreed standards. The audit noted that consent practice showed good compliance with relaying the benefits and risks of procedures. However, it was noted that patients did not always receive sufficient information about the anaesthetic process. We saw that this practice had been reviewed and patients were now provided with further information at their pre-operative assessment.

- Staff we spoke with gave clear explanations of their roles and responsibilities under the Mental Capacity Act 2005 (MCA) and could clearly describe their roles in safeguarding patients who lacked capacity to make decisions about their care and treatment. Staff in theatres gave clear explanations about their roles and responsibility in ensuring patients understood the treatment they had consented for and the process they would follow if they had concerns.
- In the 12 months prior to our inspection, the Care Quality Commission (CQC) received no notifications of Deprivation of Liberty applications.

## Are surgery services caring?

Good 

Our rating of caring stayed the same. We rated it as **good**.

## Compassionate care

### Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

- The annual patient survey report was published every January. In January 2018, we saw that 98% of inpatients would recommend the hospital to friends and family, and 97% of patients rated the quality of care as 'excellent' or 'good'. The response rate varied between 20% and 30% each month.
- Patient 'thank you' cards and letters were collected and reviewed to ensure positive patient feedback could be shared with all staff. We saw multiple example of cards and letters praising the kind, considerate and respectful attitudes of various members of staff.

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- In the 2018, in the Patient Led Assessment of the Care Environment (PLACE), the hospital scored better than the national average for ensuring patients privacy and dignity was protected. In accordance, we saw that patients were provided with dressing gowns to promote dignity around the wards and hospital. The ward environment ensured privacy as there were only single occupancy rooms.
- Patients we spoke with about their care told us the nurses were excellent and provided excellent care. All patients we spoke with were consistently positive about the care they received.

## Emotional support

### Staff provided emotional support to patients to minimise their distress.

- Patients had access to psychological support and counselling services via a service-level agreement with a local hospital. Staff were clear how they could access these services if needed. Staff told us that psychological support was discussed at handover to ensure this was a key part of patient care and support was offered if needed.
- We observed different members of staff supporting patients at different stages of their hospital stay. For example, we saw theatre staff reassuring nervous patients and taking their time to explain procedures. We also saw physiotherapy staff providing encouragement to patients who had undergone joint replacement surgery.

## Understanding and involvement of patients and those close to them

### Staff involved patients in decisions about their care and treatment

- Patients told us they felt fully involved in planning their care and treatment. They told us that staff were respectful to their wishes and ensured their family were involved as and when required.
- Patients were provided with written information leaflets about what to expect upon discharge and who they could contact if they had any concerns about their

recovery. Various information leaflets were available to ensure patients could re-read information if needed. We saw that staff kept a log of which leaflets had been given to patients.

- The hospital provided information and support with the payment of fees through the admissions office, which patients could contact during office hours. There was written information available on how to pay for treatment.

## Are surgery services responsive?

Good 

Our rating of responsive stayed the same. We rated it as **good**.

## Service delivery to meet the needs of local people

### The hospital planned and provided services in a way to meet the needs of the patients that used the services. Patients could access services quickly and patients were positive about the booking process. People could access the services when they needed it.

- The service had been adapted to meet the needs of their patient population. As the hospital offered private care, most of the surgeries undertaken were elective. This meant that admissions to the surgical inpatient wards were planned with the patient in mind.
- The housekeeping team could put a compassionate bed in the room of a patient, if the patient requested. This meant that a patient could have a relative stay the night. There was also a daily guest menu for relatives.

Theatre utilisation was arranged to ensure there was capacity to accommodate extra surgeries as and when patients were booked. Consultants could book extra slots easily as capacity allowed this. Theatres generally operated between 7am and 9pm Monday to Friday, 8am until 2pm on a Saturday, and as and when required on a Sunday.

## Meeting people's individual needs

### The hospital provided support to patients with additional needs. Staff had received training on how to support patients and staff champions had been introduced in all areas with additional training.

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- The hospital had met with a hearing loss charity to establish ways to help improve the experience of patients and staff who had experienced hearing loss. Suggestions were actioned, including the addition of equipment and training for staff. This included basic sign language training, as well as assistive technology and hearing loops being installed.
- A committee had been established to review how easy it was for patients with additional needs to access services. The committee met every two months and there had been clear improvements made in managing patients as a result. For example, we saw a butterfly scheme introduced, which alerted staff to patients that may be living with dementia or memory loss.
- In the 12 months prior to our inspection, the hospital had commissioned a company to review accessibility for patients. The review noticed that ramp access into the hospital was steep and the signage within the hospital was not consistent or easy to read. The hospital had rectified these issues.
- A Patient Led Assessment of the Care Environment (PLACE) audit took place in May 2018. The assessment looked at the non-clinical aspects of the patient environment including food quality, building appearance and privacy. Results demonstrated an above average score in all areas.
- We saw multiple examples of where the hospital responded to individual needs of patients through a 'you said, we did' scheme. For example, patients voiced concerns about blankets and gowns and these were replaced quickly to address these concerns.
- The hospital did not admit many non-English speaking patients. However, staff on the wards were able to describe how they would access interpreters via a telephone line if required. They also told us that there were staff who spoke other languages in the hospital who were willing to interpret if needed. Staff could access braille, British sign language and lip-reading services if required.
- The hospital had access to multi-faith chaplains in the local community. Staff could access these via telephone if required for patients.
- Patients spoke positively about the range of food available to them. We saw that food available catered for those with different nutritional requirements, including those with food allergies, halal, kosher, vegetarian and vegan requirements. We saw that the chef visited patients to discuss options available where necessary.
- We saw chaperone posters displayed throughout the hospital, which detailed information offering every patient a chaperone.
- Although the service did not treat many patients with complex needs, there were arrangements in place and staff had received training. We saw that staff attended both dementia and learning disability training and a butterfly scheme was in use which alerted staff to these patients. Each area of the surgical services had dementia and learning disability champions. These individuals were staff who had extra training in caring for patients living with dementia or learning disabilities. We saw that a 'this is me' booklet had been introduced for patients experiencing memory loss.
- Since the last inspection, the hospital had recruited a palliative care specialist consultant and one of the senior nurses had attended and completed a palliative care course. We saw that the end of life care policy had been reviewed and training had been provided to all current staff in best practice standards. This ensured that all patients being cared for at the end of their lives at the hospital had appropriate care and treatment was provided by trained staff.
- Staff told us they could provide beds for relatives in patient's rooms if required. Visiting times were flexible to accommodate visiting arrangements which suited the patient.

## Access and flow

### People could access the service when they needed it.

- There were no wait times for patients at the hospital. Booking was completed via a booking system and patients were offered appointments within a two-week period. Patients we spoke with were positive about the booking process and told us they had not waited for their treatment.



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- We saw daily bed management meetings took place, attended by senior staff to plan patient admission and discharges. We saw that staffing levels were reviewed to ensure the correct skill mix was available to meet the needs of patients.
- We saw patients being discharged promptly from the ward. Nurses told us there were not usually delays in the discharge process due to most patients being self-caring and not requiring complex care arrangements.
- Details provided by the hospital demonstrated that the Theatre Department currently had capacity to enable Consultants to book extra theatre time when necessary to meet the need of patients.
- Patients booked pre-assessment appointments via the booking phone line. Once pre-assessment was completed, patients could book in for surgeries at a time that suited them.
- The hospital had low rates of hospital cancelled appointments. During our inspection, we saw that one patient was cancelled because they were unfit that day for surgery. The theatre manager told us reasons for non-hospital cancelled procedures ranged from patients changing the date for their own convenience, to booking to go elsewhere for their procedure.
- The service used a multidisciplinary discharge planning tool which was completed on admission, or within 24 hours of admission. The planning tool assessed a patient's home environment and social situation and helped plan support needs if required. We saw the planning tool completed in all patient notes we reviewed.

## Learning from complaints and concerns

**The service used complaints and concerns to learn lessons and improve services. We saw examples of patients concerns leading to service improvement.**

- Ward staff dealt with informal complaints in the first instance. The matron made daily ward rounds to ensure that patients were happy with care. If a complaint became formal, the matron would deal with this.
- A complaints leaflet was available in all areas which described the process should a patient want to raise a concern. There was information about how to contact the independent sector complaints adjudication service

(ISCAS) if patient were unhappy about the outcome of their complaint. Patients and relatives we spoke with were aware of the complaints process and said that staff were always there to resolve any concerns.

- A leaflet was available to patients which detailed how to make a complaint about the service and the process involved. The leaflet detailed the 20-day time frame in which the patient should expect to receive a response. We saw an up-to-date complaints policy which reflected these aims.

There were 21 recorded formal complaints from March to August 2018 relating to surgery. Of these, 10 related to poor nursing care and poor attitudes of staff. We reviewed complaints with managers and were told that noise levels and how staff spoke with patients in recovery had been discussed at theatre team meetings to try and address these concerns.

## Are surgery services well-led?

Good 

Our rating of well-led improved. We rated it as **good**.

## Leadership

**Managers within the surgical services had the right skills and abilities to run a service providing high quality sustainable care. Staff were positive about the leadership team and told us they were well supported**

- We saw evidence that the surgery leadership team were skilled and knowledgeable and were visible and approachable. Clinical leadership of the surgical service was the responsibility of the theatre manager and the matron.
- There was a clear senior and ward management structure within the hospital. The hospital had a clinical nurse manager in place who oversaw all the inpatients on both wards and day care ward. The clinical nurse manager line managed the day and night ward sisters. The director of nursing was commonly referred to as the matron and line managed the clinical nurse manager. The service was actively looking for a deputy director of nursing at the time of our inspection. The chief executive officer (CEO) managed the overall running of the hospital.

# Surgery

- The surgery services were led by the matron who oversaw the running of the wards and theatres via a theatre manager. The theatre manager had been in post for two years and had good oversight of the department and staff.
- Staff in theatres told us they were well supported by the theatre manager, who was open to new ideas and suggestions and supported staff to make changes in the department.
- Staff on the wards were positive about the leadership of the matron and told us she was visible and approachable.

## Vision and strategy

**The hospital had a vision for what it wanted to achieve and workable plans with objectives for each department. Staff were aware of the hospital vision and knew how their work related to this and the hospital values.**

- The King Edward VII's Hospital had a vision to establish itself as the leading private hospital in the UK with a focus on women's health, men's health, musculoskeletal and later life care, while supporting veterans through charitable work.
- We saw there was a clear mission statement, which was to deliver the highest standards of personalised patient centred care, in a safe and kind environment, through exceptional and empowered teams.
- The values of the hospital included: professionalism, quality, respect, safety and teamwork. Staff we spoke with on inspection were clear how these values related to their roles and could give examples on how these were reflected in their work. For example, staff told us that they would always report incidents to ensure safety was a priority.
- We saw a clear theatre vision and strategy, with clear objectives which aligned itself to the hospital vision.

## Culture

**Managers and senior staff across the service promoted a positive culture that supported and valued staff. Staff had access to ongoing training and career development**

- Staff we spoke with on the wards and in theatres told us they felt supported, respected and valued within the teams they worked in. They told us that since the last inspection, the culture had become more positive, encouraging openness and honesty. Learning from incidents was now a priority.
- Staff told us they were proud of the teams they worked in and spoke highly of their managers, who were supportive and encouraged a culture of openness and honesty. Staff told us their managers promoted a 'no blame' culture and supported them when things went wrong. Staff we spoke with gave recent examples of incident investigations where they were supported through the process.
- All staff we spoke with had up-to-date appraisals and told us about opportunities for career development. Senior staff told us they had attended leadership and management training and that career development was a priority.
- Staff survey results demonstrated 94% staff felt they worked as part of a team, 93% of staff said they were proud to work at the hospital and 92% of staff said that managers treated them with respect. A total of 126 out of 172 staff members replied to the survey. This totalled an overall response rate of 73%.

## Governance

**The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.**

- The previous inspection identified areas where the governance throughout the hospital needed improvement. Since the last inspection, a director of governance post had been created to provide focus and structure to these improvements.
- Since the last inspection, the hospital had introduced a weekly governance meeting to review incidents and share learning. These meetings were called CLIPA (Complaints, Legal, Incidents, Patient feedback and Audit). During inspection, the theatre manager and matron told us that they attended these meetings. However, senior nurses on the wards told us they did not have the opportunity to attend these. The director of governance chaired this meeting, which was attended

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by other members of the senior executive team. This meeting discussed infection control rates, patient satisfaction survey results, complaints and the risk register.

- We saw that information from CLIPA meetings was shared with staff in theatres during theatre meetings. We saw meeting minutes in the staff room which demonstrated discussion of incidents and learning.
- We saw that a Governance strategy for 2018-21 had been developed, outlining improvements needed over the next three years. The strategy focussed on embedding governance that was owned and valued by everyone.
- Staff in theatres had a good understanding of incidents, risk and local performance. However, this was not what we found on the wards. We asked ward staff who undertook audits such as hand hygiene. We were told that the matron did this. Staff on the wards did not seem to have oversight or feel involved in safety management or performance within their local areas.
- Since our last inspection the hospital had introduced mortality review meetings which were chaired by the medical director, which met in the event of a patient death.

## Managing risks, issues and performance

**The surgical services had effective systems in place for identifying risks. We saw up to date risk registers in each area which reflected current and ongoing risks.**

- We saw that department risk registers were up to date and referenced ongoing risks. For example, in theatres we saw six risks on the register which were all relevant and reviewed regularly. Risks included staff safety concerns due to heavy doors and lead gowns, and lift maintenance (which was ongoing at the time of our inspection).

- An annual audit program had been introduced since our previous inspection to ensure performance was monitored and managed consistently. We saw appropriate actions were taken from internal audit results.
- Performance information displayed on information boards in local areas was hospital-wide. Performance boards did not detail performance for that area and nurses on the ward had little oversight of performance for their individual area.

## Engagement

**The service engaged well with patients and collaborated with partner organisations effectively.**






- Patient views about care and treatment were captured using a patient feedback survey. Feedback from survey results were reviewed at the monthly patient experience committee and suggestions could be made to the executive committee. For example, all blankets were replaced with duvets after several concerns were made about the quality and comfort of the blankets.
- Inpatient response rates averaged 35%. A new online patient feedback survey had been introduced to improve on this and capture more responses.

## Learning, continuous improvement and innovation

**The hospital was committed to improving services by learning from when things went wrong.**

- We saw new checklists had been introduced across the theatre department to cover cleaning rotas, drug checks, equipment checks, expiry dates and training records. We saw these had led to improvements in compliance with standards and all staff were engaged in the process.
- Virtual reality (VR) techniques were being used in theatres to assist in the training of both surgeons and scrub nurses simultaneously to drive improvements in performance.

# Critical care

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

## Are critical care services safe?

Good 

We have rated this service for the first time and we have rated it as **good**.

### Mandatory training

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

- Mandatory training for critical care unit (CCU) staff included: bullying and harassment, data protection, equality and diversity, hazardous substances, health and safety, internet user, lone working, manual handling, risk assessment, safeguarding, infection prevention and control and slips, trips and falls.
- Data provided showed mandatory training compliance rates met the hospital target of 100% at the time of inspection.
- The training was either delivered via e-learning or face-to-face sessions. Each member of staff had an individual training record and staff told us they would receive email alerts when training was due to be renewed.
- The hospital offered basic life support, intermediate life support and advanced life support training to staff. Intermediate life support training had been completed by 100% of CCU staff.

### Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

- All staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. Staff understood safeguarding procedures and knew how to report concerns. Safeguarding policies were up to date and readily available for staff. There was a named safeguarding lead within the hospital. Staff knew who the safeguarding lead was and were aware of the escalation process. Staff showed in-depth understanding of female genital mutilation (FGM).
- All clinical staff we spoke with were aware of the doctors' holding powers and nurses' holding powers under the Mental Health Act (MHA).
- Safeguarding vulnerable adults and children training was part of mandatory training. Data provided showed a 100% compliance rate with adult and children safeguarding level 1 and 2 training for CCU staff at the time of inspection. Although children were not admitted to the CCU, the unit manager had completed children safeguarding level 3 training.
- There was a 'restraint policy' in place for extra observation or supervision and restraint. There was a restraint monitoring chart that was used by staff to assess patients at risk of suicide or self-harm.
- At the last inspection, we found that senior leaders were unable to confirm the level of safeguarding training provided. Safeguarding training was provided by an external organisation and senior leaders said the

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company could not confirm in writing that what level the training was. At this inspection, we found that there were clear systems in place to know which staff had completed the relevant level of safeguarding training.

