

Nuffield Health Bournemouth Hospital

Quality Report

67-71 Lansdowne Road
Bournemouth
Dorset
BH1 1RW

Tel: 01202 375617

Website: www.nuffieldhealth.com/hospitals/bournemouth

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

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

The Nuffield Health Bournemouth Hospital is one of 31 hospitals and treatment centres provided by Nuffield Health.

The hospital provides a range of medical, surgical and diagnostic services. The onsite facilities include an endoscopy suite, three operating theatres (two with laminar airflow, one without), a cardiac catheter laboratory, 41 inpatient beds, two minor operations rooms, one treatment room and 13 consulting rooms. The hospital offers physiotherapy treatment as an inpatient and outpatient service in its own dedicated and fully equipped physiotherapy suite.

Services offered included general surgery, orthopaedics, cosmetic surgery, ophthalmology, general medicine, oncology, endoscopy, and diagnostic imaging. Most patients are self-paying or use private medical insurance. Some services are available to NHS patients through the NHS e-referral service.

Care and treatment of children and young people aged 0-16 years accounts for 5% of the overall activity at this hospital. There is no provision for medical care of children and young people aged 0-16 years. There were no children receiving care and treatment at this hospital at the time of our inspection. Care of children and young people was not inspected as a separate core service and is included within the reports for surgical services and outpatient and diagnostic imaging.

The announced inspection took place between 24 and 25 May 2016, followed by a routine unannounced visit on 9 June 2016.

This was a comprehensive planned inspection of all core services provided at the hospital: medicine, surgery and outpatient and diagnostic imaging.

The Nuffield Health Bournemouth Hospital was selected for a comprehensive inspection as part of our routine inspection programme.

The inspection was conducted using the Care Quality Commission's new inspection methodology.

The overall rating for this service was requires improvement. We rated medicine and surgery as requiring improvement and outpatient and diagnostic imaging as good.

Our key findings were as follows:

Are services safe at this hospital/service

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

- We rated safe as inadequate in surgery, requiring improvement in medicine and good in outpatient and diagnostic imaging services.
- Infection prevention and control in theatres did not meet the requirements of the Health and Social Care Act, 2008, Code of Practice on the prevention and control of infections and related guidance. Operating theatres were in a poor state of repair with worn, torn and rusty equipment. Staff in theatres did not consistently adhere to best practice guidance or Nuffield policy in relation to prevention of infection. This was in breach of Regulation 12 of the Health and Social Care Act, 2008, and we issued a Warning Notice to the hospital to take urgent action.
- Nurses who were responsible for decontamination of nasendoscopes were not trained to undertake the decontamination process for those particular nasendoscopes. They had received training in general decontamination of equipment.
- There was inconsistent tracking and tracing of endoscopes meaning that staff could not be assured that the scopes used were clean and ready for use.

Summary of findings

- Mandatory training overall compliance at the hospital was 84% against a hospital target of 85%. Training compliance was particularly low in theatres with overall compliance of 74%.
- The wards were clean and cleaning schedules were well maintained. In theatres and outpatients there were significant gaps in the cleaning schedule recordings and the schedules were not effective in ensuring the environments were clean. We saw areas of visible uncleanliness in theatres and outpatient departments.
- Medicines, including controlled drugs, were not always stored securely and records were not appropriately maintained in all areas. Verbal orders were routinely being used to prescribe medicines in the cardiac catheter suite.
- Risk assessments were completed but there were gaps in the assessments of venous thromboembolism (VTE) and in the World Health Organisation (WHO) safer surgical checklist.
- Staff understood the requirements of Duty of Candour legislation and could give examples of when it should be applied.
- Staff across all departments understood their responsibilities in safeguarding individuals from avoidable harm and/or abuse. The matron was the hospital's safeguarding lead.
- Staff knew how to report incidents and did so. The system was accessible and easy to use. Incidents were investigated and learning was mostly shared across the hospital and the wider organisation.
- Staffing was sufficient to provide safe care and treatment. Where there were gaps, regular bank and agency staff were used to promote consistency of care.
- The Resident Medical Officer provided medical care as needed to patients. Consultants led care and treatment and were always available for advice and support if required.

Are services effective at this hospital/service

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

- We inspected but did not rate effectiveness in outpatients and diagnostic imaging as we do not currently collect sufficient evidence to do so. We rated surgery as good for effective care and treatment. We rated medical services as requiring improvement.
- Care and treatment in surgery and outpatients took account of national guidance.
- Patient outcomes are monitored appropriately at a local at a local and national level with the exception of patients undergoing gastrointestinal endoscopy.
- There were no standard operating procedures for gastrointestinal endoscopy.
- Appraisal rates were low at 78% for nursing staff.
- Practising privileges were granted and monitored appropriately by the Medical Advisory Committee (MAC). Nursing and operating department practitioners' registration was monitored by the human resources manager.
- The hospital participated in national audits such as the National Joint Registry.
- With the exception of patients post knee replacement surgery, the hospital wide unplanned readmission rate was similar to or better than other independent hospitals.
- Patients consented to procedures and staff were clear what action they take if they thought a patient lacked capacity to give informed consent. However, in theatres written consent was obtained on the day of the procedure which did not allow for a 'cooling off' period, and not in line with national guidance.

Summary of findings

- Endoscopy leads were working towards achieving Joint Advisory Group (JAG) accreditation. The cardiac catheter suite leads were working towards British Cardiac Intervention (BCIS) Society accreditation.
- Some staff were not sufficiently trained to perform their roles. In endoscopy there was no training plan to ensure that staff were competent in the use of use of endoscopes.
- Patients' nutrition and hydration needs were mostly met. Patients reported being offered a wide range of food choices but there were gaps in the monitoring of food and fluid intake in some cases

Are services caring at this hospital/service

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

- Overall, caring was rated as good. We found evidence of kind and compassionate care in medicine, surgery and outpatients and diagnostic imaging. Staff treated patients with kindness and compassion.
- The hospital staff received consistently positive feedback from patients through the Friends and Family Test (FFT). FFT results showed that during the period January 2016 to March 2016, overall satisfaction with patient experience was 94% and rating for being treated with respect and dignity 97%. This information was displayed at the hospital.
- Patients and their relatives were involved in decisions about their care and treatment. Patients told us they were given sufficient information to make informed choices.
- Open visiting hours at the hospital allowed for patients to be emotionally supported by their friends and family throughout their stay.

Are services responsive at this hospital/service

By responsive, we mean that services are organised so that they meet people's needs.

- Overall, this hospital was rated as good for responsive care. Service planning took account of individual needs and preferences. Patients were offered appointment times to suit their personal circumstances and all inpatients were cared for in private bedrooms with individual bathrooms.
- Staff could describe what actions they would take to meet the needs of vulnerable patient groups such as individuals with a learning disability and/or living with dementia. They would discuss with senior staff or the nominated link nurses and resources were allocated to meet the needs of individuals before their planned treatment.
- The Patient Led Assessment of the Care Environment (PLACE) for 2015, PLACE rated the hospital at 88% dementia friendly, compared with other independent hospitals at 81%.
- The hospital consistently met the national 18 week referral to treatment target for NHS patients across all departments.
- Complaints were taken seriously and responded to in a timely and responsive manner. Learning arising from complaints was used to improve patient care and experience.
- Patients who did not attend for outpatient appointments were followed up proactively but this was not formally monitored.
- Outpatient appointments and surgery were planned mostly between Monday and Friday. However, there were on call services to support responsive care outside of usual working hours such as pharmacy and radiology if required.
- There was no inclusion or exclusion criteria but patients were screened by the lead consultant prior to the onset of the treatment or procedure. This ensured that their treatment could be planned according to their individual needs.

Summary of findings

Are services well led at this hospital/service

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

- Overall, we rated leadership at this hospital as requiring improvement though we found leadership in outpatient and diagnostic imaging was good.
- The theatre manager did not have sufficient support or capacity to fully fulfil the requirements of the role. Staff valued the day to day operational leadership but surgical services and endoscopy lacked strategic vision and oversight.
- There were governance arrangements in place with clear reporting lines from frontline staff to the senior management team. The clinical governance group met monthly and ensured that learning occurred following incidents, audits and complaints. However, risks were not always given sufficient priority for action and service leads did not always act promptly where there were areas of increased patient risk or non-compliance.
- The Resident Medical Officer (RMO) was not included in the overall governance structure.
- The Cardiac Catheter Suite provided a service that local cardiologists felt was lacking in Dorset. Staff were proud of the suite as it was the only service of its type available in the independent sector locally.
- Staff were mostly aware of the corporate vision, strategy and values.
- Staff were committed to providing quality compassionate care.
- Staff had confidence in their managers and reported the senior team were accessible and approachable. The senior team were committed to providing excellent customer care but this distracted from improving clinical standards.
- Senior staff could not always accurately describe the risks within their department. The risk register did not accurately reflect the risks which meant that sufficient priority was not always afforded.
- The Medical Advisory Committee oversaw appropriate granting and scrutiny of practising privileges.