## Cleanliness, infection control and hygiene

**The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.**

- The provider had an infection prevention and control (IPC) policy, which was up to date. There was an IPC link nurse and all staff were provided with annual training in IPC.
- Green 'I am clean' stickers were used to identify which equipment had been cleaned by staff and was ready to be reused, such as commodes. We saw stickers had been marked with the date the item had been cleaned and observed staff replacing stickers once they returned the clean equipment.
- We reviewed patient areas and inspected various pieces of equipment such as trolleys and blood pressure monitoring equipment. We found these to be clean.
- Infection prevention and control was part of the clinical update mandatory training which had been completed by 100% of staff. This met the hospital target of 100%. CCU staff had also received training on hand washing, with a 100% compliance rate.
- The clinical dashboard showed it had been 109 days since the last infection in the service. Between September 2017 and August 2018, there were no cases of meticillin-resistant staphylococcus aureus (MRSA) or Clostridium difficile (C-Diff). MRSA and C.Diff are both healthcare-associated infections (HCAIs) that can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. During the same time period, the hospital reported one case of MSSA (meticillin susceptible staphylococcus aureus - a type of bacterium that can live on the skin and develop into an infection, or even blood poisoning). We saw evidence in recent patient records that MRSA risk assessments were completed and that MRSA screening was carried out where appropriate.

- Intensive Care National Audit and Research Centre (ICNARC) data for April 2018 to September 2018, showed the rate of unit acquired blood infections. The CCU was performing worse than comparator units. The CCU manager informed us that this was based on two cases and they had reviewed both of those cases. As a result, appropriate actions were taken and learning was shared with all staff.
- Staff adhered to the bare below elbow (BBE) dress code and used personal protective equipment (PPE), such as gloves and aprons appropriately where indicated.
- There were dispensers with hand sanitising gel situated in appropriate places around the unit. Hand washbasins were equipped with liquid soap, disposable towels and sanitiser. Guidance for effective hand washing was displayed at the basins. Hand hygiene audit results showed 100% compliance in April 2018 to September 2018, except in May 2018 when compliance dropped to 99%. We saw staff hand washing practice during the inspection and all staff washed their hands in line with 'Five Moments for Hand Hygiene' guidance.
- There were safe systems for managing waste and clinical specimens. Staff used sharps bins appropriately; all containers were dated and signed when full to ensure timely disposal, not overfilled and temporarily closed when not in use.

## Environment and equipment

**The service had suitable premises and equipment and looked after them well.**

- The CCU was clean, well-lit and spacious with appropriate equipment. Bed spaces in the CCU complied with the Department of Health's Health Building Note 00-09, which dictates a minimum standard of space for effective infection control.
- Needle sharp bins were available at each bed space. All bins we inspected were correctly labelled and none were filled above the maximum fill line.
- There were hand washing basins at each bed space, which were easy to access.
- There was a resuscitation trolley available in the CCU. We checked the records and found the contents of the trolleys were checked daily by nursing staff and were tagged and sealed.



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- There was a 'difficult airway' intubation trolley, which contained equipment to help staff intubate patients with challenging anatomy. The content of the trolleys met recommendations from the Difficult Airway Society (DAS) 2013. At the last inspection, we found that the trolley was stored upstairs within theatres and recovery and not in the CCU, which could pose a risk to patients, if both services required the use of the trolley at the same time. At this inspection, we found that the unit had rectified this and had a separate trolley within the unit.
- Patients were protected from the risks associated with the unsafe use of equipment because staff maintained a reliable and documented programme of checks. Equipment was labelled and listed in the unit asset register. Maintenance and servicing was planned and carried out in accordance with manufacturer guidance.
- Staff completed competency based equipment training during the probationary period of their employment and worked under supervision until successful completion of their first line assessment. We looked at seven staff records which showed competence was reassessed bi-annually. Agency nurses were required to sign a declaration of the equipment they were competent to use and were provided with training for any equipment they were not familiar with.
- There was an electronic swipe card entry system for staff, and a buzzer entry system at the entrance to the CCU, which was used by visitors. This meant staff could control who accessed the CCU when the door was secured.
- Patients and visitors shared the same entrance. This was against recommendation in the Health Building Note 04-02 to prevent visitors from observing patients coming in and out of the critical care unit. However, staff informed that they were limited by the unit design and closely monitored when patients were wheeled into the unit.
- A Patient Led Assessment of the Care Environment (PLACE) audit took place in May 2018. The assessment looked at the non-clinical aspects of the patient environment including food quality, buildings appearance and privacy. Results demonstrated an above average score in all areas.
- The unit had one separate single room that was used as a side room. The room did not fulfil requirements for an isolation facility as per Health Building Note 00-09, as the room did not have a lobby. Senior leadership of the unit were aware of this and this was on the unit's risk register. The CCU manager informed us that they did not admit any infectious patients and this was one of the exclusion criteria in the admission policy.

## Assessing and responding to patient risk

**Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.**

- Safety meetings were held twice a day on the CCU to give an overview of critically unwell patients within the hospital. All hospital resident medical officers (RMOs), the site lead, the CCU nurse in charge, the CCU fellow and the CCU nurse manager attended this meeting.
- The hospital had a resuscitation team for emergencies. Team members were assigned specific roles in the safety meeting. The CCU fellow was part of the resuscitation team. Between September 2017 and August 2018, the team attended two resuscitation calls within the hospital.
- There was a dedicated critical care outreach service, available 24 hours, seven days a week. There was an established critical care outreach team (CCOT) staffed by the ward manager (when on duty), an ITU fellow (on bleep) and a critical care nurse. The CCOT team delivered level zero to level three critical care to non-critical care areas and identified patients that may need to be transferred to the critical care unit. The CCU fellow and CCU consultants would discuss or review referred patients if required.
- Hospital staff used the National Early Warning Score System (NEWS) to monitor patients for signs of deterioration. This was in line with guidance from the Royal College of Physicians and compliant with the 'NICE clinical guideline 50: Acutely ill patients in hospital' guideline. Patients triggering review were seen by the critical care outreach nurse or the CCU fellow. Where required, cases were escalated to the consultant. We saw evidence of early warning scores in use in medical records. NEWS was documented in all five records we reviewed.

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- Staff used assessment tools for assessing and responding to patient risk. For example, the venous thromboembolism tool (VTE), Nasogastric (NG) tube bundle, central venous catheter (CVC) bundle, airway and ventilation care bundle and Safer Skin Care (SSKIN) were all in use. This information was utilised to manage and promote safe patient care. We saw the CCU care bundle booklet, which was introduced in October 2018 and incorporated all these tools. Staff informed us that the booklet was useful, as all assessment tools were in one place.
- Staff recorded patients' consciousness levels using the Glasgow Coma Scale (GCS). The Richmond Agitation-Sedation Scale (RASS) was used to monitor agitation in sedated patients. There was evidence of this in all five records we reviewed.
- Since the last inspection, the unit had made improvements in assessing patients with delirium. Staff used the Confusion Assessment Method for the Intensive Care Unit (CAM ICU) to assess whether patients were delirious while on the unit. This practice was in line with current best practice guidance from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units.
- Staff used a standardised sepsis screening tool and sepsis care pathway. There was a sepsis policy for staff to access. Sepsis training was offered to staff and data provided showed a 100% compliance rate with this at the time of inspection.
- A fall safety awareness week had recently taken place at the hospital. The week focussed on reducing falls risk and introducing staff to the new falls risk assessment. During inspection, we saw the use of 'call don't fall' posters in the unit and saw that admitted patients were given information which explained why they may be at a greater risk of falls. Falls risk assessments were fully completed in all patient notes we reviewed.
- Immediate life support training was mandatory for clinical CCU staff and data provided showed a 100% compliance rate at the time of inspection. All CCU fellows and 71% of CCU nurses had advanced life support (ALS) training. The clinical nurse manager informed us that all staff without current ALS certificates had been booked for a course.

- We reviewed the 'transfer of critical care patients' policy. This policy ensured timely transfer of an intubated/ critically ill patient from the hospital CCU to another critical care unit within the London North West Critical Care Network or alternative hospital. The policy described the procedure staff must take in the event of a transfer/ retrieval. Data showed that there had been one transfer in the 12 months preceding our inspection. In case of an emergency transfer to another hospital, the CCU consultant on call would come in to support the unit or the transfer.

## Nurse staffing

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

- We found the CCU to be well staffed. Staffing levels were based on the Faculty of Intensive Care Medical Core Standards for Intensive Care Units. This states that all ventilated patients (level three) are required to have a registered nurse to patient ratio of a minimum of 1:1 to deliver direct care, and for level two patients a ratio of 1:2. Patient allocation records demonstrated critical care complied with the required staffing levels. Patients with additional care needs would be nursed by two nurses. There was a supernumerary nurse in charge for every shift, in line with standards for intensive care services, published by the Joint Standards Committee of the Faculty of Intensive Care and the Intensive Care Society (2013).
- There were nine whole time equivalent (WTE) members of qualified nursing staff who worked across critical care. These included the ward manager, a sister, five band 6 and two band 5 nurses.
- The CCU reported no vacancies at the time of inspection.
- Data provided showed a staff turnover rate of 8% for the 12 months prior to inspection.
- The sickness rate for September 2017 to August 2018 stood at 1%.
- New staff completed a period of supernumerary working supported by a mentor and were allocated a



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mentor to support them during the induction period. There were specific competencies in place that had to be signed off by their mentor before the staff member was able to work independently.

- Staff told us that any gaps in the shift cover were filled by regular bank and agency staff. Best practice guidance suggests no more than 20% agency staff should be used per shift. Nursing staff rotas we reviewed during the last inspection and this inspection, demonstrated the service was not always compliant with this standard. Data provided by the service indicated between December 2017 and November 2018, the bank and agency fill rate ranged from a low of 15% to a high of 53%. The CCU manager informed us two additional nurses had been recruited since the last inspection; the use of bank and agency was only to cover annual leave or staff training days.
- Bank and agency staff underwent an induction programme to ensure they were competent to care for patients. We were shown evidence of staff competency files.

## Medical staffing

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

- The CCU fulfilled all medical staffing requirements of Core Standards for Intensive Care. This was an improvement since last inspection.
- There were five intensive care consultants, all of whom also held NHS contracts working a 'one week in five' rota to provide 24 hours a day, seven day cover. There was a second on-call rota, with cover shared by these consultants. At the last inspection, we were not assured that there was appropriate consultant cover due to consultants working across two different hospitals at the same time. At this inspection, we found the unit had rectified this. The consultants we spoke with confirmed they had no other clinical commitments whilst on call and they were required to be able to reach the unit within 30 minutes. They performed ward rounds twice daily, meeting the Intensive Care Society Standards.
- Consultants worked under a practicing privileges arrangement. The granting of practicing privileges is an

established process whereby a medical practitioner is granted permission to work within an independent hospital. The medical advisory committee reviewed each application for practicing privileges and advised the hospital accordingly.

- There were three permanent CCU fellows. The rest of the CCU fellows were recruited via bank or agency. All CCU fellows either held NHS contracts or had previous experience in anaesthesia and intensive care. This met the Intensive Care Society guideline for ensuring there was immediate access to a practitioner with skills in advanced airway techniques.
- CCU fellows provided 24 hour, seven days a week cover on the CCU. The CCU fellows worked 24-hour shifts during the week. A senior ward manager told us that extended work time beyond 24 hours would have to be authorised by a member of the senior leadership team, and 48-hour shifts were only allowed at weekends. The CCU fellows we spoke with confirmed they did not work longer than 24 hours during the week. We reviewed the CCU fellows' rota for February, March, June and July 2018 and found it to be compliant, except on one occasion where a 48-hour shift occurred during the week in order to cover staff sickness. This was an improvement since last inspection, when we found several occasions where CCU fellows worked 48-hour shifts.
- Staff we spoke with confirmed that sufficient medical staff were available to care for patients.

## Records

**Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.**

- All documentation was paper based. We found patient records to be detailed and fit for purpose. They included multidisciplinary input and evidence of personalised care.
- We looked at five medical records and found daily documentation from nursing and medical staff about ward rounds, results, patients' progress and family discussions. All records included details of allergies, daily treatment plans and evidence of daily consultant reviews.

# Critical care

- Doctors and nurses could view patients' monitors with vital signs at the nursing station and staff escalated concerns as appropriate.
- Paper records were stored safely in locked cupboard by the nursing station.
- All nursing staff and full time CCU fellows had completed data protection training, against a hospital target of 100%.
- Staff demonstrated a good understanding of the need for confidentiality and we observed them using electronic password protection systems effectively to access blood test and imaging results.
- We reviewed paper-based prescriptions, which were written clearly. Medication administrations were signed for or coded and recorded as to why they were not given.
- We reviewed five paper-based prescription charts and saw they were fully completed, including details of any missed doses. Allergies were clearly documented and antibiotics were prescribed as per guidelines.
- The unit had made improvements since last inspection, as clear monitoring documentations were kept for the insertion of invasive lines.

## Medicines

**The service followed best practice when prescribing, giving and storing medicines. Patients received the right medicine at the right dose at the right time.**

- Medicines were stored securely in a locked cupboard and were available for patients when needed, including controlled drugs.
- A dedicated pharmacist spent time on the CCU daily to review medication plans and prescriptions. Pharmacists took part in regular departmental meetings and provided clinical input and advice to staff and patients.
- Controlled drugs (CDs) were stored in a separate locked cupboard. CDs were checked by two nurses and patient identification was confirmed prior to administration. We looked at the CD register, which was managed accurately. However, we found two boxes of diazepam tablets with missing expiry dates, as the flaps with expiry dates were ripped. We highlighted this to the CCU manager, who rectified it immediately and removed the boxes and informed the pharmacist.
- Some medicines were stored in fridges. Fridge temperatures were checked and monitored by an automatic system.
- All staff had access to the British National Formulary (BNF), as well as policies and information relating to medicines management, including the antimicrobial formulary.

## Incidents

**The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.**

- There were 56 incidents reported in CCU between December 2017 and December 2018. Of these incidents, 49 (87.5%) resulted in 'no harm' or 'minor harm', six resulted in 'moderate harm'. The hospital also recorded deaths as an incident. There was one unexpected death which was investigated as a serious incident.
- There had been no 'never events' reported in the service since 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 harm or death, but neither need have happened for an incident to be a never event.
- Staff we spoke with understood how to raise concerns and report incidents on the electronic incident reporting system. Lessons learned from incidents were shared during handovers, via emails and hospital newsletters.
- Staff were aware of the duty of candour. 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 reasonable support, truthful information and a written apology to that person.

# Critical care

- There were weekly complaints, legal, incidents, patient feedback and audit (CLIPA) hospital-wide meetings where all recent incidents were reviewed. Requirement for further investigations were discussed and identified in this multidisciplinary meeting.
- We saw a root cause analysis of the unexpected death that had occurred on the unit. The report contained clinical information, lessons learned and an action plan. For example, the unit changed its admission, discharge and transfer policy to ensure admitting consultant review the patient within two hours after their admission/transfer to critical care. The rectified policy also clarified the consultant's roles and responsibilities for dual care of patients within the CCU. The surgeon remained responsible for the surgical care whilst the critical care consultant had responsibility for overall case management.
- Senior leaders told us that due to low rates of mortality and morbidity (M&M) they did not hold separate monthly M&M meetings. Instead, this was incorporated as a standing item in the monthly CCU clinical governance meeting. Hospital-wide mortality review meetings were held on a responsive basis as needed. Cases were discussed and recommendations and actions would be assigned. We saw minutes of those meetings where patient cases were presented for the group to review and discuss.
- Between December 2017 and November 2018, there were no catheter-associated urinary tract infections (UTIs), no falls and no instances of venous thromboembolism (VTE). There were four incidents of hospital acquired pressure ulcers (grade 1-2).
- Staff were aware of their responsibility to reduce and report incidents such as falls, pressure ulcers and UTIs relating to the use of catheters.

## Are critical care services effective?

Good 

We have rated this service for the first time and we have rated it as **good**.

### Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.**

- Policies and procedures were available on the hospital's intranet page. Intensive care specific policies and procedures were up to date and referenced current best practice from a combination of national and international guidance. Staff showed us how they accessed these policies online, or within a policy folder. At the last inspection, we found that agency nurses were not be able to access these policies online so could only access policies via the policy folder. The hospital had rectified this by providing a generic log-in for agency staff to access clinical guidelines.
- The lack of critical care audits was highlighted during the last inspection. The service had since implemented a detailed local audit programme. This included care bundle audits, audits for pain/sedation/delirium, audit of nasogastric tubes and a sepsis audit.
- The Critical Care Unit (CCU) contributed to the Intensive Care National Audit and Research Centre (ICNARC) database for England, Wales and Northern Ireland. This meant care delivered and patient outcomes were benchmarked against similar units nationally.

### Safety Thermometer (or equivalent)

**The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.**

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as new pressure ulcers, catheter and urinary tract infections (CUTI and UTIs), falls with harm to patients and venous thromboembolism (VTE) incidence. The hospital did not use the NHS safety Thermometer as it was a private healthcare provider. The hospital monitored such harm to patients but this information was not openly displayed.