Our key findings were as follows:

- Infection control and prevention did not meet the requirements of the Health and Social Care Act, 2008, Code of Practice on the prevention and control of infections and related guidance. This was in breach of regulation 12 of the Health and Social Care Act, 2008, and we have issued a warning notice to the provider.
- Cleaning schedules were not consistently maintained and did not ensure that overall cleanliness was maintained.
- Staffing levels were sufficient to provide safe and effective care and treatment. Regular bank and agency staff were used where gaps occurred.
- Staff had not completed mandatory training in line with targets identified by the provider.
- Some staff were not sufficiently trained to perform their roles. In endoscopy there was no training plan to ensure that staff were competent in the use of endoscopes.
- Patients nutrition and hydration needs were mostly met. Patients reported being offered a wide range of food choices but there were gaps in the monitoring of food and fluid intake in some cases.
- Staff were caring and compassionate and patients were included in decisions about their care and treatment.

Summary of findings

- Staff valued support from their immediate line managers and reported the senior team was accessible and approachable. However, leadership was focussed on customer service and experience which distracted from the monitoring and improvement of clinical standards. The theatre manager was not afforded sufficient capacity or support to fully fulfil their role.

There were areas where the provider needs to make improvements.

Importantly, the provider MUST ensure that:

- Theatre environments are safe and follow infection prevention and control procedures in line with the Health and Social Care Act, 2008, Code of Practice on the prevention and control of infections and related guidance.
- Staff complied with bare below the elbows guidance and adhere to best practice and Nuffield's own policies in relation to infection prevention and control.
- Linen is safely stored and handled in theatres.
- Clinical waste is safely stored away from areas of direct patient care until disposal.
- Equipment is safe for use and that the condition of equipment allows for efficient cleaning.
- An effective system is implemented to ensure that worn, torn, broken or rusty equipment is identified, withdrawn from use and replaced in a timely manner.
- Cleaning schedules and effectiveness of cleaning are monitored to ensure that cleaning occurs at agreed intervals.
- All staff receive mandatory training in line with the hospital set minimum target of 85%.
- All staff complete an annual appraisal
- There is an effective and monitored system for the tracking and tracing of endoscopes.
- Staff working in endoscopy are trained and assessed against an identified competency framework that is specific to their role.
- All patients have a documented risk assessment for venous thromboembolism.
- The five steps to safer surgery checklist (WHO) is always appropriately completed.
- The storage and management of medicines including controlled drugs meet the requirements of current legislation, Nuffield policy and standard operating procedures.
- Verbal orders for medicine prescribing are not used when undertaking planned procedures.
- Departments should maintain their own risk registers and ensure staff are fully aware how to raise matters and place them on the risk register.
- There are robust systems and processes for assessment, identification and mitigation of risks across all services and departments of the hospital.
- Risk register includes all risks that may adversely affect patient safety and is shared with and understood by staff across all departments.
- Patient records of care and treatment, including nutritional monitoring, are legible and complete.

In addition the provider SHOULD ensure that:

- Learning from incidents is consistently shared across all hospital departments.
- Ensure pharmacy staff discuss medicines with patients in a manner that maintains patients' privacy.

Summary of findings

- Medicines are stored at the appropriate temperature and there are clearer recording systems so there is assurance that medicines in endoscopy department have been stored within the correct temperature range.
- Relevant staffs receive appropriate training for decontamination of nasendoscopes.
- Ensure there are systems in place to check daily maintenance of nasendoscopic equipment.
- Implement formal systems to inform patients of waiting times of clinic.
- Ensure results of patient satisfaction surveys are shared with staff and displayed publicly.
- That consultants are capturing data after carrying out endoscopy procedures at the hospital, and plan how this data can be used to improve patient outcomes.
- All resuscitation trolleys are checked at agreed intervals and this is reflected in the recording of such checks.
- Boxes are not stored on the floor in the cardiac catheter suite storeroom to enable effective cleaning of the storeroom.
- The theatre manager is afforded capacity and support to fulfil the requirements of the role.
 - Develop a pre-operative fasting policy in line with national guidance.
- Consent forms are signed by patients on the day of their procedure to allow a 'cooling off' period in line with national guidance.
- The Resident Medical Officer is part of handover and team meetings.
- A strategy for surgical services is developed.

Professor Sir Mike Richards Chief Inspector of Hospitals

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Rating

Summary of each main service

Medical care

Requires improvement



Overall we rated medical care as requires improvement. We rated safe, effective and well led care as requiring improvement and responsive and caring as good.

There was not a training plan for staff working in endoscopy, to support staff achieving competencies effectively for the specialty. Appraisals were at 78% for staff working in theatres against a hospital target of 85%. In endoscopy suite local standard operating processes were not in place to support systems and processes. We found an inconsistent approach to the tracking and tracing of endoscopes. Management of controlled medication in endoscopy was not always consistent with legislation. Nursing staff administered medication during procedures by nursing staff in the cardiac catheter laboratory with a verbal order, when there should have been a written prescription by the consultant.

We were not assured how risks were managed, as risks identified in endoscopy were not on the hospital risk register. The endoscopy service was taking action to be able to meet current evidence based guidance. The hospital did not have Joint Advisory Guidance (JAG) accreditation in gastrointestinal endoscopy but there was an action plan in place towards achieving this. Risk assessments were completed but we found gaps in completion of venous thromboembolism (VTE) and the World Health Organisation (WHO) surgical checklist.

Staff had an awareness of safeguarding, and steps to take to prevent abuse from occurring. Staff were aware of the process for reporting incidents, and there was a culture of learning following incidents and audits. For example, audits undertaken of the management of controlled medicines, patient records and resuscitation equipment, where non-compliance identified, action plans put in place. Mandatory staff training across the hospital overall was at 84% against a target of 85%.

Summary of findings

Staff within the cardiac catheter suite had the knowledge and skills to deliver effective care and treatment. This was supported by robust standard operating procedures. Cardiac patient outcomes were being measured.

During the inspection, we saw that staff were caring, sensitive to the needs of patients, and compassionate. Patients commented positively about the care provided from all of the endoscopy, cardiac catheter suite and ward staff. Patients were treated courteously and respectfully. Patients felt well informed and involved in their procedures and care. This included their care after discharge from an endoscopy procedure, a cardiac intervention and on the ward.

The service met national waiting times for patients requiring a planned gastrointestinal endoscopy or a cardiac procedure to wait no longer than 18 weeks for their procedure after referral. The service was responsive to patients in the admission criteria, with average waiting times of one to four weeks. Care and treatment was coordinated with other providers. The needs of different people were taken into account when planning and delivering services.

Surgery

Requires improvement



We rated surgery at this hospital as requires improvement overall. We rated safe as inadequate, well led as requires improvement and effective, caring and responsive as good.

The service failed to ensure that care and treatment was being provided in a safe way for service users. This was in breach of Regulation 12 of the Health and Social Care Act 2008. We have issued a warning notice to the provider to take urgent action to improve.

The fabric of theatre environments was in a poor state, with broken, torn and rusty equipment. The building infrastructure had been temporarily redecorated many times over the eight years since being placed on the hospital's risk register but refurbishment had not been given sufficient priority. The hospital condemned over 100 items of theatre equipment including rusting trolleys, worn limb rests and gel pads after concerns were raised

Summary of findings

by the inspection team. The poor state of the environment and items of theatre equipment was an infection prevention and control risk as it prevented effective cleaning and decontamination. The theatre environment was not consistently cleaned. We found areas of visible dirt and cleaning records showed gaps of up to two weeks in one month in cleaning being completed. Maintenance records showed that action was required to improve the effectiveness of the laminar flow air system in theatres. However, this had not been addressed and was not detailed on the risk register.

Mandatory training compliance levels were 74% overall on 5 April 2016. This was below the hospital target of 85%.

Only 78% of nursing staff had completed an annual appraisal against a hospital target of 85%.

Leadership in theatres focussed solely on day to day operational management. There was little strategic direction in the theatre department and the theatre manager lacked capacity and support to fulfil the full requirements of the role.

Medicines were not always stored securely and records not routinely maintained appropriately in theatres.

There were risk, quality and governance structures, managed at departmental, hospital and corporate levels, and systems were used to share information and learning. The risk register did not highlight the severity of the risks in theatres and senior theatre staff could not accurately describe the risks within their own department.

The resident medical officer was not included in the hospital's overall governance structure.

Staff reported incidents of harm or risk of harm and appropriate actions and learning occurred as a result.

Staffing levels and skill mix were planned, implemented and reviewed to keep people, including children and young people, safe at all times. Any staff shortages were responded to quickly and adequately. There were effective handovers and shift changes to ensure staff managed risks to people who used services.

Summary of findings

Care and treatment took account of nationally-recognised evidence-based guidance. Policies and guidelines were developed to reflect national guidance.