# Critical care

- The hospital used a sepsis screening tool and sepsis care pathway based on the 'sepsis 6', which is a national screening tool for sepsis.
- Lack of delirium assessment was highlighted at the last inspection. The unit has since made improvements. Staff used the Confusion Assessment Method (CAM), and patients were daily assessed for their level of delirium, as recommended by the Intensive Care Society Standards and NICE guidelines. Audit data of September 2018 showed 100% compliance rate with these assessments.
- Staff assessed patients' level of sedation using Glasgow Coma Scale (GCS) and the Richmond Agitation and Sedation Scale (RASS), which is a validated and reliable method in intensive care units.
- At the last inspection, we found no documentation to show the service was using and auditing care bundles. For example, there was no evidence of compliance with ventilation care bundles within patients' medical records. At this inspection, we found that the unit had introduced a comprehensive care bundle booklet, which included airway and ventilation care bundles. We saw evidence of completed booklets within patient records. Audit data from October 2018 showed 100% (two patients) compliance with the ventilation care bundle.
- We saw evidence in medical records of patients receiving physiotherapy as required by the Intensive Care Society Standards.

## Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.**

- Patients were enabled to eat or drink independently if possible. We saw that drinks were placed within patient reach.
- At the last inspection, we found that the service had access to an on-call dietitian who was based at another hospital. This provision was not compliant with the British Dietetic Association recommended numbers for WTE dietitians for the number of critical care beds that

were available. The British Dietetic Association recommends that there should be 0.05-0.1 WTE dietitian per 1 bed and that the lead dietitian for ICU should be at least a band 7. At this inspection, we found that the Dietitian services were provided via a service-level agreement (SLA) with a nearby hospital. Although the unit was not fully meeting this recommendation, we saw from patient records that the needs of patients were still being met. The lead dietitian informed us that all patients were seen within 48 hours of referral, in line with best practice. The lead dietitian was also part of the hospital-wide nutrition working group.

- We reviewed five patient records and found evidence of input from a dietitian in four out of five cases.
- Staff used a CCU nutrition scoring tool as part of the risk assessment. All five patient records we reviewed had comprehensive fluid balance monitoring on the daily care chart. At the last inspection, we found that staff did not audit the use of this tool. At this inspection, we found that a monthly 'nutrition and hydration' audit was carried out at hospital level. Between April 2018 and October 2018, compliance ranged from 91% to 99%.
- Staff told us if a patient required enteral feeding, it was started upon agreement of the CCU medical team. Enteral feeding refers to the delivery of a nutritionally complete feed, containing protein, carbohydrate, fat, water, minerals and vitamins, directly into the stomach.
- Total parenteral nutrition (TPN) was started upon agreement of the CCU medical team. TPN could be started out of hours or at weekends by critical care staff. TPN is the feeding of a person intravenously, bypassing the usual process of eating and digestion. The person receives nutritional formulae that contain nutrients such as glucose, salts, amino acids, lipids and added vitamins and dietary minerals.
- Staff could order hot meals on demand from the hospital kitchen. Relatives we spoke with told us that they enjoyed the food provided. All patients told us that the food was lovely and they had a menu to choose from.

## Pain relief

# Critical care

## **Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**

- Staff assessed pain using a numeral rating scale (NRS), where pain was scored between zero and 10 by the patient. We reviewed five patient records, which showed that staff used the standardised scoring tool to assess patients' pain and recorded pain assessments in patients' notes.
- Staff utilised a critical care pain observation tool (CPOT) for patients unable to report pain themselves.
- Pain was managed by the CCU clinical fellow and the consultant intensivist. The CCU manager informed us that since the last inspection, a nurse had attended a pain management course and was the pain management champion for the unit.
- The GMC recommends the 'Abbey Pain Scale' is used for people living with dementia. The unit did not use any specific pain scale for people living with dementia.

## **Patient outcomes**

### **Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.**

- The critical care service contributed data to the ICNARC database for England, Wales and Northern Ireland. This meant care delivered and patient outcomes were benchmarked against similar units nationally. ICNARC data quoted relates to the period from April 2018 to September 2018.
- The mean length of stay reported by ICNARC stay was 4.4 days, which was higher than other similar units (2.9 days). Data submitted showed that the risk of overstaying patients was on the unit's risk register. The CCU manager told us that an audit of all overstaying patients would be carried out in 2019 to review any trends and themes.
- Patients discharged 'out of hours' (between 10pm and 7am) were associated with worse outcomes and ICNARC data demonstrated the CCU unit was performing better than (0%) other similar units (0.5%).

- In the same reporting period, there were two unplanned readmissions (5.1%) within 48 hours from discharge, which was more compared to similar units (1%).
- According to the ICNARC report, there were 0% high-risk admissions from the ward. This was better compared to similar units (2.8%). There were less high-risk sepsis admissions from the ward (0%) compared to similar units (5.4%).
- There were no occurrences of non-clinical transfer to another unit in the same period. This was better than similar units (0.1%).
- The risk adjusted acute hospital mortality (Exponentially Weighted Moving Average Plot) was below calculated expected acute hospital mortality.

## **Competent staff**

### **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.**

- Absence of a critical care practice development nurse and lack of evidence of regular teaching sessions for nursing staff were noted during the last inspection. Since then, the hospital had developed a collaborative teaching programme with an NHS trust. All nursing staff had undertaken a four-week rotation in the CCU of the NHS trust to update and develop their skills. The CCU manager told us that the practice development nurse from the other NHS trust would be attending the hospital in January 2019 to deliver a further developmental course for the nurses. In addition to this, we saw evidence of teaching sessions run by the clinical fellow for nursing staff on key clinical topics.
- All staff completed an induction programme that ensured they were competent to carry out their roles.
- Bank and agency staff completed an induction programme to ensure they were competent to care for patients. We saw evidence of completed induction forms. All newly appointed bank staff worked a supernumerary shift for induction purposes. Relevant critical care competencies and skills were checked before employing agency staff and they were allocated to duties appropriate to their skill set. All bank and agency staff were required to be critically care trained.



# Critical care

- Seventy-one percent of the nurses held a post-registration award in critical care nursing. This was above the recommended minimum requirement (50%) of the Royal College of Nursing.
- CCU nursing staff completed additional clinical training required for their roles as critical care nurses. We reviewed training records and saw the majority of staff had up-to-date training.
- Staff had completed additional training in specialist equipment such as ventilators or invasive cardiac monitors.
- Data provided showed the appraisal rate for staff was 100%. Staff we spoke with told us that the appraisal process was used to identify areas for development and found that the process encouraged them to progress within their role.
- Nursing revalidation is the process by which registered nurses are required to demonstrate that they fulfil certain requirements to remain on the nursing register. Nurses told us that they had been helped through this process by the hospital and had been offered workshops, guidance and support.
- Consultants with practising privileges and CCU fellows had their appraisals and revalidation undertaken by the NHS trust they had contracts with.

## Multidisciplinary working

**Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.**

- The CCU policy 'admission transfer and discharge' clearly stated who would and would not benefit from admission to the unit. All staff we spoke with were clear about the admission process to the unit.
- There was a safety meeting every morning after handover, organised by the outreach nurse, and attended by all hospital RMOs. The team was made aware of critical patients in the hospital.
- We observed a nursing handover of care during our visit. The handover was given by the nurse in charge to all the nurses coming onto the next shift. A handover sheet was used to record any key information. The handover demonstrated good leadership, with each member of staff given clear responsibilities appropriate to their role.
- We observed no multidisciplinary team meetings (MDTs) during our inspection on CCU. Staff told us there were no formal MDT meetings planned. However, discussions between the consultant, nursing staff, pharmacist and physiotherapist occurred daily, as and when required, for each patient. We observed discussions between different disciplines and noted a friendly, relaxed and professional atmosphere, in which all staff were encouraged to participate and speak.
- All staff we spoke with said there was good MDT working between nurses, doctors and physiotherapists. Physiotherapists worked closely with ward staff to implement rehabilitation plans for each patient. We saw nursing staff and therapists working together to complete one patient's tasks and rehabilitation plan during the inspection.
- Physiotherapists were available every day and we saw evidence of physiotherapy assessments and therapy sessions in the five patient records we reviewed.
- The decision to discharge a patient from the CCU was made by the consultant intensivist in liaison with the admitting consultant. When patients were discharged to the ward, the CCU fellow provided a handover to the duty RMO. Nursing staff used a 'CCU ward transfer form' to document all details and printed this out to add to notes. We saw evidence of this in patient records we reviewed. The outreach nurse reviewed all recently discharged patients on the wards as part of a routine follow-up.
- Speech and language therapists were contracted to work for the hospital under a service-level agreement (SLA) and provided cover five days per week to see inpatients. The CCU fellow informed us that response time was between 12 and 48 hours, depending on the urgency of the referral. Telephone advice was also available.
- The CCU did not have a dedicated occupational therapist (OT). OTs were employed as bank staff members. Senior staff told us that although this did not meet the Faculty of Intensive Care Medical Core

# Critical care

Standards for Intensive Care Units recommendation (of 0.22 WTE OTs per level three bed), there were very few patients that required OT input. This was assessed according to individual patient need.

- The critical care outreach team (CCOT) provided clinical cover for patients triggering escalation thresholds according to NEWS, and other clinical emergencies. For example, patients experiencing cardiac arrest, as well as other medical emergencies, as well as the review of all CCU step-down patients.

## Seven-day services

- There was 24 hour, seven days a week CCU fellow cover for the CCU.
- A consultant intensivist was available 24 hours a day, seven days a week and was available to attend the unit within 30 minutes.
- Dietitians, speech and language therapy (SALT) services and occupational therapy (OT) services were available via a service-level agreement, from Monday to Friday. Dietitians and OTs provided services 8am to 5pm, whereas the SALT team saw patients between 8am and 8pm to accommodate a dinner meal assessment.
- Physiotherapy services were available seven days a week.
- Pharmacy services were available Monday to Friday between 8.30am and 6.30pm, and 9.30am – 5pm on Saturdays. There was an on-call pharmacist for out-of-hours support.
- Diagnostic imaging services were available 24 hours a day, seven days a week via an on-call radiographer.

## Health promotion

- We did not find any leaflets on smoking cessation, alcohol cessation or keeping fit that could be made available if a patient required. However, the CCU manager informed that once the patient was well enough, staff would offer smoking cessation advice and nicotine patches if appropriate.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.**

- Staff adhered to the systems in place to protect people from the risks associated with providing care and treatment without appropriate consent. Our review of patient notes found that in all cases, consent to treatment had been obtained and documented wherever possible prior to treatment and whenever a patient's condition changed.
- We reviewed five consent forms in patients' notes and all were completed correctly.
- Staff could tell us how they would obtain consent. Where consent could not be obtained, staff told us care was provided in the patient's best interest. The CCU fellow assessed the mental capacity and staff also routinely re-assessed capacity whenever a person's condition improved, in line with the guidance of the Mental Capacity Act (2005).
- Accordingly, 100% of CCU staff had received training in Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA). All staff we spoke with knew about the principles of DoLS and MCA. There was a hospital-wide policy on DoLS and the MCA. Staff knew how to access it.

## Are critical care services caring?

Good 

We have rated this service for the first time and we have rated it as **good**.

## Compassionate care

**Staff cared for patients with compassion.**

- Staff provided services in a caring and compassionate way.
- We saw staff treating patients and visitors with dignity and respect. Staff ensured patients' privacy and dignity was maintained, for example by putting privacy screens around beds when providing personal care. In the 2018



# Critical care

Patient Led Assessment of the Care Environment (PLACE), the hospital scored better than the national average for ensuring patients privacy and dignity was protected.

- We spoke with one relative who was very happy with the care on the unit and had no criticisms or concerns. We spoke with three patients who said staff made them feel comfortable.
- Physiotherapists encouraged patients with their rehabilitation in a supportive and positive way.
- The hospital collected patient feedback via a hospital-wide survey. In January 2018, 98% of patients said they would recommend the hospital to friends and family and 97% of patients described their care as 'excellent' or 'good'.
- We noted many 'thank you' cards and letters received from patients praising the care they had received during their stay in critical care. We saw a 'thank you' card from a patient stating: 'Thank you for your kindness, you are all quite amazing.'

## Emotional support

### Staff provided emotional support to patients to minimise their distress.

- The CCU nurse manager and hospital matron visited all patients individually on the unit to assess whether they had any concerns.
- Staff explained tasks before performing them on the patient to reduce anxiety. Staff would give reassurance to patients and relatives and offer their support.
- Patients had access to a psychologist if required.
- There was a multi-faith prayer room available for patients and relatives, open at all times.
- Though there was no chaplaincy service within the hospital, patients and relatives could request support with religious or spiritual needs.

## Understanding and involvement of patients and those close to them

### Staff involved patients and those close to them in decisions about their care and treatment

- We spoke with a patient who had been in the CCU for an extended period. They told us how satisfied they were with the care and treatment they had received. They felt treated with kindness and compassion and said, "Care from nursing and medical staff was marvellous".
- Discussions with patients and families were evident in all the notes that we examined, including in discharge planning, decisions to transfer to the ward and obtaining consent.
- Friends and relatives of patients said they were kept informed and involved with decisions where required. Relatives we spoke with said that they were updated about the patient on each visit to the unit.
- Patients could have support from family members and friends. Staff helped making them feel comfortable at the bed space.

## Are critical care services responsive?

Good 

We have rated this service for the first time and we have rated it as **good**.

## Service delivery to meet the needs of local people

### The service planned and provided services in a way that met the needs of people who accessed the service.

- The unit provided care and treatment primarily to patients after elective surgery and some medical patients. The unit did not take emergency admissions from other hospitals or critical care units. The unit could accommodate patients escalated from wards in the hospital if their condition deteriorated or unexpected complications occurred following planned surgery.
- The service provided by the unit was planned with the admitting consultant. Unplanned admissions to the CCU were referred to the consultant on duty and the ICU fellow, who were responsible for deciding whether patients should be admitted for care.

# Critical care

- The CCU could flex patient distribution to respond to patient need. For example, the CCU was intended to care for up to four patients. There were four beds, which staff said could be used as both level two and level three beds.
- ICNARC data from April 2018 and September 2018 showed that CCU primarily admitted planned admissions following elective/scheduled surgery (64.3%). Admissions from wards or intermediate care area represented 23.8% of admissions. There were no patients transferred from an emergency department and no unplanned admissions following elective surgery.
- Senior staff attended daily bed management meetings to plan patient admissions and discharges. Staffing levels were reviewed to ensure the correct skill mix was available to meet the needs of patients.
- Staff told us that a significant number of patients came from overseas and did not speak English. Staff could access interpreting services at any time. There was a full time Arabic liaison co-ordinator to liaise with families and embassies.
- Staff were aware of cultural differences and differing needs of patients and did their best to accommodate this. For example, female patients would be seen by a female physiotherapist if requested.
- We saw that food available catered for those with different nutritional requirements including those with food allergies, halal, kosher, vegetarian and vegan requirements. Patients spoke positively about the range of food available to them.
- Although the service did not treat many patients with complex needs, there were arrangements in place for this and staff had received training. Staff attended both dementia and learning disability training and a butterfly scheme was in use, which alerted staff to these patients. All staff we spoke with had good understanding of meeting the needs of patients living with dementia and patients with learning disabilities. The CCU manager was the dementia champion for the unit and had extra training in caring for patients living with dementia. We saw that a 'this is me booklet' had been introduced for patients with memory loss.
- Since the last inspection, the hospital had recruited a palliative care specialist consultant and one of the senior nurses had attended and completed a palliative care course. The end of life care policy had been reviewed and training had been provided to all current staff in best practice standards. This ensured that all patients being cared for at the end of their lives at the hospital had appropriate care and treatment by trained staff.

## Meeting people's individual needs

### The service took account of patients' individual needs.

- Patients told us that they felt safe on the unit and they had received adequate pain relief in a timely manner. One relative told us although there were set visiting times, staff were accommodating and they could visit or contact the unit anytime to receive an update about the patient.
- The facilities in the relatives and visitors' waiting area were well maintained and clean. There was sufficient comfortable seating available, with access to toilets. There was a machine with a selection of hot beverages and a water dispenser.
- A multi-faith room was available within the hospital. Though there was no onsite chaplaincy available. The hospital had access to multi-faith chaplains in the local community. Staff could access these via telephone if required for patients.
- We saw examples of where the hospital responded to individual needs of patients through a 'you said, we did' scheme. For example, patients wanted to be nearby while their relative was admitted to CCU. Relatives were now able to stay in the patient room on the ward while the patient was in CCU.

## Access and flow

### People could access the service when they needed it.

- The critical care unit had an admission policy and admission to critical care was usually agreed by the consultant on shift. For planned admissions, the admitting consultant had to book the admission to the critical care unit (CCU) via the hospital's admission office. The policy stated that at no time must a patient

# Critical care

be admitted to CCU without the consultant's permission, except in an emergency. In the event of an emergency, the hospital's resident medical officer (RMO) would instigate the admission with the CCU fellow.