Feedback from patients about their care and treatment was consistently positive. We observed that patients were treated with kindness and compassion throughout our visit. Patients told us they felt informed about their treatment and had been included in decisions about their care. The hospital was flexible and adaptable and ensured specific individual needs were met. Patients were able to choose their surgery date or appointment time to suit their needs.

Outpatients and diagnostic imaging

Good



Overall we rated outpatients and diagnostic imaging as 'good'. We rated safe, caring, responsive and well led care as good. We did not rate the effectiveness of care and treatment.

There were appropriate systems in place to keep patients, including children and young people, safe. Staff reported incidents and shared learning of these incidents. Outpatient areas were clean and equipment was well maintained. Staffing levels were appropriate without any use of agency staff. Patient records were available for appointments and the department had timely access to test results. However, nurses who were responsible for decontamination of nasendoscopes were not trained to undertake the decontamination of that equipment. They had received training in general decontamination of equipment.

There was good multidisciplinary team working. Staff told us there was good training and support in their role, with appropriate opportunities to develop their skills further.

Staff were caring, compassionate, and treated patients with dignity and respect. Patients told us they felt informed about their treatment and had been involved in decisions about their care.

Hospital staff, together with consultant private secretaries, managed and scheduled clinics appropriately. This ensured good availability of appointments for patients across all specialities. Staff worked effectively in teams and were generally positive about the leadership of the

Summary of findings

service at both a local and senior level. There was an open culture and staff were encouraged to make suggestions to improve services for patients. The hospital used different methods to gather feedback from patients about their experience.

Summary of findings

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Requires improvement



Nuffield Health Bournemouth

Services we looked at

Medical care; Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to Nuffield Health Bournemouth Hospital

Nuffield Health hospital was opened in 1957 and moved to its current site on Lansdowne Road in 1993. An MRI scanner was installed at the hospital in 2013 and all the bedrooms were refurbished in 2014. The hospital site is made up of five buildings and has 41 beds used for inpatients and day cases.

The following services are outsourced to other independent contractors:

- Catering
- Facility Management
- Medical Equipment Management

- MRI
- Resident Medical Officer

We inspected the hospital as part of our planned inspection programme. This was a comprehensive inspection and we looked at the three core services provided by the hospital: medicine, surgery and outpatients and diagnostic imaging.

The registered manager at the time of inspection was Mr David McNair and he was registered on 1 October 2010.

The nominated individual from the provider, Nuffield Health, was Andrew Watkin Jones.

Our inspection team

Our inspection team was led by: Emma Bekefi, Inspection Manager, Care Quality Commission (CQC).

The team of ten included five CQC inspectors, and a variety of specialists: an oncology nurse, an endoscopy nurse, a surgery nurse, a trauma nurse, a radiographer and a radiotherapy lead.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information that we held about the hospital. We carried out an announced

inspection visit between 24 and 25 May 2016, and a routine unannounced inspection on 1 June and 9 June 2016. We spoke with staff and managers individually. We spoke with patients, relatives and staff from the ward, oncology day unit, physiotherapy department, operating department, endoscopy unit and outpatient services. We observed care and treatment and reviewed patients' records.

We would like to thank all staff, patients, carers and other stakeholders for sharing their views and experiences of the quality of care and treatment at Nuffield Health Bournemouth hospital.

Information about Nuffield Health Bournemouth Hospital

The hospital provides a range of services to patients at any age though most commonly patients are aged 18 years and over. Between January 2015 and December

2015, one per cent of the hospitals overall activity was care and treatment delivered to children aged 0 to 2 years, 3% to children aged three and 15 years old and one

Summary of this inspection

percent was delivered to young people 16 or 17 years old. The majority of care and treatment delivered to children and young people was done so within the outpatients department. 19% of all patients are NHS funded.

Hospital activity during the year January 2015 and December 2015 included:

- 1,352 overnight inpatients
- 4,839 day-case patients
- 6,191 visits to theatre
- 13,128 outpatients (first attendees)
- 8,471 outpatient (follow up appointments)

There were 6191 visits to the theatre between Jan 15 and Dec 15. The five most common surgical procedures performed were:

- Injections into joint (with and without xray control) (1888)
- Phakoemulsification of lens with implant - unilateral (425)
- Diagnostic endoscopic examination of bladder (including any biopsy) (222)
- Diagnostic gastroscopy includes forceps biopsy, biopsy urease test and dye spray. (194)
- Multiple arthroscopic operation on knee (including meniscectomy, chondroplasty, drilling or microfracture) (155).

The most common medical procedure between January 2015 and December 2015 was diagnostic gastroscopy (171).

The accountable officer for controlled drugs was David McNair.

Detailed findings from this inspection

Overview of ratings






Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Inadequate	Good	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good

Notes

* Inspected but not rated as we currently do not collect sufficient evidence to do so.

Medical care

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

Information about the service

Nuffield Health Bournemouth medical care service provides endoscopy and a cardiac catheter laboratory as day cases. Three patients since November 2015 had required an overnight in cardiology when the procedures had been complex.

There were 337 gastrointestinal endoscopies from January 2015 to December 2015. There were 222 endoscopic diagnostic examinations of the bladder (including any biopsy). The endoscopy unit consisted of a treatment room, a scope washer room with clean and dirty processing areas, a drying cabinet and a three bayed recovery area.

There is a dedicated cardiac catheter suite, which opened in November 2015. Since November 2015, they had undertaken 170 elective procedures. These included diagnostic angiography, percutaneous coronary intervention and pacemaker insertion. The cardiac catheter laboratory suite consisted of a treatment room, a viewing area, and three recovery trolleys.

The endoscopy suite is available for elective procedures between Monday and Friday from 8.30am to 8.30pm. Each day there were three sessions. The morning session ran from 8.30am to 12.30pm, the afternoon session from 1.30pm to 5pm and the evening from 5.30 pm to 8.30pm. The cardiac catheter suite was available Monday to Friday from 9am to 5pm.

Staff at the hospital provide healthcare to patients with private medical insurance, those who self-pay, and NHS through the NHS e-referral system. January 2015 to December 2015 there were 801 medical procedures performed at the hospital.

As part of our inspection we visited the Nuffield Health Bournemouth on 24 and 25 May 2016 and we carried out an unannounced inspection on 1 June 2016.

We inspected the clinical environment and equipment; we reviewed trust policies and procedures, staff training records, audits and performance data. We looked at computerised records and reviewed data provided by the trust.

We spoke with six patients and 14 staff, including doctors, nurses, operating department assistants, senior managers, a radiographer and a cardiac physiologist. We reviewed 12 sets of patient records across endoscopy and the cardiac catheter suite.

Medical care

Summary of findings

Overall we rated medical care as requires improvement.

There was not a training plan for staff working in endoscopy, to support staff achieving competencies effectively for the specialty. Appraisals were at 78% for staff working in theatres against a hospital target of 85%. In endoscopy suite local standard operating processes were not in place to support systems and processes. We found an inconsistent approach to the tracking and tracing of endoscopes.

Management of controlled medication in endoscopy was not always consistent with legislation. Nursing staff administered medication during procedures by nursing staff in the cardiac catheter laboratory with a verbal order, when there should have been a written prescription by the consultant.

Risk assessments were completed but we found gaps in completion of venous thromboembolism (VTE) and the World Health organisation (WHO) surgical checklist.

We were not assured how risks were managed, as risks identified in endoscopy were not on the hospital risk register. The endoscopy service was taking action to be able to meet current evidence based guidance. The hospital did not have Joint Advisory Guidance (JAG) accreditation in gastrointestinal endoscopy but there was an action plan in place towards achieving this.

Staff within the cardiac catheter suite had the knowledge and skills to deliver effective care and treatment. This was supported by robust standard operating procedures. Cardiac patient outcomes were being measured.

Staff had an awareness of safeguarding, and steps to take to prevent abuse from occurring. Staff were aware of the process for reporting incidents, and there was a culture of learning following incidents and audits. For example, audits undertaken of the management of controlled medicines, patient records and resuscitation equipment, where non-compliance identified, action plans put in place. Mandatory staff training across the hospital overall was at 84% against a target of 85%.

During the inspection, we saw that staff were caring, sensitive to the needs of patients, and compassionate.

Patients commented positively about the care provided from all of the endoscopy, cardiac catheter suite and ward staff. Patients were treated courteously and respectfully. Patients felt well informed and involved in their procedures and care. This included their care after discharge from an endoscopy procedure, a cardiac intervention and on the ward.

The service was responsive to patients in the admission criteria, with average waiting times of one to four weeks. Care and treatment was coordinated with other providers. The needs of different people were taken into account when planning and delivering services.

Medical care

Are medical care services safe?