- Since the last inspection, the unit had developed clear service-level agreements with neighbouring NHS trusts for acute cardiology and acute stroke patients. This was lacking at the time of last inspection.
- Between December 2017 and November 2018, there were 160 admissions and 156 discharges. There were four deaths reported by the unit during this period.
- Between September 2017 and August 2018, bed occupancy rates for level three beds ranged from 0% to 74%, with an average of 13%. For level two beds the occupancy rate ranged from 13% to 67%, with an average of 34%. There had been no identified instances of delayed admission to CCU in the same period.
- ICNARC data for April 2018 to September 2018 showed there had been no bed days of care followed eight-hour delayed discharges. This was in line with other similar units. This meant that no patient waited for more than eight hours once decision was made to discharge to a ward.
- During the same period, there had been no bed days of care following 24-hour delayed discharges. This was in line with similar units.
- There were two (5.1%) unplanned re-admissions to the critical care unit within 48 hours. This was worse than other similar units (1%).
- Data provided by the trust showed that no elective surgical procedures were cancelled in the last 12 months due to the lack of critical care beds.
- Recommendations from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units identify that patients should not be transferred to other units for non-clinical reasons. ICNARC data from April 2018 to September 2018 showed that there was no occurrences of non-clinical transfers to another unit in the same period. This was better than similar units (0.1%).

## **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.**

- Staff told us that, where possible, they would resolve any issues with patients informally, prior to a formal complaint being made. Any concerns raised by patients on the unit would be addressed immediately by a member of staff, or escalated to the clinical nurse manager.
- There had been one formal complaint relating to CCU in the last 12 months. The complaint was responded to within 20 days as per hospital policy. Actions and learning points from the complaint were shared with staff via the unit meeting.
- Complaints were recorded on the electronic incident reporting system. Complaints were discussed at the weekly CLIPA (Complaints, Legal, Incidents, Patient feedback, Audit) meeting. The Head of department shared information about complaints discussed at CLIPA at their departmental team meetings, to ensure shared knowledge and learning.
- Aside from CLIPA, complaints and any emerging themes were also reviewed at the Integrated Governance Committee, a sub-board committee. At this meeting, the heads of departments provided a report that included complaints and complements in their own areas, as well as the governance team providing an overall report on complaints. There was also a patient experience committee, chaired by the deputy matron, which reviewed all the patient survey feedback.
- A complaints leaflet was available in all areas which described the process should a patient want to raise a concern. There was information about how to contact the independent sector complaints adjudication service (ISCAS) if patient were unhappy about the outcome of their complaint. Patients and relatives we spoke with were aware of the complaints process and said that staff were always there to resolve any concerns.

## **Learning from complaints and concerns**

# Critical care

## Are critical care services well-led?

Good 

We have rated this service for the first time and we have rated it as **good**.

### Leadership

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

- There was a clear senior and ward management structure within the hospital. The director of nursing was commonly referred to as the matron. The matron line managed the clinical nurse manager. The service was actively looking for a deputy director of nursing at the time of our inspection. The chief executive officer (CEO) managed the overall running of the hospital.
- Clinical staff reported to the medical director who sat on the board and had oversight of the consultants and CCU fellows. The medical director's office took the lead on consultant's scope of practice and managed the human resource (HR) files.
- The clinical lead of the CCU worked closely with the nurse manager. They held daily conversations and formal meetings, at least monthly. Nurses and CCU fellows we spoke with felt well supported by the clinical lead and other consultants.
- Staff told us that managers were visible, approachable and supportive. The clinical nurse manager had her office within the unit and practised an open-door policy.

### Vision and strategy

**The service had a vision and strategy for what it wanted to achieve and workable plans to turn it into action.**

- The hospital had a vision to establish itself as the leading private hospital in the UK, with a focus on women's health, men's health, musculoskeletal and later life care, while supporting veterans through charitable work.
- At the last inspection, we found that there was no formal strategy in place to show the steps the CCU would take

to increase patient numbers. At this inspection, we found that there was a formally approved CCU strategy. The strategy had five key work streams including: staff development, to embed quality improvement within the unit, patient safety by building a culture of reporting incidents, increasing the number of staff and increasing revenue recapture.

- Staff knew how their work contributed to the overall vision of the unit and were aware of the plans for the CCU.

### Culture

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

- There was a strong team spirit and each member of staff said, in their opinion, their contribution was valued, which meant morale in the department was high. There was good team working between nurses and the unit manager. Nurses in charge and clinical leads were very committed to supporting their staff.
- We saw collaborative working between CCU, pharmacy and physiotherapy teams. Clinical fellows felt very well supported in their supervision. The CCU team worked well together, with consultants being available for doctors to discuss patients and to give advice.
- We noted staff were proud of the team dynamics and showed willingness to go the extra mile to deliver care.
- All staff we spoke with were passionate about providing empathetic care. Staff told us they enjoyed working in the department and all said everyone got on well. All staff spoke highly about their work and were able to contribute as part of the team. One member of staff said, "It's like a family."
- Staff understood the importance of being open and honest when things went wrong. Staff told us that there was a culture of 'no blame' should things go wrong. We were given an example of a serious incident and how the staff involved felt supported through the whole process. No one felt that they were to blame.
- At this inspection, we found that staff knew what duty of candour was and gave us examples when they had applied it previously. This was an improvement from the last inspection.

# Critical care

## Governance

**The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.**

- The hospital had clear governance structures and there were clear reporting lines from the unit to the board.
- The CCU clinical governance meeting minutes were shared amongst the team via email, and also kept in a folder by the nurse's station. We reviewed examples of meeting minutes and found incidents, audits, training or feedback were discussed. 'Mortality and morbidity' was a standing item on the agenda at these meetings.
- Since the last inspection, the hospital had introduced governance meetings to review incidents and share learning. These meetings were called Complaints, Legal, Incidents, Patient feedback and Audit (CLIPA) meetings. Senior staff informed us that complaints and incidents were reviewed and discussed at this meeting, which was attended by heads of department and executives. Incidents and complaints were also reviewed and discussed at the monthly Executive Committee and the quarterly Board meeting.
- The CLIPA meetings also reviewed audit results, recommendations to improve clinical practice. Information from CLIPA meetings was shared with staff during unit meetings. We saw meeting minutes in the staff information folder.
- The CCU clinical lead was a member of the medical advisory board, which reviewed applications for practising privileges and advised the Chief Executive (CEO).
- A Governance strategy for 2018-21 had been developed outlining improvements needed over the next three years. We reviewed the strategy document which focussed on embedding governance that was owned and valued by everyone.

## Managing risks, issues and performance

**The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**

- The management of the risk register was highlighted as an area of concern at the last inspection. Managers had

since then amended the content and made changes to the management of the local risk register for the CCU. Data submitted showed the CCU risk register was up to date and referenced ongoing risks. There were seven risks on the register, which were all relevant and reviewed regularly. All risk register items were given a colour coded RAG (red for high, amber for moderate or green for low) status, dependent upon levels of risk. The risk register was reviewed monthly at CCU governance meetings by the nurse manager and clinical lead and mitigating actions and updates were documented. Senior staff knew about risks in their department, which corresponded to items on the risk register.

- The absence of a clear critical care specific admission policy was highlighted during the last inspection. Since then, the admission policy had been updated to include clear exclusion criteria.
- The lack of performance monitoring was identified as an area of concern during the last inspection. Since then, a comprehensive clinical audit programme had been implemented, which was used to monitor services and compliance against national and local standards. Nursing staff participated in local audits, with the resulting information shared amongst teams to promote improvement.
- Managers audited unit compliance against Faculty of Intensive Care Medicine Core Standards. The self-assessment data submitted by the hospital showed progress notes and updates.

## Managing information

**The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**

- The intranet was available to all staff and contained links to current guidelines, policies and procedures. All staff we spoke with knew how to access the intranet and the information contained within.
- Staff we spoke with told us they could access the information they needed to provide safe and effective care. There were systems in place to manage and monitor care records.

# Critical care

- All staff had access to their work email and we were shown that they received organisational information on a regular basis, including clinical updates and changes to policy and procedures.

## Engagement

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

- From speaking with staff, reviewing the minutes of meetings and from our observations, we found that staff at all levels were able to provide feedback and input into the running of the service.
- Staff told us that appraisals were a useful process and development was positively encouraged. All staff told us they felt valued for the work they did and it was like a second family.
- CCU Staff survey results demonstrated 94% staff felt they worked as part of a team, 93% of staff said they were proud to work at the hospital and 92% of staff said that managers treated them with respect.
- Patients and relatives were asked to complete a feedback questionnaire about their experience in the

CCU. Relatives and one patient we spoke with told us that they felt involved in care and treatment decisions and that the level of information given to them was appropriate and very clear.

## Learning, continuous improvement and innovation

**The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.**

- At the last inspection, we had concerns around the sustainability of staff skills on critical care. Senior leaders identified concerns relating to staff becoming deskilled due to low occupancy levels of critical care patients within the service. There was no formal plan in place to mitigate this risk and no regular teaching sessions for staff nurses. At this inspection, we found that the unit had made improvements in this regard. There had been a collaborative teaching programme with an NHS trust. All nursing staff had been rotated to complete four weeks in the CCU of the NHS trust, which had upskilled the staff. The CCU manager told us that the practice development nurse from the other NHS trust would be attending the hospital in January 2019 to deliver a further developmental course for the nurses. In addition to this, we saw evidence of teaching sessions run by the clinical fellow for nursing staff on key clinical topics.



# Outpatients

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

## Are outpatients services safe?

Good 

Our rating of safe improved. We rated it as **good**.

### Mandatory training

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

- Staff received mandatory training on a rolling annual programme which was provided through a mix of classroom based sessions and e-learning. Topics included: moving and handling, safeguarding, hazardous substances, dementia, fire safety, infection prevention and control, conflict resolution, cyber security, information governance, consent, slips, trips and falls, data protection, health, safety and welfare, and equality and diversity. Data provided showed mandatory training completion rates for outpatient nursing staff were all 100% at the time of inspection.
- Basic life support training was part of mandatory training for all outpatient staff. Data showed 100% compliance at the time of inspection. Registered nurses and the clinical services manager were trained in immediate life support.
- The clinical service manager had oversight over mandatory training of all outpatient staff and sent reminders if necessary. Mandatory training completion was reviewed during regular one-to-one meetings with

staff and during appraisals. Staff told us they checked themselves if any training was due and that they were given sufficient time to complete training modules during working hours.

### Safeguarding

**Staff understood how to protect patients from abuse.**

- Safeguarding policies and procedures were in place. These were available for staff to refer to on the hospital's intranet. Staff were aware of their roles and responsibilities to safeguard people and knew how to raise matters of concern appropriately. There was a named safeguarding lead and staff were aware of them.
- Female genital mutilation (FGM) was included in safeguarding training and staff were aware of their responsibilities if they identified a patient who had undergone FGM.
- Data provided showed outpatient staff had 100% compliance with safeguarding training of vulnerable adults and children levels 1 and 2. Children were not treated in outpatient clinics; however, children could be in company of patients attending the outpatient department.
- There were chaperone signs throughout the outpatient department advising how to access a chaperone should patients wish to do so. Staff in the outpatient department undertaking chaperoning were staff nurses and health care assistants. The presence of a chaperone was documented in a logbook. All staff were aware of the chaperone policy and we saw evidence of completed training in this area.

# Outpatients

## Cleanliness, infection control and hygiene

### The service controlled infection risk well.

- All clinical and waiting areas we visited were visibly clean and tidy. We saw completed cleaning checklists dating back three months for all outpatient areas, as well as bright 'I am clean' stickers on equipment with information about when it was last cleaned. Disposable curtains in consultation and treatment rooms were dated when they were put up and when they were due to be changed. Personal protective equipment (PPE), such as gloves and aprons, were readily available to staff.
- There were sufficient hand wash basins and hand sanitisers available in all areas of the outpatient department. Posters with illustrated hand wash instructions were placed above each basin. We saw staff adhering to bare below the elbow (BBE) guidelines and being compliant with recommended hand hygiene practices.
- A monthly hand hygiene audit was carried out observing 35 members of staff in different outpatient areas. Results in June and July 2018 showed 92% and 97% compliance, respectively. As a result of audit results, additional hand wash posters were placed in various areas and staff were reminded of the BBE policy. Hand hygiene audit data showed improvement, with 99% to 100% compliance rates for the outpatient department in August 2018 to November 2018.
- The 2018 patient-led assessments of the care environment (PLACE) audit results for the hospital showed a score of 99.6% for cleanliness. This was better than national average (98.5%).
- We observed a patient (after obtaining consent) undergoing tests during an ophthalmology appointment. Staff wiped equipment clean in front of the patient before using it and washed and sanitised their hands appropriately.
- An infection prevention and control (IPC) nurse and microbiologist were available to support staff with any IPC issues.
- All clinical areas contained domestic waste and clinical waste bins. Clinical waste was contained in yellow bins and the lids were closed when not in use.

We saw that sharps bins in use were signed and dated and not overfilled. Waste emptied by clinical staff was stored in locked dirty utility rooms and collection was arranged through housekeeping. Waste awaiting collection by an external healthcare waste management company was stored in a holding bay area, which had clinical and domestic waste bin holders. Spill kits for bodily fluids or biohazard fluids were stored in the dirty utility rooms. A waste management audit was performed by an external provider in May 2018 and found the outpatient department compliant in all areas.

## Environment and equipment

### The service had suitable premises and equipment and looked after them well.

- All outpatient areas we visited were well lit and free from clutter. Consultation rooms were spacious, with a separate clinical area with an examination bed. Treatment rooms were locked and equipped with electric reclining chairs. Storage cupboards were organised and sufficiently stocked.
- There was a nurse call system in all consultation and treatment rooms and toilets, linked to screens in the reception areas and corridors. Consultants used the system to call for assistance or for the chaperoning service, for example.
- We saw equipment was labelled with information about the last safety testing date and next due date. The hospital's clinical engineering service kept a register of all equipment and when servicing was due. Consultants were only allowed to use their own equipment in clinics after registering it with the hospital and having it safety tested.
- The therapies department was spacious, with a waiting area offering hot and cold refreshments. The main gym contained curtained cubicles, gym equipment and an adjacent water pool with hoist. We saw clean towels ready for use, piped oxygen and Entonox, and cleaning equipment for treatment couches (such as antibacterial wipes). The hydrotherapy pool in the therapies department was maintained by the hospital's estates department, along with an external service contractor for the pumps and filters. The water quality was tested weekly by an external contractor with the results being sent to

# Outpatients

the heads of department for estates and infection control. Phosphate and chlorine levels were tested daily according to hospital policy. The estates department arranged six-monthly service days, where all equipment was serviced and the pool was deep cleaned by hospital housekeeping staff.

- Emergency resuscitation equipment was stored in various areas within the outpatient department. Resuscitation trolleys were located in all outpatient buildings and were checked daily, in line with national resuscitation council guidelines. The multi-storey outpatient building was equipped with additional wall mounted and portable oxygen, as well as automatic external defibrillators on the first, second and third floor. Additionally, there were emergency grab bags. We saw evidence of weekly defibrillator and oxygen tank checks on each floor.

## Assessing and responding to patient risk

### Staff completed risk assessments for each patient.

- Staff knew in advance what patients were attending clinics that day. All new patients filled in a health questionnaire. Patients requiring additional assistance or support were highlighted in the electronic patient file and on the daily list of attendance. Front door staff would escort patients to the appropriate outpatient area if required.
- The hospital staff were aware of patients' needs and what to do in case someone deteriorated. If a patient checked in at the reception desk and looked unwell, the front of house team would alert a staff nurse or the clinical services manager. If a patient was identified as deteriorating, staff nurses would use the national early warning score (NEWS) and sepsis screening tool to monitor the patient and record their observations. They would inform the patient's consultant and escalate to the crash team if appropriate.
- All clinical rooms were equipped with an emergency call system. The cardiac arrest call system in the outpatient building was connected to the hospital's critical care unit, meaning the CCU fellow could be easily reached in an emergency situation. The separate outpatient building adjacent to the main hospital had direct access on two floors. Staff in the Veteran's Centre pulled the cardiac arrest bell and

contacted 999 in case of a cardiac arrest. All staff we spoke with knew the crash call process. Staff were able to describe the procedure of what to do if a patient suffered from a cardiac arrest or anaphylaxis.

- There was a hydrotherapy operational policy, which contained contraindications against hydrotherapy pool use. Physiotherapy staff working in the hydrotherapy pool were trained in the hydrotherapy evacuation procedure and hoist use, in case a patient became unwell in the pool. Data provided showed evidence of staff competencies in this area.

## Nurse staffing

**The service had staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. However, the rate of bank staff was high.**

- Outpatient clinics were covered by three members of staff, with at least one of them being a registered nurse, supported by health care assistants (HCAs). The clinical services manager was supernumerary but was 'hands on' and would support a clinic if needed. The service was staffed with 1.2 whole time equivalent (WTE) outpatient nurses and two HCAs. There was a 0.3 WTE nurse post vacant at the time of inspection and no vacancies for HCAs. A regular outpatient bank nurse covered vacant shifts, as well as annual leave or study leave days.
- Total use of bank staff in June to December 2018 varied between 31% and 37%. The rates of use of nurse bank staff varied from 14.9% to 37% in the same period, with bank HCA use ranging between zero to 17%. Increased rates in November (37%) and December (34%) for nurse bank staff were explained by the unavailability of HCA bank staff during those months. The service did not use agency staff.
- There had been no unfilled nurse shifts from June to December 2018.
- Staff turnover rate from September 2017 to August 2018 was reported as zero.
- Nursing staff sickness rate from June to December 2018 was reported as zero.