Requires improvement 

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

We rated safe as requires improvement because;

- There were gaps in the endoscopy tracking and tracing records. We also found gaps in cleaning and equipment (including equipment used for resuscitation) records. This meant staff could not be assured that the environment and individual items of equipment including endoscopes were clean, checked and fit for use.
- Staff in the cardiac catheter suite were not following the hospital's procedure and practice guidelines for administering medicines. Nursing staff were regularly administering some medicines in the cardiac catheter laboratory following a verbal order from the consultant, rather than a prescribed order on a medication chart.
- The controlled drug register was not maintained appropriately in the endoscopy suite and staff were not routinely following the hospital's policy on medicines management. In endoscopy, we saw that controlled drugs were routinely being recorded as administered by one, rather than two theatre staff.
- There were gaps in the recordings of medication fridge temperatures in endoscopy meaning that the efficacy of medicines could not be assured.
- Records did not always contain risk assessments pertinent to clinical care. Nine out of 12 records we reviewed did not contain a venous thromboembolism (VTE) risk assessment.
- Mandatory training overall compliance was below the hospital target of 85% with low numbers of staff having completed training in aseptic technique, infection control for non-clinical staff, blood transfusion and paediatric life support.

However;

- The Five Steps to Safer Surgery checklist was in use, and audits January to March 2016 had shown 100% completion.

- Incidents were reported and learning was shared following adverse incidents to prevent similar recurrence.
- Staff followed procedures and used personal protective equipment in endoscopy and the cardiac catheter laboratory.
- Patients completed a comprehensive health assessment before a procedure, which was reviewed by nursing staff. Risks were identified through pre-assessment procedures, monitored and escalated if required.
- Staff could describe what might be a safeguarding concern, and were aware of their responsibilities to act if they suspected a patient was at risk of harm and/or abuse.
- There were sufficient numbers of staff, as planned, to provide safe care.

Incidents

- Staff in endoscopy and the cardiac catheter laboratory were aware of how to report incidents. The hospital reported there had been two clinical incidents in endoscopy in the period January 2015 to April 2016, and six in the cardiac catheter laboratory in the period October 2015 to April 2016.
- We saw where shared learning took place after an incident. Staff we spoke with said that reporting incidents had positive outcomes for patient care. For example, staff reported an incident in the cardiac catheter laboratory, following which a root cause analysis was undertaken. This identified issues with building design, and the requirement to re-position equipment, which was shared across the Nuffield group to shape future building works.
- Staff in endoscopy and cardiology were aware of the duty of candour legislation. 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 matron, theatre manager and catheter laboratory lead understood their responsibilities in terms of offering an apology to patients and meeting with and writing to patients if harm had been caused. If an incident occurred in oncology or endoscopy, nursing staff knew to be open and honest with patients.

Medical care

- There had been no never events in the endoscopy service or in the cardiac catheter laboratory during the period January 2015 to April 2016. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

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

- The hospital displayed audit information in the hospital reception. The audit data showed that in April 2016 there had been no meticillin-resistant staphylococcus aureus (MRSA), Clostridium difficile. The hospital also monitored patient feedback about the cleanliness of their room, which for April 2016 was 96%. The hospital did not use NHS safety thermometer within endoscopy or the cardiac catheter laboratory, as there were no NHS patients.

Cleanliness, infection control and hygiene

- We observed the weekly cleaning schedule for the endoscopy room. There were some gaps in the record so it was not clear whether the endoscopy room had been cleaned during these periods. We saw that the last week in February and three weeks in April 2016 had not been signed. This meant staff working in the endoscopy room could not be assured that the room had been cleaned though the room had continued to be used for procedures.
- We saw a daily checklist in use to record the cleaning of the washer disinfectant and the endoscopy dryer. However, there were gaps in the records. For example, in one week of May the record showed that the endoscopy dryer had only been cleaned twice in that week rather than daily and one week there was no record at all.
- The endoscopy list did not take account of recommendations to undertake 'clean' cases (gastroscopies), before 'dirty' procedures (colonoscopies) to minimise the risks of cross infection. Administrative staff organised the endoscopy lists without input from clinical staff. This meant there was limited consideration of clinical risk factors in relation to infection prevention and control (IPC) in relation to the

order of the lists. Clinical endoscopy staff we spoke with were not concerned about the organisation of endoscopy lists and did not recognise the potential infection risks.

- Cardboard boxes with excess stock were stored on the floor in a storeroom adjoined to the cardiac catheter laboratory. This made cleaning the storeroom more difficult. The cardiac services lead planned to address this concern.
- Compliance with infection prevention audits had been inconsistent. During 2015, compliance had not risen above 87%, lowest level of compliance 78% from April 2015 to June 2015. From January to March 2016, the compliance was 82%. The matron had discussed this with heads of department during quality and safety meetings. Staff awareness was raised about ensuring temperatures are recorded daily in theatres, and ensuring hand hygiene and compliance with asepsis. Hospital wide staff training compliance with infection control was at 90% against a hospital target of 85%. Staff were also expected to attend practical infection prevention and control training. Only 65% of staff overall had completed the practical training but this included 100% of all clinical staff. Aseptic technique training completion was just 16% but senior staff reported that training programme for this had changed recently meaning they had to re-train all eligible staff mid-year.
- Staff working in endoscopy decontaminated the endoscopes on site. There was a designated area for dirty scopes for an initial clean, which we observed being undertaken thoroughly. Staff then placed endoscopes in an automated washer, which had a pass through hatch, enabling staff to remove from the washer in a clean area, where staff could then place them in a designated dryer.
- Staff took weekly samples of the rinse water in endoscopy to check for decontaminants. These records showed a range between satisfactory and borderline. The latest results were satisfactory. The theatre manager described actions taken when results had been borderline which had included the engineering department working on the water supply pipes, and extra cleaning cycles of the endoscopy washer. The theatre manager also informed the outpatient's lead of the results, as theatre staff decontaminated endoscopes that were used in outpatients for diagnosis.

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- The hospital had policies and procedures in place to manage infection prevention and control (IPC). Staff were able to access these on their intranet. We saw policies and processes for the management of waste and decontamination.
- All areas we observed were visibly clean. We observed staff cleaning equipment between each patient having an endoscopy procedure.
- Disposable aprons and gloves were readily available. We observed staff using them when delivering care and treatment to patients, to reduce the risk of cross infection.
- Staff adhered to the 'bare below the elbow' as in National Institute for Health and Care Excellence guidance when providing care and treatment.
- The hospital scored 100% for cleanliness, compared to the national average of 98%, for the patient-led assessment of the care environment (PLACE) audit in 2015.
- The hospital had no incidences of clostridium difficile, meticillin-resistant staphylococcus aureus (MRSA) or meticillin-sensitive staphylococcus aureus (MSSA) in the period January 2015 to December 2015.
- Equipment in the endoscopy suite and cardiac catheter laboratory was visibly clean. In the cardiac catheter laboratory, staff used 'I am clean' labels to show when equipment was cleaned and ready for use. These had date, time and a staff signature on them.

Environment and equipment

- The number of endoscopes and size of scopes enabled the scheduled endoscopy lists to proceed uninterrupted. This met the standards set by the Joint Advisory Group on gastrointestinal endoscopy. There were also a sufficient number of monitors, cameras and printers.
- Environmental risks were managed appropriately to ensure patient and staff safety was maintained. For example, in the endoscopy treatment room the endoscopy lead had covered trailing wires with appropriate surgical theatre flooring tape to remove a trip hazard.
- There was not a suitable cupboard to store endoscopes in when they were removed from the endoscopy dryer and stored rather than used. Staff were storing the endoscopes coiled. The theatre manager told us there was no suitable facility to store the endoscopes hanging

straight to prevent any water collecting in the channels and maintain them in good working condition. The theatre manager was planning to speak with the estates department to arrange for the work to be undertaken.

- Maintenance and repair contracts were in place for the endoscopes, a machine that processed the water for rinsing, the washer disinfector and the drying cabinet. We saw maintenance records were up to date during our inspection.
- Staff working in endoscopy had checked the anaesthetic machine according to the anaesthetic machine association of anaesthetists for Great Britain and Ireland infection control (2008) guidelines.
- Endoscopy staff advised that if the endoscopy automated washer broke down, the company were very responsive, and would give advice over the telephone or come the same day or the next day. This meant the endoscopy list was not disrupted and the theatre manager confirmed if any delay; the department had an agreement for the endoscopes to be decontaminated at a nearby NHS trust.
- A transfer slide was available in the endoscopy suite to assist a patient from the treatment table to a recovery trolley if needed.
- There was a resuscitation trolley in endoscopy recovery, and in the cardiac catheter laboratory. Records showed that both trolleys were checked daily to ensure the contents were complete and in date. Both trolleys had tamper evident tags to prevent access by unauthorised personnel.
- There was also a resuscitation trolley in a recovery bay in Purbeck ward, where endoscopy and cardiac catheter laboratory patients went before and after procedures. This showed three days in May 2016, when the checklist was not signed, and four days in April 2016. A charge nurse explained the gaps might have been where the ward was closed, for example, at a weekend. However, this was not indicated on the record. The charge nurse said an audit was planned, so as actions could be taken to improve compliance where needed.
- There was sufficient equipment in the cardiac catheter suite. The suite was newly built so equipment was modern and in good working order.

Medicines

- Staff in the cardiac suite were not following hospital procedure for the administration of intravenous medicine. Patients in the cardiac suite were offered a

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relaxant intravenously immediately before a procedure was performed. The consultant did not prescribe this medicine prior to administration on a medication chart, but gave a verbal order. As this is not in 'exceptional circumstances' but a planned procedure, this practice is not within the provider's medicines management policy. The policy was re issued in January 2015. The Matron told us this policy was under further review at the time of our inspection. A senior nurse explained this concern was raised with the pharmacist at the hospital. At the time of our unannounced inspection, the pharmacist at the hospital was reviewing this concern.

- Medicines were available in endoscopy and the cardiac catheter laboratory if a patient reacted adversely to sedation or pain medicines.
- There was an aide memoire in the cardiac catheter laboratory of common medicines to support staff in their understanding of medications in use.
- Medicines were stored in locked cupboards. Medicines that required storage below a certain temperature were stored in a locked fridge, specifically for that purpose. During our inspection, we saw that the checking of minimum and maximum temperatures took place. These checks were not carried out daily, but when there was an endoscopy or cardiac catheter laboratory list. When we checked the recordings, they were all within the acceptable range. The leads told us staff were aware of actions to take if temperatures were not within the minimum and maximum range, and there was guidance on the recordings sheets. There were 18 days in March 2016 where there was no fridge temperature recorded. It was not clear if staff checked maximum and minimum temperatures before a day of procedures, so could be assured the temperatures had been maintained in the correct range and medications ready for use.
- We reviewed the storage of controlled drugs (CDs). CDs are prescription medicines that are controlled under Misuse of Drugs legislation. In endoscopy, staff were not routinely following the hospital's procedures and current guidance on the management of CDs. The hospital completed an audit of controlled drugs storage, usage and records in December 2015, in accordance with regulations 11,14 and 15 of the controlled drugs (supervision management and use) regulations 2006, in endoscopy. The pharmacist found endoscopy were 50% compliant regarding controlled medicines being stored at the right temperature, 90% complaint with signatures being authorised (if an agency nurse) and 90%

compliant with two signatures against each entry. The pharmacist wrote an action plan put in place in January 2016. A further audit was undertaken in April 2016, which showed 60 % compliance with CD's being stored at the right temperature, and remained at 90% compliance with all signatures being authorised and for two signatures against each entry. We found six controlled drug entries on our announced inspection on 9 May 2016 had only one signature instead of two. This was where a patient had one dose of a CD then needed a further dose of the same medication to be comfortable. The theatre manager confirmed the practice of a single signature had become routine practice in endoscopy. Planned actions included a proposed plan by the provider for the centralisation of theatre temperature recordings. The hospital was awaiting a site visit. Also, the theatre manager was to raise concerns through 'communications' but it was not clear specifically how this was planned. This was regarding the issue of two person signatures being required against all controlled medicine entries. Awareness had been raised with theatre staff to ensure all new staff need to sign CD schedule in pharmacy before administration. Staff working in the cardiac catheter laboratory stored and recorded controlled drugs appropriately.

- The hospital had an onsite pharmacy staffed led by a pharmacy manager with three other team members to support the staff.

Records

- Staff working in endoscopy kept tracking and traceability records regarding the endoscopes. However when we checked these records, five entries during the month of May 2016 were incomplete. Staff had not completed fully all sections, which included equipment processed and number, loading disinfection cycle number, date and time of cycle completion, and patient information sections. The theatre manager was aware of this inconsistency, and had arranged for staff to be re-trained on 27 and 28 June 2016.
- We reviewed 12 patients' medical and nursing records for endoscopy or cardiac catheter laboratory procedures. We found records were not always fully completed. For example, seven out of seven records of

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cardiac patients did not include a venous thromboembolism risk assessment. In one record there was no modified early warning score for cardiac interventions.

- Staff in the cardiac catheter laboratory had completed the Five Steps to Safer Surgery checklist in nine out of 10 eligible patient records. The cardiac intervention patient record where the checklist was incomplete was not filled in at all by staff.
- A records audit of the new cardiac pathway was undertaken in May 2016. This audit reviewed 10 records and achieved an overall score of 78% compliance. The result had been shared with the cardiology team through a newsletter. They were planning to arrange a staff meeting to discuss the audit findings, and develop an improvement plan.
- The hospital undertook a health record keeping standards audit quarterly. The compliance results in 2015 had ranged from 93% to 98%, against a target of 90%.
- Records were legible, available at the point of care delivery and stored in a lockable cabinet when the patient on the ward.

Safeguarding

- Staff working in endoscopy confirmed there had been no safeguarding incidents in the January 2015 to April 2016. Staff working in the cardiac catheter laboratory confirmed there had been no safeguarding incidents from November 2015 (the start of the service) and April 2016.
- Staff could explain how they would respond if they witnessed or suspected abuse, and would report it to the matron, who was the safeguarding lead.
- Policies and procedures in safeguarding were available to staff to refer to and inform their practice. Staff could access the hospital's safeguarding policies and procedures via the intranet. The safeguarding policy was last reviewed in July 2015.
- Level 1 for safeguarding children and young adults was mandatory for all staff and at 24 May 2016, 92% had completed. Safeguarding training at level 1 for safeguarding vulnerable adults was mandatory for all staff and 24 May 2016, 90% had completed. Level 2 training was the minimum level required for non-clinical and clinical staff that have some degree of contact with children, and or parents. Fifty-two staff required safeguarding training at level 2 for safeguarding children

and young adults and compliance was at 94% at 24 May 2016. Level 3 training was face to face, and required by all clinical staff working with children and young people who could potentially contribute to assessing, planning and intervening the needs of a child. Three clinical staff required safeguarding training at level 3 for safeguarding children and young adults and compliance was at 100% at 24 May 2016.

Mandatory training

- Staff were required to complete mandatory training, which included resuscitation, health and safety, moving and handling and information management.
- Mandatory training compliance for the hospital overall was 84% against a hospital target of 85% at May 2016.
- We saw gaps in mandatory training completion in some areas. For example, paediatric basic life support was mandatory for all staff but had only been completed by 73%. We were told this was because it had only recently become part of the mandatory training requirement for all staff. Only 73% of staff had completed safer blood transfusion training. Senior staff were aware of the gaps in mandatory training compliance. However, there was no action plan in place to ensure staff were accessing the required mandatory training.

Assessing and responding to patient risk

- Patients attending for endoscopy were asked to complete a postal pre-assessment health check questionnaire. A registered nurse checked the returned questionnaires prior to the procedure to assess a patient's suitability and fitness for endoscopy. The pre-operative assessment nurse advised the doctors of any medical risk factors that the consultant needed to be aware of so they could revise the treatment plan if required.
- Patients undergoing a cardiac intervention were seen by staff in the cardiac pre assessment clinic at the hospital where potential risk factors were explored and recorded.
- Staff recorded individual patient risk factors on the endoscopy list. For example, the lead told us if a patient had diabetes, it would be highlighted for nurses to manage to prevent the possibility of low blood sugar in the pre-operative fasting period.
- Staff working in endoscopy and the cardiac catheter laboratory used the five steps to safer surgery checklist (WHO). This is a nationally recognised system of checks before, during, and after surgery, designed to prevent

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avoidable harm and mistakes during surgical procedures. We observed staff performing the checklist correctly and consistently during our visit. The hospital had carried out an observation audit of the use of the 'five steps to safer surgery' WHO checklist. From October to December 2015, compliance had been 92%, previously in observational audits in 2015 compliance had been 100%. From January to March 2016, compliance improved to 100%.

- Nursing staff used a modified early warning system to record patient's observation during endoscopy or cardiac procedures. This meant they could identify any decline in a patient's condition and ensure medical support was accessed if required.
- A transfer policy and standard operating procedure was in place for a cardiac patient who may require urgent transfer to a local NHS trust. This had worked well for a patient undergoing a cardiac procedure in the cardiac catheter laboratory. The patient was discharged home the following day from hospital.
- At the hospital, nine staff, which included the RMO, had advanced life support training, and compliance with intermediate life support training was at 84%. The cardiac charge nurse undertook scenarios six weekly where different mock emergencies were managed. Scenarios had included cardiac arrest and sepsis. Following the charge nurse organising a mock cardiac arrest scenario in May 2016 when the outcome was positive. There were some recommendations which were taken forward. These included a reflection on team communication, and the purchase of a higher step for undertaking effective cardiopulmonary resuscitation.

Endoscopy and cardiac catheter staffing

- The hospital did not have a dedicated team of staff working in endoscopy. Theatre staff from the main theatres staffed the endoscopy suite.
- The theatre lead was providing leadership for the gastrointestinal endoscopy lists, whilst awaiting an endoscopy lead to start at the hospital, who had recently been recruited.
- Staffing was sufficient to provide a safe endoscopy service. We observed the theatre lead nurse, an endoscopist, an anaesthetist, two operating department practitioners and a healthcare support worker undertaking decontamination were present during endoscopy procedures.