## Medical staffing

# Outpatients

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

- Consultants worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. Consultants were invited to join the staff at the hospital following identification of suitability via the Consultant Selection & Review Committee (CSRC). Approval was required at the medical committee, before the medical director sent a formal letter of invitation. Most consultants with practising privileges had their appraisals and revalidation undertaken by their respective NHS trusts.
- The hospital's decision-making group (DMG) had oversight of the conduct and performance of consultant working in the outpatient department. The DMG oversaw the handling of any concerns raised about an individual clinician, ratified decisions on revalidation of doctors, and reviewed performance of individual practitioners across their scope of practice.
- The breast centre was set up with eight breast surgeon consultants and seven radiologists, who worked in the breast unit exclusively and undertook ultrasound guided biopsies.

## **Records**

### **The service had improved their medical record keeping system which contained information of patients' care and treatment and staff had access to it.**

- Record keeping was highlighted as an area of concern during last inspection. Since then, the service had implemented improvements to make patient data more accessible. Medical information was kept on an electronic patient record system that all staff had access to. Consultants dictated clinic letters after each patient appointment, or filled in a medical documentation sheet provided by the hospital. The clinic letter contained information about the patient interaction, assessments, medication prescribed and treatment provided by the consultant. Those documents were then scanned into the electronic

patient record system. The provision of a summary of the patient consultation was made a requirement in the terms and conditions for all consultants using outpatient facilities. Non-compliance would lead to removal of practising privileges. The service had commenced an audit on compliance with provision of documentation. Results showed compliance rates between 66% and 76% between May and August 2018. All non-compliant consultants had been addressed individually. Consultants we spoke with were eager to cooperate with guidelines.

- Each consultant's secretary was responsible for the production and sending of the letter within two weeks. If they were not received, staff would raise this with the consultant or their medical secretaries. Patients always received a copy of the letter for their own records and could share it with their GP.
- We reviewed 10 electronic patient records and most contained a complete summary of the consultation. However, one document was found to be incomplete. In addition to the consultant letter, all minor procedures performed within the outpatient department were registered in a logbook. Specimens obtained during minor procedures and sent out to external laboratories were registered in a separate logbook.
- Patient information was stored securely and we found no patient identifiable documentation or information openly displayed during inspection.

## **Medicines**

### **The service followed best practice when prescribing, giving, recording and storing medicines.**

For our detailed findings on medicines please see the safe section in the surgery report.

- All medicines in the outpatient department were stored securely in locked cupboards in locked rooms, enabling only authorised personnel to enter. There were no controlled drugs stored in the outpatient department. Controlled drugs were prescribed and acquired from the hospital pharmacy if required.

# Outpatients

- The drug fridges and drug room temperatures were monitored electronically. Senior staff would be alerted via email in case temperatures were out of range. We saw medicines rooms and fridge temperatures were within recommended range during inspection.
- Consultants used hospital prescription pads to write prescriptions, which patients could fill in any external pharmacy. Prescription pads were stored securely in a locked cupboard in a locked room. Each consulting room was assigned a different numbered prescription pad, which would be signed out and handed to consultants when clinics started. The use of prescription pads was documented in a logbook.
- Incidents were reported using an electronic reporting system. Staff could tell us how to report incidents and felt encouraged to do so. We saw an example of a thorough investigation started after a reported incident.
- Incidents were discussed at various regular hospital governance meetings. Learning from incidents was cascaded through departmental team meetings. We saw evidence of this in meeting minutes. Outpatient staff we spoke with could provide examples of recent incidents and learning as a result of these.
- 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 reasonable support to that person. The hospital provided a duty of candour booklet for staff to raise awareness and understanding in this area. Duty of candour requirements were part of the incident and serious incident policy and procedures, which were available on the hospital intranet. All staff we spoke with were aware of the duty of candour and could give us examples of when professional duty of candour was applied. For example, after a patient had to return to have tests repeated as initial specimens were not correctly labelled. There had been no recent incidents when statutory duty of candour had to be applied.

## Incidents

### The service managed patient safety incidents well.

- There were no 'never events' reported in the period December 2017 to November 2018 specific to outpatient services. 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.
- No serious incidents were reported for outpatient services in the same period. A serious incident requires investigation and can be identified as an incident where one or more patients, staff members, visitors or member of the public experience serious or permanent harm, alleged abuse or a service provision is threatened.
- There were 54 clinical incidents reported for outpatient services in the period between December 2017 to November 2018. Most incidents (37) caused 'low' or 'no harm' and 11 were categorised as 'near misses'. One incident resulted in 'moderate harm'. Themes were pathology related (meaning samples not arriving at the external laboratories or results not being available), data documentation errors, medication storage issues, communication problems or related to environment.

## Emergency awareness and training

### The service had plans in place in case of an emergency and staff were aware of them

- The service had contingency business plans in place in case of an emergency. Each department stored a copy of the business continuity plan. Staff had awareness of what actions they would take in the event of a major incident, including a fire. According to data provided, 100% of all outpatient staff had completed fire safety training. We saw fire evacuation plans throughout the department and staff were aware of them.
- Department specific evacuation procedures and department specific business continuity plans were available. Staff knew where to access these.



# Outpatients

Emergency evacuation chairs were installed within multi-storey outpatient buildings for mobility impaired people. Data provided showed 100% of outpatient staff had completed training for this.

## Are outpatients services effective?

Good 

We do not rate effective in outpatient services.

### Evidence-based care and treatment

#### The service provided care and treatment based on national guidance and evidence of its effectiveness.

- Policies and procedure guidelines relevant for outpatient services were accessible for staff on computers, stored in a shared document folder. The policies we sampled were aligned to national guidance and were in date, with review dates noted.
- The outpatient department undertook monthly consent form and hand hygiene audits as part of the regular audit programme. The breast centre undertook a pathology documentation (to ensure results were sent and received) and a WHO (World Health Organisation) checklist audit. Results showed 99.8% and 100% overall compliance respectively, in June to November 2018.
- The clinical services manager had developed a minor procedure pathway for outpatients, which was in the process to be rolled out at the time of inspection. It included allocated sections for the medical history, vital signs, WHO checklist, procedure details, discharge checklist and wound management.

### Nutrition and hydration

#### The service provided nutrition and hydration

- Patients had access to hot and cold beverages at all times in waiting areas. Biscuits or sandwiches could be obtained for patients if required.

### Pain relief

#### Staff assessed and monitored patients to see if they were in pain.

- A pain management clinic was set up in the Veteran's Centre, employing a team of consultants in pain medicine and clinical psychology, clinical nurse specialists and physiotherapists. They worked together to treat veterans suffering from chronic pain (often in association with post-traumatic stress disorder). Objectives of the pain management programme were: to help veterans to improve their mood, to develop a better understanding of their pain and to increase levels of meaningful activity, self-management skills and overall quality of life.
- Consultants assessed patients in their clinics and administered or prescribed pain medication accordingly. Patients received local anaesthesia for minor procedures performed in the outpatient department.
- The hospital's resident medical officers could be used to assess patients and prescribe pain relief in cases requiring urgent attention.

### Patient outcomes

#### Managers did not monitor the effectiveness of care and treatment.

- The service did not provide evidence of benchmarking against other similar organisations or NHS trusts, or monitoring patient outcomes for outpatients specifically. However, the clinical services manager had plans to align the service with a local independent hospital to share best practice and compare outcomes.

### Competent staff

#### The service made sure staff were competent for their roles.

- Nursing staff and health care assistants we spoke with confirmed they were encouraged to undertake continual professional development and were given opportunity to develop their skills and knowledge through training relevant to their roles. For example, they could undertake wound care training. A practice development nurse supported staff in their training. Regular wound care, diabetes and pain management study days were organised for staff to attend.



# Outpatients

- All new staff attended an induction at a local level at the hospital, before they were allowed to begin working. The human resources department within the hospital ensured all training and revalidations were correct and up to date.
- The hospital employed clinical nurse specialists for breast care, fertility, endometriosis, urology, orthopaedics and pain who worked in the outpatient department in specialised clinics. These advanced practice nurses provided expert advice related to specific conditions or treatments. They worked alongside consultants, performing various tests in clinics and offering advice and support to patients.
- The clinical service manager appraised staff's work performance and held regular supervision meetings with them to provide support and monitor the effectiveness of the service. We saw evidence of staff appraisals and according to data provided, appraisal rates were 100% for outpatient staff.
- All consultants working at the hospital had practising privileges which gave them the authority to undertake private practice within the hospital. The hospital practising privileges review process was annual and included a review of the consultant's scope of practice. This ensured the hospital had oversight of their ability to practice.

## Multidisciplinary working

### Staff of different kinds worked together as a team to benefit patients.

- There were good working relationships between consultants, nurses and allied health professionals. Members of the physiotherapy team worked with consultants in the orthopaedic clinics or in the pain management programme.
- Consultants of different specialities worked together to achieve optimal results for patients. For example, pain management consultants and clinical psychology consultants worked closely in the Veteran's Centre.
- The breast centre held monthly multidisciplinary team (MDT) meetings to review patient cases, both prospectively and retrospectively. The team discussed complex cases and recommendations and patient

communication were documented in the hospital medical records. We saw terms of reference for the breast centre MDT meetings, which were reviewed annually.

## Seven-day services

### The service operated over a five-day period.

- The service provided clinics Monday to Friday, 8am until 8pm. There were no regular weekend clinics. However, staff told us about occasional Saturday morning clinics or planned late appointments during the week.

## Health promotion

### Health promotion material was available.

- The physiotherapy service offered treatment for patients in the hospital gym and hydrotherapy pool. Individual or group sessions helped patients improve strength, mobility and independence.
- Most patient information leaflets were held by consultants' secretaries and were sent to patients prior to appointments. Hospital staff had access to various patient information leaflets on the intranet and could print them off to hand out a copy if required.

## Consent and Mental Capacity Act

### Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

- Mental capacity and Deprivation of Liberty Safeguards (DoLS) policies were available on the hospital's intranet. Staff we spoke with were aware of the Mental Capacity Act (MCA) 2005 and its implications for their practice, although they told us they rarely saw patients with mental capacity issues in their service. Training in MCA was covered in the consent course module, which all outpatient staff had completed at the time of inspection.
- The hospital had a consent policy in place and staff were aware of it and knew how to access it. Consent was obtained prior to the delivery of care and treatment. Written consent for minor procedures was obtained by consultants. We saw examples of this.

# Outpatients

- A consent audit for minor procedures in the outpatient department was performed monthly. Ten randomly selected consent forms were reviewed against agreed audit criteria, representing approximately 25% of the total number of procedures carried out per month. Results were reviewed at CLIPA (complaints, legal, incidents, patient feedback, audit) meetings, audit and standards committee meetings and at outpatient departmental meetings. Results showed 92% and 96% compliance rates for October and November 2018. The compliance rate was 87% in September. This was due to patients not having received a wound care information leaflet and not receiving a copy of the consent form. As consequence, a generic wound care information leaflet was developed to be distributed and staff reminders were sent out.

## Are outpatients services caring?

Good 

Our rating of caring stayed the same. We rated it as **good**.

### Compassionate care

#### Staff cared for patients with compassion.

- We observed staff addressing patients and visitors in a polite and friendly manner and actively offering their assistance.
- The outpatient department collected local patient feedback using a patient satisfaction questionnaire specific to their service. We saw these leaflets throughout the department for patients to pick up. Part of the questionnaire was to ask patients how likely they would recommend the hospital to friends and family. In April to June 2018, 89% of participants (143) were extremely likely or likely to recommend outpatients services to friends and family. In June to September 2018 only 36 patients (<1% response rate) participated in the survey and 100% were extremely likely or likely to recommend the service to friends and family.
- Patient satisfaction results for the outpatient service in April to June 2018 showed that 97% of patients rated consultants as 'excellent', 96% rated outpatient nurses

as 'excellent', 100% rated specialist nurses as 'excellent' and 93% rated physiotherapy as 'excellent'. Including the respondents who answered 'very good' to these same questions, all rates stood at 100%.

- Patients' privacy was respected and we observed closed doors when having consultations or treatment. Staff respectfully knocked on doors before entering consulting rooms. This enabled a safe atmosphere for patients and allowed confidential conversations to take place. Patient feedback data from January to September 2018 showed that 100% (231) of participants felt they were given enough privacy when discussing their treatment or condition, and 99% felt treated with dignity and respect during their visit.

### Emotional support

#### Staff provided emotional support to patients to minimise their distress.

- Nursing staff provided emotional support to patients in the outpatient department. Staff explained how they gave patients time in a quiet environment when needed. We saw separate quiet areas were available throughout the department for confidential conversations.
- Staff told us how they would support each other as a team, including consultants, in stressful situations.
- The breast care unit recommended a local breast cancer support centre and provided leaflets to patients to help cope with emotional effects of breast cancer.
- There was a multi-faith prayer room accessible in the hospital for patients and staff.

### Understanding and involvement of patients and those close to them

#### Staff involved patients and those close to them in decisions about their care and treatment.

- Patient feedback data showed that 100% (143) of respondents in April to June 2018 felt they were given all the information they needed during their visit, and 99% agreed they were given answers in a way they could understand.

# Outpatients

- Patients were informed about fees before visits through consultants' secretaries when making appointments.
- We observed a patient giving his consent during an ophthalmology appointment. The technician and the ophthalmologist fully explained in a friendly and professional way the tests and the results to the patient beforehand.

## Are outpatients services responsive?

Good 

Our rating of responsive stayed the same. We rated it as **good**.

### Service delivery to meet the needs of local people

#### The service planned and provided services in a way that met the needs of local people.

- The waiting areas were furnished to a high standard and provided sufficient comfortable seating. There was a range of free hot and cold beverages available, as well as newspapers and magazines to read.
- There were 11 consulting rooms in the outpatients building and six additional rooms in the main hospital building. All were spacious and appropriately furnished, with a separate clinical area and hand wash facility.
- The orthopaedic clinic employed a member of staff to escort patients from the reception area to clinic rooms or imaging department. This helped patients finding their way around the building.
- The outpatient department offered occasional Saturday morning clinics or late evening clinics to 9pm. Staff told us that this was well received by patients. This allowed easier access for patients who worked during the week.
- The breast unit offered a one-stop service for patients, which included consultation, ultrasound, mammography and biopsy if required. Radiologists dedicated to the breast unit reported images immediately.

- There was adequate signposting and good lift access in all outpatient areas.

### Meeting people's individual needs

#### The service took account of patients' individual needs.

- Secretaries and staff would enquire if patients had special needs or required additional support when booking appointments. This allowed staff to make arrangements ahead of visits.
- Staff told us they would come in earlier or stay late if a patient requested this, to accommodate their work or travel schedule, for example.
- The hospital had a document called 'this is me' for dementia patients. This document recorded details about the patient, their preferences, their likes and dislikes, specific memories, and other personal details. This was to help staff care for, and treat the patient in a way that they would wish, as the patient may not always be able to make this known to staff.
- Patient-led assessments of the care environment (PLACE) put patient views at the centre, using information from patient assessors to report how well a hospital is performing in different areas. Hospital-wide results for 2018 showed scores of 92.5% for dementia and 94.7% for disability, both better than national average (78.9% and 84.2%).
- The clinical services manager and business manager of outpatient services were members of the hospital's 'patients with additional support needs' group, which discussed how to improve services. We saw meeting minutes with action plan. Learning disability training had been organised for hospital staff to act as learning disability champions in their departments.
- The outpatient department offered hearing loops for patients with hearing impairment. Deaf awareness and visual awareness training was offered to staff.
- The Veteran's Centre offered a pain management programme for veterans, which was tailored to specific needs of individuals and veterans. The group room was equipped with bean bags to provide comfortable seating for veterans with disability or chronic pain.

# Outpatients

- The physiotherapy team told us how they would accommodate to female patients' preference to be treated by a female physiotherapist.
- There was wheelchair access to outpatient areas and disabled toilets were available.
- Interpreting services were available through an external organisation and staff knew how to access these.

## Access and flow

### People could access the service when they needed it.

- Patients could book appointments over the phone through individual consultants' secretaries, where a confirmation email would then follow. The secretaries provided a list of booked patients to the outpatient reception team 24 hours before clinics took place.
- Nursing and reception staff told us that patient waiting times to be seen after arriving in the clinic were usually short and aimed to be less than 15 minutes. This was not audited. However, staff told us most patients were seen straight away or within few minutes. During inspection, we did not observe patients sitting in waiting areas of the outpatient department. Patients we spoke with and patient feedback data confirmed short waiting times. Patient feedback results from April to June 2018 showed that 95% of participants (130) answered they were seen early or on time of their appointment.
- Patients could access the breast unit through self-referral, outlined in the hospital's self-referral mammography policy. All patients filled in a mammography patient questionnaire and were given a verbal result before leaving the unit.
- Data provided for 2018 showed that 11% of booked outpatients appointments had been cancelled, mostly initiated by patients. The percentage of did not attend (DNA) was 3.9%. For cancellations, re-booking was offered to patients and staff would try to accommodate last minute arrangements for appointments.