- There had been less than 20% agency nursing staff and operating department assistants' use in theatres for seven out of 12 months during the period January to December 2015, and from 20% to 39% for five months in this period. The theatre manager explained induction for agency staff was in place, and recruitment was ongoing.
- The cardiac services manager led a dedicated team of staff supporting the procedures in the cardiac suite.
- We observed sufficient staffing in cardiology during our inspection. We saw that a cardiologist, the cardiac services manager, their deputy (also a cardiac radiographer), cardiac scrub nurse, two supporting nurses and a cardiac physiologist were present to safely manage the cardiac list we observed. There were three specifically cardiac recovery nurses to support cardiac patients in recovery. In addition, a ward cardiac lead nurse was responsible for cardiac patients nursing pre assessment, and before and after care in the ward area.
- There were adequate staff in the cardiac catheter laboratory and the cardiac service manager advised us that recruitment was taking place for a forthcoming vacancy.

Medical staffing

- Consultants worked at the hospital under practising privileges. Practising privileges give medical practitioners the right to work in an independent hospitals following approval from the medical advisory committee (MAC). This included the hospital checking disclosure and barring service (DBS) checks, qualifications and experience to undertake procedures. There were nine consultants undertaking gastrointestinal endoscopies and 10 undertaking cardiac intervention procedures with practising privileges working at this hospital. Clinical care was booked according to consultant availability, which ensured there was always adequate consultant cover.
- A resident medical officer (RMO) provided 24 hour, seven day a week cover at the hospital. There were two RMOs working in alternate one week blocks to ensure that medical advice and emergency support was always available. The RMOs were provided through an external agency who could provide additional cover for sickness or other unscheduled leave as required.
- The consultants maintained overall responsibility for the patients 'care throughout their admission to the hospital. The RMO had immediate access to the

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responsible consultant if required. They could also attend at short notice in case of an emergency as staff said they were within 30 minutes' drive from the hospital. Staff told us that they had been able to contact a consultant if needed.

Major incident awareness and training

- The endoscopy and cardiac catheter laboratory staff were aware of the major incident policy at the hospital. Staff could access major incident policies and guidance on the staff intranet if required.
- The hospital had business continuity plans in place. Arrangements included a back-up generator in case of power failure, which would provide power for sufficient time to allow power to be restored.

Are medical care services effective?

Requires improvement 

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

We rated effective as requires improvement because

- There was no plan to support the specific training needs of staff working in endoscopy, and staff working in endoscopy had not had specific competencies to work though until April 2016. The theatre manager was aware this was a priority for action but was awaiting the appointment of a designated endoscopy lead to implement.
- There was not a local standard operating procedure in place for gastrointestinal endoscopy at the hospital.
- The hospital was not routinely monitoring gastrointestinal procedure outcomes.
- Appraisals for nursing staff in the theatre department were 78% against a target of 85%.

However,

- Staff took account of National Institute for Health and Care Excellence (NICE) guidance.

- Patient outcomes were collected in the cardiac catheter laboratory since the service commenced in November 2015 at the hospital, but until the number of procedures reached 250 these could not be accepted by the British Cardiac Intervention Society (BCIS).
- Staff working in the cardiac catheter laboratory, undertook specific training, supported by competency framework and assessments.
- We saw evidence of effective multidisciplinary team working to support patient care.
- Medical staff obtained informed consent from patients prior to endoscopy and cardiac catheter laboratory procedures. Staff demonstrated an understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards

Evidence-based care and treatment

- Theatre staff working in endoscopy took account of National Institute for Health and Care Excellence (NICE) guidance, but did not have Joint Advisory Group (JAG) accreditation. The service had completed an endoscopy global rating scale (GRS) self-assessment. The GRS is a quality improvement system designed to provide a framework for continuous improvement for endoscopy services to achieve and maintain accreditation. In April 2016, the hospital had assessed themselves using the GRS scale. The hospital was aware further work needed in the clinical quality, quality of patient experience and workforce domains. For example, the development of an agreed annual education and training plan, supported by management, that reflects staff and service needs.
- The theatre leads had an endoscopy action plan to support their goal of achieving JAG accreditation. Actions included developing a local standard operational policy (SOP) that supported evidence based care and best practice. However, the actions to achieve this were on hold until the new endoscopy lead was in post. Following an information request we received a corporate level SOP for endoscopy published in June 2016, which the hospital would be using to inform a localised hospital SOP.
- Staff working in the cardiac catheter laboratory took account of National Institute for Health and Care Excellence (NICE) guidance, and were working towards

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British Cardiac Intervention Society (BCIS) accreditation. The cardiac lead said when 250 cardiac procedures performed, a request would be made for an external visit from the BCIS.

- An audit schedule was in place for 2016, supported by an audit calendar. These audits monitored compliance with hospital procedures, for example compliance with the controlled drug, rather than clinical outcomes.

Pain relief

- Staff offered patients undergoing a gastrointestinal endoscopy a throat spray to reduce discomfort and/ or intravenous sedation, to minimise any discomfort and/ or pain. Medical staff also performed gastrointestinal endoscopies under a general anaesthetic where appropriate.
- In the cardiac catheter laboratory interventions were performed with a local anaesthetic to the skin and to patient choice. For the intervention we observed a patient had decided to have sedation intravenously, during their procedure.
- Nurses monitored a patient's pain using a pain scale of 0-10, and offered pain relief when appropriate.
- Staff would offer patients stronger analgesia if the patient self-rated their pain above five out of 10.

Nutrition and hydration

- Patients having a gastroscopy were advised not to eat anything for six hours and then to have water only two hours up to admission time, to enable good views of the stomach.
- Patients who were due to attend for a colonoscopy, was given detailed advice on how to prepare for the procedure. This included administering a laxative and advice regarding dietary and fluid intake.
- The consultant advised patients having an intervention in the cardiac catheter laboratory not to eat anything six hours before the procedure, but could drink water up to three hours prior to a procedure.
- Nursing staff offered patients a drink and light snack prior to discharge after gastrointestinal endoscopy or an intervention in the cardiac catheter laboratory.
- The Patient Led Assessment of the Care Environment (PLACE) in 2015 rated the quality of ward food as 99%, the England average was 94%.
- The quality indicators displayed in the hospital reception by the matron and executive director showed the overall quality of catering service rated at 95%.

Patient outcomes

- Consultants reviewed patient outcomes on an individual level through follow up appointments and individual review but the hospital were not collecting data on overall patient group outcomes. The hospital was not routinely collecting outcome data for gastrointestinal endoscopy, as described in JAG for gastrointestinal endoscopy. The hospital had installed an electronic management system in August 2015 in the endoscopy suite to enable to consultants to input data to capture outcomes following endoscopy procedures. Use of the system was being encouraged by the theatre manager standing with the consultants to support them with inputting data. The theatre manager advised that at present not all consultants' outcomes were being routinely captured, with further information technology support needed from theatre staff with the consultants to embed the system.
- The IT system in use was not the same as the consultants used in their NHS work. The lack of data collection meant the hospital were unable to measure the outcomes of gastrointestinal endoscopy procedures. The data told the consultants information such as average amount of sedation and analgesia they have used with patients. The data also included the completeness of their patients with bowel preparation, and percent of procedures undertaken that were confirmed complete by an image.
- The cardiac consultants were collecting outcomes of procedures, for inputting into the British Cardiac Intervention Society (BCIS) when 250 procedures performed. In May 2016, the hospital had performed 170 cardiac intervention procedures. By November 2016 the hospital had registered the cardiac catheter laboratory with BCIS, and data was due to be included in the BCIS audit March 2017.
- The registered manager informed us that the Nuffield group was working with the private healthcare information network (PHIN), in relation to the collection and publication of clinical outcomes. They had raised awareness amongst the consultants at a medical advisory committee meeting held in January 2016.

Competent staff

- The medical advisory committee (MAC) was responsible for approving practising privileges for medical staff. We reviewed five records, which demonstrated there was a

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process in place to ensure consultants' documentation, including, general medical council registration/ relevant speciality and scope of practice, appraisal and disclosure and barring service check were up to date.

Two of the five records we reviewed demonstrated overdue appraisals. Consultants were e mailed if there were any overdue sections. After a period of time, and dependent on which element was not evidenced, a letter sent from the executive director proposing suspension of practising privileges if the relevant information not sent. For example if medical indemnity insurance was not evidenced, a letter would be sent after one week. The executive director had issued a suspension letter shortly before our inspection to a consultant who had then provided the necessary evidence the following day and the suspension was revoked.