## Learning from complaints and concerns

### The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

- Complaints were dealt with by staff verbally in the outpatient department in an attempt to resolve issues locally and informally. If this was unsuccessful, staff would escalate issues to the clinical services manager or director of nursing.
- We saw leaflets with information on how to make a complaint. The leaflets detailed the complaint process and how to contact the Independent Sector Complaints Adjudication Service (ISCAS) if patients were not pleased with the hospital response.
- There had been 10 formal complaints in the outpatient department in the 12 months prior to inspection. All had been formally responded to within the time scale set by the hospital and eight complaints had been upheld or partially upheld. None had been referred to ISCAS. Complaints received were about delayed appointments, payments and care and treatment. All formal complaints were investigated and discussed in meetings at various levels. We saw evidence of this in meeting minutes. For example, complaints were discussed in monthly departmental team meetings.

## Are outpatients services well-led?

Good 

Our rating of well-led improved. We rated it as **good**.

## Leadership

### The service had newly appointed a manager with the skills and abilities to run a service providing high-quality sustainable care.

- The outpatient department was a separate department, led by a clinical services manager together with a business manager. The clinical services manager reported to the director of nursing. At the time of inspection, the clinical services manager had been in post for six months and demonstrated a sound knowledge of performance in their area of responsibility. They were aware of risks and challenges to the service.

# Outpatients

- Staff felt valued and supported by local leaders and found them to be approachable and visible. The clinical services manager was 'hands on', and highly valued by staff for very good leadership skills and support.
- Staff were aware of the executive team and told us about good communication, especially with the director of nursing. Staff told us the director of nursing was visible and approachable, visiting outpatient areas daily.

## Vision and strategy

### The service had a vision for what it wanted to achieve and workable plans to turn it into action.

- The service's vision was to provide an outstanding outpatient service. This was aligned to the hospital's vision to be the leading private hospital in the UK and to support an increased number of veterans through charitable work.
- The mission statement for the outpatient department was to provide exceptional outpatient care, whilst maintaining a safe and caring environment for all that exceeded expectations. The hospital values were: professionalism, quality, respect, safety and teamwork. Staff incorporated these values into their daily performance.
- Senior management told us about plans to expand outpatient services by recruiting new consultants, extending clinic hours and a relocation to a bigger facility by 2020. We saw documentation of this in the departmental business service plan. Staff showed us the building site with works in progress for the new outpatient building.

## Culture

### Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

- The clinical service manager and staff we spoke with had a strong commitment to their role. They were proud of the team working, quality of care, positive impact on patient care and experience, and improvements they had made to the service since the last inspection.

- Staff expressed high job satisfaction and it was clear from talking to staff that there was a good working relationship between staff of all different levels. There was a good sense of teamwork and people helped each other out.
- Outpatient nurses said they enjoyed the variety of working with consultants in different specialities and assisting in minor procedures. Staff attended monthly team meetings and data showed meetings were well attended.
- Staff felt supported in their work and said there were opportunities to develop their skills and competencies, which managers encouraged. Staff told us they felt valued and supported by colleagues and managers.
- The hospital undertook a culture survey in August 2018. The response rate of staff fell below expectations and a repeat study had been planned for Summer 2019. Response rate for outpatients' staff was 25%, which was higher than hospital average of 21%. The questions were focussed on incident reporting, attitude to blame, perceived consequences of admitting mistakes, organisational response to problems and sharing of experience. Results highlighted areas for improvement around incident reporting and current work procedures. We saw an action plan resulting from findings of the study.
- There was a whistleblowing policy available on the hospital's intranet and a freedom to speak up guardian available for staff to contact. Senior managers told us the service was committed to continuously improving patient safety and staff experience by ensuring that all staff could speak openly about things that went wrong or the things that worried them.
- All staff were entitled to free meals in the hospital restaurant.

## Governance

### The service had improved governance processes to maintain high quality of care by creating an environment for excellent clinical care to flourish.

- Governance was highlighted as an area for improvement during last inspection. Since then, the hospital had appointed a director of governance and



# Outpatients

patient safety and risk lead to manage and improve governance processes. Complaints, legal, incidents, patient feedback, audit (CLIPA) meetings had been introduced to review governance data, timeliness of investigations, shared learning and improve monitoring of actions and improvements. The outpatient clinical services manager attended CLIPA meetings and shared information at departmental level. All staff CLIPA meetings were held monthly.

- Governance issues related to outpatient department were presented in quarterly reports to the integrated governance committee. We reviewed examples of reports, which contained a fixed agenda with topics such as departmental risks, audit results, incidents, complaints or issues related to staffing.
- Outpatient managers attended monthly senior clinical team meetings where governance issues were discussed. Departmental team meetings for all outpatient staff were scheduled monthly and were chaired by the business manager. We saw meeting minutes with a structured agenda and action points. Staff discussed current issues and shared information. Meeting minutes were emailed to staff and were available to read in a shared folder.
- The clinical services manager used daily staff meetings in the morning to share information and updates.
- The hospital's decision making group (DMG) provided assurance of appropriate management of concerns to maintain safety and quality in terms of medical practitioners. The DMG was chaired by the medical director and reported to the board. Other members were the chief executive officer, the responsible officer or chair of the medical committee, the director of nursing and the director of governance in an advisory role. The DMG met quarterly and agenda items included: updates on ongoing investigations, ratification of revalidation decisions, performance review of consultants, or updates on any new national guidance.
- A monthly hospital newsletter 'Governance Gazette' informed all staff about updates, learning from

incidents or upcoming events. A separate newsletter 'The Consultant' was produced to keep all doctors with practising privileges regularly informed and updated.

## Managing risks, issues and performance

### **The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.**

- The service had clear processes and systems in place for identifying and mitigating risks. The business manager and clinical services manager reviewed the risk register for the outpatient department monthly.
- We saw the departmental risk register, which contained description of risks, controls in place, further control measures, progress notes and dates for re-assessment. Each risk was rated in red, amber or green and had a named handler. The clinical services manager named and discussed departmental and hospital-wide risks with us during the course of the inspection. A risk management policy was available on the hospital intranet. We saw risk assessments were undertaken and covered all aspects of the service, staff, environment and equipment. Risks were discussed at departmental team meetings and at the integrated governance meetings. High risks were escalated to the hospital risk register.
- The outpatient department, including the Breast Centre, performed monthly local audits to monitor and improve quality of service.

## Managing information

### **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**

- Staff used King Edward VII hospital's computer systems to access hospital policies and resource material. Each member of staff had their personal log-in information to access the systems. During inspection, we saw staff logging off before leaving computers and we did not see unlocked computer screens. This prevented unauthorised access to data.



# Outpatients

- Staff had access to electronic patient records on the hospital's computer systems. Paper documents were scanned into the electronic system by staff in medical records and then destroyed.
- Information governance, general data protection regulation, internet, email and social media and cyber security were part of mandatory training. Data provided showed 100% compliance of outpatient staff with this training.

## Engagement

**The service engaged with patients, staff, and the public to plan and manage appropriate services. However, survey response rates did not always meet expectations.**

- Patient views were actively sought within the outpatient department with local patient satisfaction questionnaires. We saw forms available for patients and visitors throughout the department. However, the number of responses did not always meet expectations and only 36 patients participated in the survey between June and September 2018 (with approximately 2000 patients being seen in the outpatient department every month).
- Results from the hospital-wide employee engagement survey, carried out in 2018, reflected answers from 127 employees. However, only 57.5% of participants were clinical staff (69) and only one outpatient department staff participated in the study. Of these participants, 84% agreed they felt part of a team, with a further 94% feeling proud to work for King Edward VII's Hospital. However, 44% of participants did not agree that communication in the hospital was good, and a further 34% did not find the senior management team

available and visible. Our interviews with staff with during inspection did not reflect these negative results, but instead highlighted good communication with the director of nursing.






- We saw notice boards for staff and visitors with information about the service, including the 'you said, we did' initiative. This was where the hospital management team fed back the changes they had made, based on contributions by patients.

## Learning, continuous improvement and innovation

**The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.**

- There were plans for the future sustainability of the hospital which included a new and upgraded outpatient centre, due to open in 2020.
- The service offered Faecal Immunochemical Tests (FITs) in place of faecal occult blood tests. According to data provided, FITs are clinically more sensitive for cancers and advanced adenomas with high patient acceptance and participation rates. GPs could request FITs for their patients, or patients could access the service directly. All results were reviewed by a colorectal clinical nurse specialist, who called every patient directly to provide advice and counselling.
- The service offered Daylight Photodynamic Therapy as a different way to treat actinic keratoses lesions. The treatment takes advantage of a reaction which occurs between daylight and topical methyl aminolevulinate cream, which creates a chemical reaction, resulting in destruction of the tumour cells without harming surrounding healthy skin.

# Diagnostic imaging

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

## Are diagnostic imaging services safe?

Requires improvement 

We rated safe as **requires improvement**.

### Mandatory training

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

- Staff we spoke with said they completed mandatory training. Data provided by the service showed 96% (approximately 13 out of 14) staff in diagnostic imaging were up to date with their mandatory training.
- The service manager monitored uptake of staff mandatory training through a spreadsheet they maintained which was RAG (red- expired amber-due green-in date) rated.
- Staff were aware they had a responsibility to ensure they were up to date with their mandatory training and the service manager prompted staff if they were due an update.
- The hospital had 21 mandatory training modules for staff to complete, of which nine were updated annually, including: moving and handling, dementia, fire and health and safety. This was in order to comply with local policies and national legislation.
- The service ensured staff administering radiation were appropriately trained to do so. Those staff without training received adequate supervision in accordance with legislation set out under Ionising Radiation

(Medical Exposure) Regulations 2000 (IR(ME)R) to work in the radiation field. We saw records which confirmed this. This ensured staff could safely perform examinations involving radiation to keep patients safe. We also saw evidence to indicate all staff had confirmed they had read the local rules.

### Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.**

- Imaging staff completed safeguarding adults and safeguarding children level 2 training annually, as one of their mandatory training modules. In the department, 96% staff had completed this training.
- The service did not treat patients under the age of 18 years. At the last inspection, the referral form was not clear about the fact that the service did not treat children. However, the form had since been updated to state referrals for under 18 years were not accepted.
- Staff understood how to protect patients from abuse. Reception staff were clear if children accompanied patients to appointments, the patient was to be asked to ensure they had someone to care for the children while they had their appointment. Alternatively, patients were offered another appointment.
- There were safeguarding adults and children policies available for staff to access electronically. Staff were aware of who to contact if they had safeguarding concerns or to gain additional advice from. For example, the hospital safeguarding lead. Staff were aware of their responsibilities if they identified a patient who had undergone female genital mutilation.

# Diagnostic imaging

- To safeguard patients against experiencing the wrong investigations, staff asked patients to confirm their identity by providing their full name, date of birth and first line of their address. This evidenced staff followed best practice and was in line with the legal requirements of IR(ME)R.
- Chaperones were required for all intimate procedures and hospital policy was to routinely offer a chaperone to all patients.

## Cleanliness, infection control and hygiene

### **The service had systems to control infection risk, however, not all staff fully complied with infection control procedures.**

- We found clinical and patient waiting areas were visibly clean and free from dust and debris. There were cleaning schedules in place. We saw staff clean equipment at the start of each day and in between patient use, using sanitising wipes for surfaces and equipment.
- The hospital contracted a specialist cleaning company to provide cleaning services for low and high-level cleaning and general areas. Radiography staff were responsible for cleaning equipment before and after patients. We saw a daily cleaning checklist on display. However, it was not signed to indicate daily cleaning had taken place on the ground floor. Following the inspection, the provider submitted cleaning checklists (September 2018 to December 2018) for the department which showed daily cleaning had taken place.
- A hospital-wide environmental cleaning audit was carried out in July 2018 and showed overall high standards of cleaning were maintained.
- Monthly cleaning audits between January 2018 and December 2018 checked the environment to ensure high standards of cleaning were maintained. The results showed issues in the imaging department which required immediate attention, including mainly dusty areas in different parts of the department.
- Monthly hand hygiene audit data provided by the service showed between May 2018 and November 2018, compliance with hand hygiene ranged between 98% and 100%. During the inspection, we saw most staff were compliant with bare below the elbows regulations and had long hair tied up. However, we saw two visiting staff were not bare below the elbow, wearing rings, a bracelet and a watch. Long hair was not tied back.
- Staff said when treating patients who had a communicable infection (such as tuberculosis, flu or diarrhoea), staff ensured their investigation was prioritised to reduce time spent with other patients. Where possible, staff booked these appointments for the last appointment of the day, as scheduled cleaning took place at the end of the day.
- Personal protective equipment, such as gloves and aprons, were available to staff. We saw appropriate use of gloves during a clinical intervention.
- The radiology department had one infection control link practitioner who was new to the role. They understood their role was to support staff comply with best practice in infection control.
- Staff undertook intimate ultrasound scanning investigations using probes. The service cleaning procedures clearly described how the probes should be cleaned, in line with standards set by the Royal College of Radiographers. However, we saw two records when staff had cleaned the probes to a lower level of disinfection than guidance recommends for transvaginal probes. This was not in accordance with hospital procedures and national guidance which recommends a manual wipe system and record of traceability (Health and Safety Executive Guidance for decontamination of semi-critical ultrasound probes: semi-invasive and non-invasive ultrasound probes 2017). This posed a risk to patient safety because of the potential for cross infection. We raised our concerns with the manager during the inspection. Following the inspection, the provider submitted documentary evidence to demonstrate the incident had been investigated, staff had been retrained and adherence to correct infection control procedures would be monitored.
- We saw not all equipment had labels which indicated the date the item had been cleaned. For example, in the ultrasound rooms we saw equipment (including the ultrasound machine) had a label dated October.

# Diagnostic imaging

One other piece of equipment had no label. Although the items looked clean, there was no assurance in place. The cleaning checklist on the wall indicated at least weekly cleaning took place.

- Clinical and non-clinic waste bins were in the rooms to allow differentiation of waste. We noted three occasions in the department when part full sharps bins were left unattended not in the safe closure (temporary close) position. One sharps bin had a cannula protruding from the top. These potentially could cause an injury.
- The breast unit on the fourth floor was clean, well-maintained and all equipment we saw was labelled to indicate items had been cleaned in the previous 24 hours.
- We saw hand sanitiser dispensers placed in prominent positions throughout the diagnostics and imaging department to encourage use by staff and patients. We observed staff use the hand sanitisers appropriately.

## Environment and equipment

### The service had suitable premises and equipment and looked after them well.

- At the last inspection, there had been an issue with the details on the equipment inventory list. This had been resolved and the imaging manager now had a complete list of all equipment, which included the age and service dates. We saw equipment was labelled with service test stickers to indicate when the next service was due. We saw the equipment list contained 57 lines, of which three were due for testing.
- Staff confirmed there were handover sheets for equipment to record the safe handover of equipment before and after maintenance.
- The hospital was undergoing refurbishment at the time of inspection. There was a waiting area near the hospital entrance supervised by two staff members who welcomed patients and directed them to the right department. There was a small waiting area for patients within the department.

- The hospital had plans to develop a new outpatient and diagnostic department in premises across the road from the hospital in 2020; enabling works were underway.
- The radiology department had working radiation warning signs outside all rooms for safety and to prevent unauthorised access.
- Rooms were clearly identifiable and controlled areas were highlighted. This helped to reduce the risk of patients or visitors inadvertently accessing radiation restricted areas. There was a pull across hazard/ safety belt outside the magnetic resonance imaging (MRI) room to prevent unauthorised entry of persons, who had not been de-metalled, into the MRI area with an active magnet. We noted during inspection that the barrier was not always pulled across when it should have been. However, the basement corridor was access controlled and could only be accessed by authorised staff who escorted patients to the area.
- The medical equipment committee approved a rolling replacement of high value equipment as part of the planned capital expenditure programme for equipment.
- Resuscitation trolleys were available throughout the department. We reviewed two resuscitation trolleys (one on each floor) and saw they had records of daily checks, including defibrillator and suction equipment.
- Each treatment room had details displayed of what activity took place in the room (radiation risk assessments/local rules).
- The service clearly labelled MRI equipment and devices. This was in accordance with Medicines and Healthcare Products Regulatory Agency 2015 recommendations. Staff labelled equipment in the MRI area. For example, the wheelchair was labelled as 'MR Safe' and the resuscitation trolley outside the MRI area as 'MR unsafe'.
- Staff wore lead aprons where appropriate, which staff screened annually to ensure they were not damaged. Staff also wore radiation exposure devices which the radiation protection advisor (RPA) analysed monthly to ensure staff were not over exposed.

# Diagnostic imaging

- A dose reference level chart was displayed on the wall specific to each area and showed the recommended dose limits.
- Staff told us cleaning materials were not stored in the department. Cleaning staff conveyed the cleaning materials on a trolley to the department when they were needed.
- The service had support for their Picture Archiving and Communication System (PACS) which was the system used to store patient images. In the event of a PACS failure, this would significantly impact on service availability. Staff told us the radiologist could view images but would be unable to report on them until the system was restored. However, this was a rare occurrence.
- The service had designated and clearly identifiable radiation protection supervisors (RPSs) available to provide guidance and support to staff in each area.
- The service had a designated radiation protection advisor (RPA), who was accessible. They provided support and guidance and said they were confident the service managed risks well.
- Local doctors and consultants referred patients to the service. The radiology administration team checked the referral for completeness and would contact the radiographer if they had any concerns.
- Staff we spoke with demonstrated they were familiar with escalation procedures. For example, they would contact the radiologist on site or the resident medical officer (RMO). If they were concerned about a result, they would speak to the radiologist who would contact the referrer to discuss the result.
- Staff we spoke with said it was a rare occurrence for patients to be violent or aggressive. However, staff were aware of how to manage a situation where a patient acted in an aggressive manner. For example, they would speak to them calmly, invite them to a private area and call for assistance.
- There was an effective process for the assessment of patients who may be pregnant. Posters were displayed in the changing rooms and toilets with a message in different languages to alert patients that if they suspected they were pregnant to speak with staff. Staff used a checklist to assess any potentially pregnant patient prior to any investigation. Patients verbally confirmed, then signed and dated on a form to confirm they were not pregnant.
- Radiography staff screened patients who required contrast media for pre-existing conditions or allergies. This was in keeping with the National Institute of Health and Care Excellence (NICE) acute kidney injury guidelines and the Royal College of Radiologists standards for intravascular contrast agent administration. Contrast media are substances which increase the contrast of structures or fluids within the body, and are used in certain types of radiological investigations.

## Assessing and responding to patient risk

### Staff completed and updated risk assessments for each patient.

- All inpatients were assessed before staff transported them to the department for a computerised tomography (CT) or MRI scan to ensure they were in a stable condition to be subject to the scan.
- Staff were aware of what action to take if a patient became unwell before, during or after a scan. The action taken depended on the specific situation and staff provided examples which showed they would take appropriate action. All rooms were fitted with emergency bells to alert other staff of concerns.
- Basic life support training was part of mandatory training for diagnostic imaging staff. Data showed 96% compliance across the department with this training.
- The department had a full set of Ionising Radiation (Medical Exposure) Regulations IR(ME)R 2017. IR(ME)R procedures and standard operating procedures as required under the Regulations. The Health and Safety Executive (HSE) regulate the Ionising Radiations Regulations 2017. Local rules appendices, relevant to the specific rooms, were on display in accordance with procedures. All areas which utilise medical radiation in hospitals are required to have written and displayed local rules, which set out a framework of work instructions for staff.



# Diagnostic imaging

- Staff reported the procedure for the collapse of a patient in MRI was to call the crash team and to remove the patient from the MRI scanning room as quickly as possible.
- Fire procedures took account of special precautions with regards to the procedure for quenching the magnet in case of fire (quench is the sudden loss of superconductivity when the temperature of the magnet is raised). Staff conducted an evacuation simulation exercise to ensure they were ready to respond in such an emergency.

## Nurse/Radiographer staffing

**The service had radiographer staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.**

- The service was fully staffed with radiographers and one imaging assistant. There were no vacancies. Two trained mammographers staffed the breast unit.
- The department had two radiation protection supervisors and one imaging superintendent.
- The service did not use agency staff. Data provided by the service showed 16% of shifts were filled by bank staff in the previous 12 months.
- Staff said the department was well staffed to ensure they allowed adequate procedure time for patients.

## Medical staffing

**The service had enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.**

- The hospital had 55 radiologists with practising privileges. Several radiologists held set sessions in the department every week or month. Each radiologist only worked within their specific scope of practice and expertise, thus ensuring the service had specialist radiologist cover seven days per week.
- Consultants worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. Consultants were invited to join the staff at the hospital following identification of suitability via the consultant selection and review committee

(CSRC). Approval was required at the medical committee, before the medical director sent a formal letter of invitation. Most consultants with practising privileges had their appraisals and revalidation undertaken by their respective NHS trusts.

- Staff we spoke with told us radiologists on call were readily available and easy to contact. This was usually one general radiologist and one neuroradiologist.
- Radiologists reported scan results between 9am to 5pm. There was no routine reporting after 5pm.

## Records

**Staff kept detailed records of patients' care and treatment.**

- At the last inspection, the diagnostic imaging referral form stated incorrectly that the service accepted referrals for patients 16 years and above. The referral form had been updated to resolve this issue and now clearly stated referrals were for those of 18 years and over.
- The department primarily used a paper referral system which was scanned onto the radiology imaging system. A number of IT systems were used for maintaining patient records, uploading images and accessing images remotely. PACS was used for storing plain film images and the associated reports. Results and reports were available electronically to radiology staff and referrers.
- Patients were given a copy of their MR and CT images on a password protected disc. The report was emailed, posted or faxed to the referrer, depending on their preference.
- Radiographers could remotely access previous images if needed through a secure password protected system.
- The service provided electronic access to diagnostic results. This ensured radiologists reported on all diagnostic investigations in a timely way, ideally within 24 hours of the investigation. For out-of-hours MR and CT scans, an on-call radiologist could access the scan results securely. The radiologists we spoke with said the system allowed high quality scans to enable remote reporting.



# Diagnostic imaging

- We saw staff who used the ultrasound rooms did not log out of the computer screens and this left patient names visible on the screen. The ultrasound room was also left open and patient information could be viewed by patients or visitors walking past the room.

## Medicines

### The service followed best practice when prescribing, giving, recording and storing medicines.

For our detailed findings on medicines please see the safe section in the surgery report

- Within the CT and MRI areas, staff stored contrast media and all medicines in locked cupboards with keys held securely. We randomly spot checked eight medicines containers, and they were all labelled and in date.
- We viewed five patient group directions (PGDs) which were in date and approved according to the area they covered. A PGD is a written instruction for the supply and/or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. PGDs allow specific health care professionals to supply and/or administer a medicine directly to a patient with an identified clinical condition without the need for a prescription or an instruction from a prescriber. The health care professional working within the PGD is responsible for assessing the patient fits the criteria as identified in the PGD. We saw staff had signed these which evidenced they had received relevant training and were competent to meet the conditions identified in the PGD.
- We observed staff checked patients for their name, date of birth and address before they administered the medicine. This assured us staff were following their medicines administration policy.

## Incidents

### The service managed patient safety incidents well.

- A 'never event' is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been

implemented by all providers. The event has the potential to cause serious patient harm or death. From September 2017 to August 2018, the imaging and diagnostic service did not report any never events.

- There were 19 incidents reported by the imaging department between December 2017 and December 2018. Of these, 15 were categorised as 'low harm' and four as 'no harm'. The service reviewed incidents for themes and trends. One theme identified, which the department was already aware of, was the delay in reporting (which was being addressed). Another issue was communication with referrers or patients. Improvements had been made as a result.
- The service reported one IR(ME)R reportable incident to the CQC and none to the health and safety executive. We reviewed the investigation report which showed lessons learned and actions taken, to reduce the risk of reoccurrence. It was clear the duty of candour regulation had been adhered to, as the patient was fully informed.
- Staff were aware of their roles and responsibilities for reporting safety incidents and 'near misses', both internally and externally. Staff told us all incidents of avoidable over irradiation were reported to the RPS and to the imaging manager. These were discussed with the RPA for analysis and for the determination of whether the incident was reportable under IR(ME)R. Staff said they received feedback from incidents they reported. They were also discussed at monthly department meetings. The hospital produced a monthly governance newsletter, which included learning from all incidents.
- The diagnostic imaging manager attended a weekly hospital governance meeting where hospital-wide incidents were discussed.

## Are diagnostic imaging services effective?

Good 

**We do not rate effective in diagnostic imaging**

# Diagnostic imaging

## **The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.**

- The service took account of IR(ME)R and guidelines from the National Institute for Health and Care Excellence (NICE), the Royal College of Radiologists (RCR), the College of Radiographers and other national bodies. This included all specialities within diagnostics.
- We reviewed a range of clinical and operational policies and procedures. The clinical policies reflected current national guidance. New NICE guidance was disseminated by the hospital governance team to department heads. The imaging manager was responsible for reviewing policies relevant to his department and ensuring they were regularly reviewed or updated in line with national guidance.
- Staff had access to policies and procedures on the shared drive. However, not all staff we spoke with could confidently and quickly access the policies we asked for.
- The service's medical physics team provided scientific support, advice and guidance on IR(ME)R regulations concerning the use of imaging equipment, and also monitored the radiology equipment and staff radiation dosages. The main legal requirements enforced by the Health and Safety Executive (HSE) are the Ionising Radiations Regulations 2017. In line with the regulations, the diagnostics service appointed Radiation protection supervisors (RPSs), whose role was to ensure staff followed the services standard operating procedures and adhered to the radiation protection procedures.
- There were policies to ensure staff did not discriminate against patients. Staff were aware of the policies and gave examples of how they followed guidance when carrying out care and treatment. Staff told us they would escalate any concerns, and seek further guidance if necessary. Staff received training in equality and diversity as part of their mandatory training modules.

- Radiographers followed evidence based protocols for scanning of individual areas or parts of the body. Radiographers we spoke with were confident to discuss protocols with consultants if they felt the consultant had chosen the incorrect protocol.
- The CT had dose modulation capability to ensure the radiation dose was optimised. This was so patients did not receive any more radiation than needed.
- The service did not offer individual health assessments. Staff said referrals to the service had a clinical justification and they would check with patients to avoid unnecessary investigations.

## **Nutrition and hydration**

### **Staff advised patients on food and drink restrictions in accordance with the investigation.**

- The referring doctors advised patients whether they had any food or drink restrictions at the time of referral. The administration staff would call patients the day prior to their appointment and confirm food/drink restrictions.
- Water and hot beverages were available in the main waiting area for patients and visitors. We saw staff offered patients drinks before and between appointments if they were in the small waiting area in the imaging department.

## **Pain relief**

### **Staff assessed and monitored patients regularly to see if they were in pain.**

- Radiology staff did not use pain relief medicines in diagnostic imaging. However, staff said they would consider the patient's pain and comfort levels. For example, they would discuss with ward staff if a patient was due to have a scan and allocate a time in relation to the patient's scheduled pain relief to reduce the patient's discomfort during the scan.
- Staff ensured patient comfort prior to completing all investigations. For example, by repositioning the patient if possible, or the use of pillows or a foot rest. We observed staff reassure patients during investigations to take account of their comfort.

## **Patient outcomes**

# Diagnostic imaging

## Managers monitored the effectiveness of care and treatment and used the findings to improve them.

- The hospital used a patient satisfaction survey to obtain feedback from patients. The imaging department results were included in the quarterly outpatient survey results. The survey results for January 2018 to September 2018 showed consistently high levels of patient satisfaction with staff. Although the proportion of patients 'extremely likely' to recommend the imaging department was variable from 80% (March 2018) to 29% (September 2018). The comments from the survey indicated the low latter score was mainly attributed to the patient dissatisfaction with the facilities in the waiting area.
- There was an annual hospital-wide audit programme (April 2018 to March 2019). Each department also had its own audits, with imaging having nine audits planned. For example, monthly audits of reporting times and waiting times, quarterly audits of diagnostic x-rays and annual audits of double reporting and imaging patient dose. We reviewed the results of the imaging department diagnostic x-ray audit for June 2018 and September 2018. The audit reviewed 10% of patients, or a minimum of 30 patient records. In June 2018, the results showed 91% compliance with the standards measured. In September, the result had improved to 98% compliance. If compliance was found to be below 90%, the audit was repeated the following month.
- The results of the annual radiation dose audit (October 2018), which compared the average patient dose with the local dose reference level, showed 100% compliance for CT, x-ray and breast imaging. However, there was only 80% compliance for the screening room, which was attributed to low numbers of a particular procedure. The audit identified actions to improve compliance and a re-audit date was set in early 2019.
- The RPA conducted an annual audit of the service. The audit in July 2018 found partial compliance with minor improvements necessary. We saw a number of the actions had been completed by the time of our inspection, with all further actions due to be completed by end of February 2019.

- The service undertook a double reporting audit, in line with the IR(ME)R requirements. Data showed between March 2018 and August 2018, the service achieved 100% compliance with agreed standards. However, the return rate of double reports was 6%, which was below the target of 10%.

## Competent staff

### The service made sure staff were competent for their roles.

- The imaging service manager conducted appraisals for all staff in the service. Staff we spoke with said they had participated in an appraisal in the previous 12 months.
- Data provided by the service showed 83% of staff had participated in an appraisal between December 2017 and December 2018.
- All consultant radiologists working at the hospital had practising privileges which gave them the authority to undertake private practice within the hospital. The hospital practising privileges review process was annual and included a review of the consultant's scope of practice. This ensured the hospital had oversight of their ability to practice.
- The manager maintained a record of staff competency assessments on modalities and equipment. We also saw an up-to-date record of radiographers Health and Care Professions Council registration (HCPC). This was in line with the society of radiographers' recommendation that radiology service managers ensure all staff are appropriately registered. None of the imaging staff had been audited by the HCPC.
- All the radiographers were senior radiographers who were skilled in most of the modalities offered by the service.
- A clinical nurse specialist in the breast care unit was due to commence work in January 2019 to enhance the service.

## Multidisciplinary working

### Staff of different kinds worked together as a team to benefit patients

- The diagnostic service provided a breast pathway, where patients could access a consultant, have the

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diagnostic investigation with the results and further treatment arranged within 24 hours. The radiologists attended a breast multidisciplinary team meeting monthly.

## Seven-day services

**The service operated over a seven-day period with the availability of on call radiologists to perform emergency diagnostic scans.**

- The diagnostics service was open 8am to 8pm, Monday to Friday, and 9am to 1pm on Saturday. Outside of these times, radiographers and radiologists were available through an on-call system. They attended the hospital within 30 minutes.

## Health promotion

**There was a lack of health promotion material available across the diagnostic department.**

- We noted within the diagnostic screening department there was a lack of health promotion materials for patients to access, such as bone health. This was not in line with the national priorities of improving the population's health.
- The manager acknowledged the lack of easily available written patient information. They explained information pre- and post-scans were normally provided verbally. However, one of the radiographers had been tasked with reviewing the information accessible on the hospital website and developing the website to include links to relevant information for patients.

## Consent and Mental Capacity Act

**Staff understood how and when to assess whether a patient had the capacity to make decisions about their care and staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.**

- Staff completed training on consent and the Mental Capacity Act (MCA) annually as part of their mandatory training modules.
- We saw the service correctly used a magnetic resonance imaging safety consent form to record the patients' consent, which also contained their answers to safety screening. Staff documented consent on the

patient's electronic care record. Discussions included a description of the investigation, the possible side effects and the recovery period. Staff gave patients the opportunity to discuss concerns or queries prior to confirming consent.

- Policies on deprivation of liberty and mental capacity were available on King Edward VII's Hospital's shared computer files. Although staff had received training on mental capacity, they said it was unlikely they would see patients who lacked mental capacity in their service. However, they were aware of what to do if they had concerns about a patient and their ability to consent to the scan.

## Are diagnostic imaging services caring?

Good 

We rated caring as **good**.

## Compassionate care

**Staff cared for patients with compassion.**

- Staff demonstrated a kind and caring attitude to patients. This was evident from the interactions we witnessed on inspection and the feedback provided by patients.
- Staff introduced themselves to patients and took adequate time to put the patient at ease.
- There was no dedicated reception desk for imaging. We observed staff were on the phone and patients would wait outside the room until a member of staff was free to attend to them (often this only was a few minutes). However, it was not conducive to maintaining patient confidentiality. For example, we saw patients standing outside the reception room for short periods of time whilst reception staff were on the phone to other patients. This meant waiting patients could overhear conversations. If patients needed privacy, reception staff asked them to wait in the small waiting area within the department.
- The MRI and CT scanners were located in the basement. There was a small patient changing room but no dedicated waiting area. If patients had to wait, there was a chair outside the scan rooms. However,

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the door to the viewing rooms was often kept open for ventilation and for staff convenience. When the door was open, passers-by could see patients in the scanner if the screen was not down. This compromised patient privacy and dignity.

- Posters informing patients about chaperones were on display throughout the department.
- Staff said they took the time wherever possible to interact with patients and their relatives. We observed staff taking time to speak with patients in a respectful and considerate way.
- Patients we spoke with were generally very satisfied with the care they received. They made comments including: “Really quick- got call same day for CT scan”, “Happy”, “Five-star hotel for medicine”. There was one negative comment from a patient who was unhappy they had to wait longer than expected for their scan.