- An audit in February 2016 of 10 consultant personnel files demonstrated 96% compliance with verification of professional registration for doctors with practising privileges. This refers to medical practitioners being granted the right to practice in an independent hospital after being approved by the medical advisory committee (MAC). The MAC chair confirmed that the medical staff working in the cardiac theatre and undertaking endoscopy procedures regularly carried out procedures in their local NHS trust.
- Theatre staff appraisal rates were 78% for nurses and 100%, for operating department practitioners and theatre department care assistants for the period January to December 2015. The hospital's target was 85%.
- Staff working in endoscopy, had not had dedicated endoscopy competencies to work through until April 2016. The theatre manager at our inspection in May 2016 advised these competencies were a priority area for staff to work through. A training plan to meet the education needed for staff working in endoscopy to be agreed when the new gastrointestinal endoscopy lead commenced in post. The theatre manager reduced the impact of these risks, staffing the scheduled gastrointestinal lists with staff with appropriate knowledge and skills.
- Consultant cardiologists performed cardiac catheter laboratory interventions supported by a dedicated team

of staff. The cardiac services manager advised us that appraisals were up to date for three staff that had been in post for a long enough period. The other members of the team were still completing their induction.

- Staff in working in the cardiac catheter suite laboratory had undertaken specific training. The two qualified cardiac radiographers, had attended a five day training course on the use of the dedicated radiographic equipment in use in the laboratory. The cardiac services manager also ensured the consultant cardiologists were competent in the use of the dedicated radiographic equipment in the cardiac catheter suite, supported by a competency framework. The cardiac services manager had undertaken a two day human factors course training in January 2016. This training was designed to enhance clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour.
- Staff working in the cardiac catheter suite had completed specific competency based training that detailed the care of a patient in the cardiac catheter laboratory before, during and after the procedure. This included care of femoral and radial artery following a cardiac intervention procedure.
- The hospital staff also ensured agency staff were competent. An agency nurse working in the cardiac catheter laboratory had previously worked within a NHS trust. The nurse had 10 years' experience of working in a cardiac catheter laboratory.

Multidisciplinary working (in relation to this core service)

- There was effective multidisciplinary working in the cardiac catheter laboratory. During our inspection, the administrative, pre-assessment, cardiologist and cardiac laboratory staff worked well together to ensure the patient pathway was effective.
- The administrative staff, medical staff and theatre staff worked as one team to support a patient undergoing a gastrointestinal endoscopy.
- The matron at the medical advisory committee meeting in January 2016, had requested the consultants provide assurance that if a patient needed referral to a NHS cancer multidisciplinary team, this referral happens. The matron advised during our inspection in May 2016 that the consultants had e mailed to provide assurance that a NHS multidisciplinary team is informed if required.

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- The consultants provided a discharge summary for the patient and GP about their care at the hospital, and their ongoing care.

Seven-day services

- The endoscopy and cardiac services operated Monday to Friday and were not available at weekends.
- Nurses provided care on the ward seven days a week.
- The pharmacy was open Monday to Friday 9am to 5pm. Outside of these hours, the resident medical officer (RMO) and the nurse in charge jointly could access the pharmacy. The hospital also had a service level agreement with a nearby NHS trust, whereby the RMO or nurse in charge could contact the on call pharmacist for the trust out of hours.
- Managers participated in an on-call system to ensure there was always a manager available to give advice and support to staff outside of usual working hours.

Access to information

- The patient received a discharge letter that included the reason for their endoscopy or cardiac intervention procedure, findings, medication and any changes, potential concerns and what to do and details of any follow up. The nurse sent a copy of this letter to the GP and placed a copy in the patient's medical records at the hospital. This also included the ward telephone number and a patient's medical care notes number, so if the patient had a problem out of hours they could contact the ward for advice.
- Staff were able to access information on their local intranet, which included clinical policies and standard operating procedures. There was also information such as patient information leaflets to support a patient giving informed consent, which staff could print for the intranet. For example information about flexible sigmoidoscopy (procedure to look at the left lower part of the colon).
- The doctors were able to access patient information, including scan results and blood tests using the hospital's information technology systems.
- The hospital kept records on site for two years after which they were sent to an offsite storage facility. Staff could access paper records stored offsite within 24 hours. This meant staff could access past clinical information about patients previously treated at this hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients received written information prior to their endoscopy or cardiac catheter laboratory procedure. This allowed patients to read the information and, if understood, give informed consent when they came for their procedure. Consent forms appropriately detailed the risks and benefits to the procedures.
- The hospital provided Mental Capacity Act (2005) training as part of the mandatory training programme. Staff talked through their understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with would seek the support of the matron, if they were concerned a patient lacked mental capacity, or if they believed a patient was being deprived of their liberty.
- At 24 May 2016, 91% of clinical staff had completed Mental Capacity Act training. At 24 May 2016, 87% of clinical staff had completed deprivation of liberty safeguards training.

Are medical care services caring?

Good 

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

We rated caring as good because:

- During the inspection, we saw and were told by patients, that staff were caring and compassionate. Patients commented positively about the care provided from all of the endoscopy and cardiac suite staff. Patients were treated courteously and respectfully.
- During the period January 2016 to March 2016, overall satisfaction with patient experience was 94% and rating for being treated with respect and dignity 97%. This information was displayed at the hospital
- Patients felt well informed and involved in their procedures and care, including their care after discharge from the endoscopy suite.
- Patients were supported emotionally with their care and treatment as needed.

Compassionate care

Medical care

- During the inspection, we saw and were told by patients, staff treated patients with kindness and respect, and maintained patients' privacy and dignity.
- Patients we spoke with that were undergoing an endoscopy or a cardiac intervention described staff as compassionate and caring. One patient described staff as being 'helpful and friendly'.
- The Friends and Family test demonstrated that between 96% and 98% of patients would have recommended the hospital to friends and family between July and December 2015.
- In the Patient Led Assessments of the Care Environment (PLACE) in 2015 privacy, dignity, and wellbeing scored 99% compared to an England average of 87%.
- During the period January 2016 to March 2016, overall satisfaction with patient experience was 94% and rating for being treated with respect and dignity 97%. This information was displayed at the hospital.
- From January 2016 to March 2016, the hospital survey showed overall confidence and trust in your consultant was 98% and overall confidence and trust in nurses 96%.

Understanding and involvement of patients and those close to them

- Patients who underwent a gastrointestinal endoscopy or a procedure in the cardiac catheter laboratory had been provided with relevant information by staff, both verbal and written, to make an informed decision about their care and treatment.
- Consultants allowed sufficient time for patients' at their appointments so they could discuss any concerns they had. A patient in endoscopy said how pleased they had been with the care and explanations.
- Staff in endoscopy and cardiology took time to explain treatment options and potential plans of care to patients and their relatives. For example, following the patient's procedure the consultant would see the patient, provide feedback on findings, and discuss the ongoing plan of care.
- Patients received appropriate information prior to their procedure. For example, for a colonoscopy, the information included preparation and time to arrive, what the procedure involved, during the procedure and aftercare.

Emotional support

- We observed staff explaining to patients about the care and treatment that would be undertaken in order to reduce any anxiety.
- Patients could telephone the ward after discharge, for further help and advice about any concerns or questions on their return home. If a consultant found a cancer, a patient would be referred to the NHS, where clinical nurse specialists provided emotional support for patients as part of their ongoing care.
- Patients were able to have emotional support from family and friends at any time, as there were no restrictions to visiting times

Are medical care services responsive?

Good 

By responsive, we mean that services are organised so that they meet people's needs.

We rated responsive as good because;

- Consultants undertook gastrointestinal endoscopy and cardiac catheter laboratory procedures within two to four weeks of referral.
- Care and treatment was coordinated with other providers.
- The individual needs of different people were taken into account when planning and delivering services.
- Complaints received by the hospital were actively managed by the matron and shared with all staff so any improvements needed could be made.

Service planning and delivery to meet the needs of local people

- Consultants undertook gastrointestinal endoscopy procedures on an insured (private) and self-pay basis. The hospital managers were planning to take on NHS work once they had received accreditation for endoscopy. Hospital managers planned the service to meet the needs of local people in collaboration with clinical commissioning groups.
- Cardiac catheter laboratory interventions were undertaken on an insured and self-pay basis.
- The Executive Director (ED) explained that, in discussion with a local clinical commissioning group, a business case had been submitted for a telecardiology (a means of two way communication between hospitals to

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transfer cardiac images) service with two nearby NHS trusts. In the hospital board meeting in March 2016 the executive director noted that the business case was approved, and the provider corporate information technology team were leading on taking the business case forward.

- Patients were cared for in single rooms, offering privacy, pre and post endoscopy and a cardiac catheter procedures.