## Emotional support

### Staff provided emotional support to patients to minimise their distress.

- Staff supported patients through their investigations, ensuring they were well informed and knew what to expect.
- Staff provided reassurance and support for nervous and anxious patients. They demonstrated a calm and confident manner in order to relax patients.
- Staff also encouraged patients to bring in their own music for relaxation and to bring someone with them as support.
- We observed staff provided ongoing reassurance and commentary to the patients during the MR and CT scan; they updated the patient on how long they had been in the scanner and how long was left.

## Understanding and involvement of patients and those close to them

### Staff involved patients in decisions about their care and treatment.

- Patients we spoke with told us they were involved with decisions about their care and treatment and were aware of what the next steps were. We saw staff relayed information at a pace suitable to the patients’ needs.
- Patients received a CD of their images to forward on to their doctor who had made the referral.

## Are diagnostic imaging services responsive?

Good 

We rated responsive as **good**.

### Service delivery to meet the needs of local people

#### The provider planned and provided services in a way that met the needs of local people.

- The environment included seating areas, adequate toilets and good availability of refreshments.
- The hospital was located in central London and was easily accessible by public transport. However, there was limited ‘pay and display’ car parking outside the hospital.
- There was access to free WIFI for patients and visitors
- The service provided some evening and Saturday appointments to accommodate the needs of patients who were unable to attend during the usual times.
- There was a walk-in service for plain film imaging and the service offered open access for CT and MRI scans from all GPs.
- Appointments were flexible to meet the needs of patients and they were available at short notice.
- The breast unit was designed to take account of the patients’ needs. It had two small waiting areas, one for patients who came for screening and one for patients who had a diagnosis of breast cancer.
- Within the ground floor imaging department, there was a small waiting area for patients if they needed a more confidential space. There was limited space for staff to have private conversations with patients.



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- The imaging department had a small changing room and lockers for patients to securely store valuables whilst they were having their scan.
- The MR and CT floor did not have a separate waiting area for patients. There was normally only one patient waiting for a short period and they were accommodated on a chair outside the scan rooms.

## Meeting people's individual needs

### The service took account of patients' individual needs.

- If patients had to wait more than five minutes after their appointment time, staff informed patients and explained the delay. If the service had to cancel a clinic such as ultrasound, staff informed patients immediately and offered the next available appointment that was suitable for their needs.
- We saw staff spent enough time as the patient needed to explain the procedure. Staff commented it was valuable to be able to spend time with patients without feeling too rushed. All patients we spoke with commented they did not feel rushed through their procedure.
- Patients attending the diagnostics service were normally only there for a short time and did not require food. There was complimentary tea and coffee and drinking water.
- Patients with mobility issues could enter the MRI scanning room on a MRI safe trolley or wheelchair. All waiting areas across the department were large enough to accommodate wheelchairs and patients with mobility issues.
- The service took account of the accessible information standard by identifying and recording communication needs at the time of booking the appointment. Hearing loops were installed and the service had access to a telephone translation service. There was also an international patient liaison office to support patients.
- Staff had received training in equality and diversity as part of their mandatory training and King Edward VII's Hospital expected staff to demonstrate these values throughout their work. Staff called patients the day before their appointment and asked if they had any special needs which the service needed to be aware of and made any necessary adjustments.

- The imaging superintendent had recently been identified as the special needs champion for the department and was due to attend training to support staff and undertake the role effectively.

## Access and flow

### People could access the service when they needed it.

- Local doctors and consultants in the hospital referred patients to the service. Administration staff made appointments in person or by telephone at a time and date agreed by the patient. Data showed the service had a low proportion of patients who did not attend for their appointment, approximately 1% over the last two years.
- Some patients came directly from a consultation with their doctors and had their scans undertaken on the same day. Staff asked other patients to come back later in the day, or the next day, depending on appointment availability.
- Administration staff said patients were normally seen within five minutes of their appointment. If patients were expected to wait more than five minutes, staff would speak to them to explain. Appointments were booked with sufficient time between them. The clinic usually operated on time. Administration staff said occasionally the MRI clinic may run over, especially if patients arrived late.
- Data showed waiting times were short and appointment times were closely adhered to. We saw this during the inspection and from the feedback received from patients. Over 90% of patients who responded to the patient satisfaction survey said they were seen early or on time.
- The report of the monthly clinic waiting time audit (April 2018 to September 2018) showed the radiology department saw on average 290 patients per month. The aim was for 95% patients to not wait longer than 15 minutes after their scheduled appointment time. The service met the standard for two out of six months. In the months where the service did not comply with the target, there were many



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appointments where the start time had not been input to the radiology information system (RIS), which impacted on results. Improving input was a recommendation of the audit.

- King Edward VII's Hospital aimed to have radiology reports available to the referrer within 24 hours of the scan taking place. The request to result target was 14 days and the service aimed to achieve a standard of 85% compliance. Data for September 2018 to November 2018 showed an average compliance rate of 88%, although 70% of this imaging was completed within three days of receiving the request.
- Data provided showed between September 2018 to November 2018, the service achieved an average report turnaround within 24 hours. This was within their target of 24 hours.
- The breast cancer service offered a one-stop service and organised CT and MRI within 24 hours.
- The service had enough capacity to accommodate approximately 20% of same day appointments.

## Learning from complaints and concerns

**The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.**

- The complaints log for March 2017 to August 2018 showed the hospital received 25 complaints, of which three complaints related to the imaging department. There was no identified theme to these complaints. Staff had investigated complaints and made the following changes in response to complaints: dressing gowns were offered to patients in addition to the regular hospital gown, and all patients were now called the day before their appointment to confirm their appointment, give them information about the scan and ask if the patient had any special needs which needed to be taken in to account.
- The imaging manager attended a weekly governance meeting where complaints were discussed, with an aim of closure of complaints within 20 days. This ensured that every complaint or incident had the correct clinical or head of department assigned for investigation, and any immediate action was taken quickly.

- The comments noted by patients in the satisfaction surveys were also acted upon by the service. These were mainly related to the availability of water or hot drinks in the waiting area, which had been improved.
- Information for patients on how to make complaints was not readily accessible on the hospital website. However, leaflets on providing feedback and complaints were available in the department.
- No complaints from the diagnostics service had been referred to Independent Healthcare Sector Complaints Adjudication Service (IHCAS).

## Are diagnostic imaging services well-led?

Good 

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

### Leadership

**Managers at all levels in King Edward VII's Hospital had the right skills and abilities to run a service providing high-quality sustainable care.**

- The diagnostic imaging service was part of the hospital's medical directorate.
- The diagnostic imaging service was led by the imaging manager and the clinical director for imaging. The imaging manager was also responsible for the physiotherapy service. There was a lead mammographer who led the breast unit.
- The imaging leadership team consisted of the imaging manager, deputy manager and the imaging superintendent. The superintendent oversaw the radiographers.
- The department had recently undergone restructuring, including an internal appointment of a deputy imaging manager. This strengthened the leadership team and capability of the department.
- We spoke with the RPA, who described a good working relationship with the imaging service manager and the RPSs. They were confident in the way the service managed risks associated with radiation. The divisional manager was aware of challenges to

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sustainability and quality of the diagnostics service and the challenges different areas might face. Staff said the manager was supportive and approachable. He was visible in the department.

- All staff reported their managers to be approachable with strong leadership skills. Staff told us leaders had the skills and experience to carry out their roles and offered valuable support.

## Vision and strategy

**The provider had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.**

- King Edward VII's Hospital's vision was to be the leading private hospital in the UK and to support an increased number of veterans through their charitable work. The hospital values were: professionalism, quality, respect, safety and teamwork.
- The diagnostics strategy was aligned with the hospital strategy. The hospital had strategic objectives to improve services through improved facilities and patient outcomes, as well as exploiting new technology, strengthening the culture of quality and safety and increasing revenue. The diagnostic and imaging department strategy had four goals: highly trained and dedicated staff, better integrated IT systems, development of an automated electronic feedback system and also an online booking system.
- Staff we spoke with were aware of the strategy for the diagnostic and imaging service and had been involved in its development.
- The radiology department had sufficient plans for the replacement of high cost equipment through managed services.

## Culture

**Managers across King Edward VII's Hospital promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**

- The imaging service was a small cohesive team. Staff said, "Everyone helps each other" and praised the "good team work". Staff attended monthly team meetings. Minutes showed meetings were well attended.
- The staff we spoke with expressed high job satisfaction. They said they enjoyed the variety of working with different modalities as this allowed them to "see the patient through". This meant the same radiographer could perform different scans on the same patient if needed. They felt this enhanced the patient continuity of care and overall patient experience.
- Staff were proud of the patient experience. Staff said they had good communication with the hospital executive team. Staff felt supported in their work and said there were opportunities to develop their skills and competencies, which senior staff encouraged. Staff told us they felt valued and supported by colleagues and senior managers.
- Staff undertook quarterly staff satisfaction surveys. The departmental results for July 2018 to December 2018 showed nearly all imaging staff were 'satisfied' or 'very satisfied' with their job.
- Staff were aware of the duty of candour (DoC) regulation and evidenced through discussion the appropriate application of the duty when required. The DoC is a regulatory duty which relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

## Governance

**King Edward VII's Hospital systematically improved service quality and safeguarded high standards of care by creating an environment for clinical care to flourish.**

- The diagnostics service had a clear systematic governance process, in line with the hospital governance framework, to continually improve the quality of service provided to patients. Staff understood their roles and accountabilities.

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- There were monthly departmental meetings for diagnostic and imaging staff to discuss and be updated by the service manager on operational, financial and governance matters relating to the department and hospital. The issues were structured into the themes of safe, caring, effective and responsive. The notes of the meetings showed they were well attended by staff.
- The diagnostic and imaging manager attended a weekly hospital CLIPA (Complaints, Incidents, Patient Experience, Legal, Audit) forum. This was facilitated by the governance team and presented a summary of themes, trends and lessons learned. A monthly CLIPA meeting was also open to all staff.
- The diagnostic and imaging manager attended the quarterly hospital integrated governance meeting, chaired by the director of governance, where each service head provided a report of risks and incidents relevant to their department. The reports for July 2018 to November 2018 covered a range of governance matters, including actions and progress from previous reports. This contributed to a governance report to the board which included risks, incidents, complaints, audits and key performance indicators to ensure they had appropriate oversight and scrutiny.
- The RPS had updated the IR(ME)R procedures and produced a comprehensive set of 27 procedures which had been approved by the RPA and ratified by the chief executive in October 2018.
- We saw minutes of the formal radiation protection meetings which took place annually and were attended by the RPA, RPS and diagnostic imaging manager. The RPA had undertaken an annual audit of the service in July 2018 and we saw the recommendations had been addressed to correct any non-compliance issues.
- Staff undertook internal quality audits and assisted in driving improvement, giving all staff ownership of things that went well and that needed improvement. This ensured staff from all disciplines were involved in quality improvement.

## Managing risks, issues and performance

### **The provider had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**

- Managers ensured risks were embedded in the quality system and added on to the registers to be reviewed monthly by the senior managers.
- There was a risk assessment framework in place locally with a process of escalation onto the corporate risk register. The corporate risk register detailed risks, their effects, their risk score and when they were last reviewed. Management reviewed all medium risks within the last month. Where risks were identified, managers took steps to identify how the risk had originated, completed analysis to identify why the risks existed, then took steps to minimise these risks. We saw risk assessments were undertaken and covered all aspects of the service, staff, environment and equipment. Risks were discussed at departmental team meetings and recorded on the departmental risk register. Departmental risks were also discussed at the integrated governance meeting. High risks were escalated to the hospital risk register.
- There were no diagnostic imaging risks on the hospital risk register (October 2018). However, the department risk register identified three risks, two of which had been discussed with us during the inspection. These related to the paper and electronic systems which incurred a risk of human error and delays. Controls were in place to reduce the risks to acceptable levels. The third risk was the adverse effect of the use of beta blockers for cardiac CT. Control measures had been implemented to reduce this risk. The imaging risks were raised at the hospital quarterly governance meeting. In particular, the double reporting audit rates were below the national standard of 10%. Actions to improve this were implemented.
- The imaging manager reviewed performance information, including activity and report turnaround times. This was recorded in a dashboard which showed activity had increased significantly for ultrasound and breast imaging compared to the previous year. For other modalities, this had increased marginally.

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- The service had a backup generator in the case of failure of essential services. The generator was tested monthly to ensure it would function safely in an emergency.

## Managing information

**The provider collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**

- The service had access to King Edward VII's Hospital's computer systems. They could access policies and resource materials from the King Edward VII's Hospital's computer system.
- There was sufficient information technology equipment for staff to work with across the diagnostics service.
- The service regularly reviewed quality performance, which managers discussed at meetings across all modalities. Managers shared this information electronically with staff through minuted meetings to ensure their awareness of where improvements in performance could be made.
- Staff could access electronic patient records easily but records were kept securely to prevent unauthorised access to data.
- Information from scans was available to view remotely by referrers which gave timely advice and interpretation of results to determine appropriate patient care.
- Radiographers had access to patient's previous scans which enabled them to identify if patients have been subject to previous scanning which may still be appropriate for use. This removed the risk of patients receiving repeated short-term exposure.
- Information governance, general data protection regulation, internet, email and social media and cyber security were part of mandatory training modules. Data provided showed 96% compliance with this training across diagnostic and imaging staff.

## Engagement

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

- The department displayed an information board for patients which included the names of all the imaging team, as well as results of patient feedback in the form of 'you said, we did' information. The service had introduced a telephone call to all patients the day before their appointment to confirm their attendance, provide information and ask for additional information.
- Quarterly staff surveys were carried out; the department results for July 2018 to December 2018 showed nearly all staff were satisfied with their involvement in the department.
- There was good management engagement with staff. The manager produced a monthly imaging review on a page, with key metrics such as patient satisfaction, performance and learning points for staff. All staff responded in the staff survey they were satisfied with the information they received. Staff we spoke with told us the management was supportive accessible and visible.
- The department held monthly team meetings. The notes of the previous three meetings showed high levels of attendance of team members. The notes demonstrated issues were communicated clearly and issues were followed through. For example, risks and complaints were discussed and actions taken in response.

## Learning, continuous improvement and innovation

**The provider was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.**

- There were plans for the future sustainability of the hospital which included a new and upgraded outpatient and diagnostic department, due to open in 2020.
- The diagnostic and imaging manager was also the clinical IT lead and was involved in implementing new IT systems to improve and streamline referrals, patient records and reporting systems.

# Outstanding practice and areas for improvement

## Outstanding practice

- The Veteran's Centre provided a tailored pain management programme for veterans. A multidisciplinary team of consultants in pain medicine and clinical psychology, clinical nurse specialists and physiotherapists, worked together to treat patients suffering from chronic pain (often in association with post-traumatic stress disorder). Objectives of the programme were to help veterans to improve their mood, to develop a better understanding of their pain and to increase levels of meaningful activity, self-management skills and general quality of life.
- The breast unit was designed and organised around patients' individual needs, taking emotional effects into consideration and valuing patients' time. It was well managed and staff were enthusiastic and compassionate.

## Areas for improvement

### Action the provider **MUST** take to improve

- The provider must ensure that diagnostic department staff comply with infection control procedures to reduce the risks to patients. This includes the appropriate level of decontamination of ultrasound probes, safe storage of sharps bins, meeting bare below the elbow requirements and completion of equipment cleaning checks.

### Action the provider **SHOULD** take to improve

- The provider should consider having full dietetic support over the weekend where necessary.
- The provider should audit completion of the WHO checklist, specifically observational audits.
- The provider should ensure that all patient observation charts are completed and actioned appropriately.
- The provider should ensure that tissue viability assessments are completed and actioned appropriately.
- The provider should consider revising adequate staffing levels for all shifts.
- The provider should consider emergency anaesthetic consultant cover for the hospital.
- The provider should ensure all medicines stored on the critical care unit are clearly labelled with expiry dates.
- The provider should improve staff practice of logging out of computers to avoid breaches of personal identifiable information.
- The provider should review the security of the MRI room so it cannot be inadvertently accessed by persons who are carrying metal.
- The provider should consider ways to improve the waiting area in the MRI/CT corridor to enhance patient privacy and dignity.
- The provider should continue to review the health promotion material available in the diagnostic and imaging service.
- The provider should continue auditing patient records to ensure they contain all relevant medical documentation.
- The provider should consider monitoring patient outcome and benchmarking the service against other similar organisations.
- The provider should endeavour to improve response rates for patient and staff feedback surveys.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment</p> <p>In the diagnostic imaging department all staff did not consistently clean ultrasound probes according to hospital procedures and national guidance, sharps bins were not all stored safely, all staff were not bare below the elbows and equipment cleaning checks were not consistently completed.</p> <p>Care and treatment must be provided in a safe way for service users. The registered person must ensure that staff assess the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.</p> <p>Regulation 12 (1)(2)(h)</p>