Access and flow

- Consultants saw patients referred by their GP as an outpatient before a non-urgent gastrointestinal endoscopy procedure. This appointment was to check the patient met the admission criteria, assess the patient, and discuss a plan of treatment. This meant that staff could plan for the flow of patients.
- The service was responsive to patients in the admission criteria with average waiting times of one to four weeks.
- The cardiac catheter laboratory only undertook planned, non-emergency procedures. A named hospital consultant cardiologist, following accepting a patient, listed them for the appropriate procedure. The consultant or secretary then sent a booking request to the hospital booking team.
- Consultant cardiologists undertook interventions within one to four weeks of referral. Patients were typically seen in a cardiac clinic on a Friday, and admitted for their cardiac procedure the following Wednesday. Most patients were day cases, unless a list finished late in the day, and a patient had not recovered sufficiently to be able to be discharged until the following morning. This had happened shortly before our inspection in the cardiac catheter laboratory intervention service due to a list with several patients with complex needs. The charge nurse in cardiology was exploring with the cardiology nurses rostering a staff member to cover a Wednesday night shift, as more complex patients who required overnight stays were planned.
- The cardiac services lead and matron were developing a business case for a dedicated two bedded area on the ward, appropriately staffed, to support the timely flow of patients from the cardiac catheter laboratory. This would enable the provision of level 2 care (patients requiring higher levels of care and more detailed observation/intervention) for short periods.

Meeting people's individual needs

- Patients endoscopy (length of stay less than 24 hours) and cardiology pre procedure questionnaire included a prompt about dementia. Staff we spoke with advised us if a health assessment indicated a patient did have a dementia they would speak with their next of kin to obtain more information, and discuss with a more senior nurse.
- The Patient Led Assessment of the Care Environment (PLACE) for 2015, PLACE rated the hospital at 88% dementia friendly, compared with other independent hospitals at 81%.
- There was a variety of menu options available for inpatients and the chef catered for the needs of patients with special diets.
- The service had level access and designated parking spaces for patients with limited mobility.
- For patients whose first language was not English, telephone translation facilities were available. We saw a welcome board in the main reception of the hospital, which welcomed patients and visitors in a range of languages. The information on the welcome board allowed patients whose first language was not English to point to their first language so an interpreter could be organised.
- The hospital admission assessments included prompts about checking patients' orientation to the surroundings and understanding about the purpose of their admission. Staff we spoke with advised us if they were concerned a person may have a learning disability, they would seek the support of a more senior nurse.
- Patients were given follow up information on discharge. The consultants went to see patients following procedures to explain what they had found, and ongoing care. Patients were also given written information about their admission and discharge. Patients we spoke with found this information provided them with reassurance.

Learning from complaints and concerns

- There had been no complaints regarding the endoscopy service in the period January 2015 to April 2016, or the cardiac catheter suite since the service had started in November 2015.
- In each patient bedroom, there was a booklet, which contained information about how to raise a concern or complaint.

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- The hospital received 33 complaints from January 2015 to December 2015. Two complaints were raised to the Care Quality Commission in the same period. The two most frequent themes were clinical care of consultants and communication by various hospital staff. In the monthly quality and safety committee meeting, which was attended by the cardiac lead and the theatre manager from the medical service, complaints were discussed and lessons shared from across the hospital. For example, we heard from staff how communication between nurses on the ward and administrative staff had improved following a complaint raised by a patient.
- Complaints and concerns (percentage of patients attending our hospital who made a formal complaint) was 0.8% during the period January 2016 to March 2016.
- Complaints were discussed with consultants at the quarterly Medical Advisory Committee meetings.

Are medical care services well-led?

Requires improvement 

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

We rated well led as requires improvement because:

- The endoscopy service risks were not identified on the risk register
- There was no designated endoscopy lead. The theatre manager was providing temporary leadership to the endoscopy service, but did not have capacity to develop the endoscopy service.
- Quality monitoring was not always undertaken as planned.
- Senior leaders did not always act promptly where there were increased risks or areas of non-compliance.

However,

- Staff were aware of the vision and values of the hospital. The cardiac catheter service had effective leadership in place. The endoscopy and the cardiac catheter service had identified clinical priorities.

- Staff spoke passionately about the service they provided and the care they offered to patients. Staff achievement was valued through staff awards.

Leadership and culture of service

- There was no designated endoscopy lead. The theatre manager had an overview, but did not have the capacity to provide leadership to develop the endoscopy service. The matron had taken action to recruit an endoscopy lead, but the post remained unfilled. Staff in endoscopy did not always have someone they could discuss concerns with as no designated endoscopy lead.
- The cardiac services manager had the capacity, knowledge and skills to run the cardiac catheter service effectively. Staff in the cardiac catheter service said they worked well as a team and felt supported by their immediate managers who lead their department well. The cardiology charge nurse, to ensure staff kept up to date with developments in the service, had produced a newsletter.
- Staff had opportunities to discuss any concerns they had with their line managers in the cardiac catheter laboratory, and were keen to see developments in their services
- The cardiac services manager had put forward the lead cardiac scrub nurse for a hospital reward and recognition award, for which they had been successful.

Vision and strategy for this this core service

- Staff spoke passionately about the service they provided and the care they offered to patients. Staff were aware of the provider values, which were to be enterprising, passionate, independent and caring. Provider values were embedded amongst the staff, which were to be enterprising, passionate, independent and caring.
- Endoscopy and the cardiac catheter laboratory service had identified clinical priorities. An action plan led by the theatre manager was in place to further develop the endoscopy service, towards achieving joint advisory group (JAG) accreditation in gastrointestinal endoscopy. A business plan was in place led by the executive director (ED) to be involved in a telecare service by the cardiac catheter laboratory. Staff working in cardiology were aware of this plan.

Governance, risk management and quality measurement for this core service

Medical care

- There was a hospital wide risk register. Each risk on the register included a description of the risk, how it was managed, and the overall risk rating. The risks we identified in the endoscopy service such as there not being a designated endoscopy lead, a competency framework or training plan, were not detailed on the risk register.
- The cardiac service was identified as a risk, with an appropriate risk description, measures in place to manage identified risks and evidence of review. Risks included unfamiliar emergency management protocols. A charge nurse had led training scenarios, but hospital still felt a risk. Another risk was that the supply chain, due to new due to new contracts and suppliers so not yet tested that equipment needs would always be met.
- A thorough review, which included the complete patient pathway was undertaken, before the cardiac intervention service commenced on 30 September 2015. The matron chaired an initial cardiac services governance review meeting in April 2016.
- There was a monthly quality and safety meeting attended by the heads of department, which included a discussion about policies, National Institute for Health and Care Excellence (NICE) guidance, incidents, training and complaints relating to various departments within the hospital.
- The medical advisory committee met quarterly. Attendance by consultants varied, from five to 10. The number of apologies during the period April 2015 to January 2016 ranged between six and 11 consultants. A gastroenterologist chaired the meeting. The meeting notes included incidents, complaints, quarterly audit results, patient satisfaction survey and approvals, renewals and removals regarding consultants holding practising privileges at the hospital. The number of consultant apologies was concerning, as regards to how representative the meeting was from the consultant body.
- Audits and their results were shared at the monthly quality and safety meetings and the quarterly medical advisory committee meetings. The hospital had some delays in some essential quality monitoring audits. For example, a decontamination audit due in April 2016 not completed until July 2016. following non-compliance being found on an audit could be slow. For example, changes following the controlled medicines audit in endoscopy.

- The risk register was discussed at the quality and safety meeting and the medical advisory committee. The matron shared the risk register with line managers.

Public and staff engagement






- The hospital participated in a staff survey in April 2015. An action plan was developed, to address six themes rated as amber that emerged from the eleven questions asked. These included themes about having enough resources to do the job and enough staff. Actions included line managers chasing up where they were items of equipment not working and ensuring staff kept updated with recruitment plans.
- A GP event was held at the hospital in September 2015. One of the services discussed was the new cardiac catheter laboratory, which ensured the GPs were aware of this service when seeing patients.
- The hospital undertook a continuous patient satisfaction survey. Most feedback in the last six months had been consistently above 90%. Questions included prompts about discharge and care and treatment. Patients had responded to three of four questions about care and treatment at being from 80% to 90% in January 2016 and February 2016, for example being given clear explanations about your procedure and involvement in decisions about care and treatment. The results of the patient's satisfaction survey were discussed with heads of departments, so they could share with staff and improve patient experience where needed.
- A provider quality and safety team newsletter in December 2015 had included a written 'patient safety conversation' following an incident. The conversation was about a patient who had left a hospital within the provider group unnoticed. The patient fell outside the hospital and sustained a fractured wrist. The detail included the background to prompt staff to consider if the incident could have happened at their hospital. For example, in this incident staff breaks had been taken as pairs, rather than individually. If staff had gone individually this would have enabled better cover on the ward and patient observation. This provided an opportunity for shared learning across the provider group of hospitals.

Innovation, improvement and sustainability

Medical care

- There was an action plan in place to support the achievement of Joint Advisory Group accreditation to support the sustainability of the gastrointestinal endoscopy service.
- The cardiac catheter laboratory was planning to apply for accreditation with the British Cardiac Intervention Society (BCIS) when 250 procedures had been undertaken.

Surgery

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

Information about the service

Nuffield Health Hospital Bournemouth provides planned surgery to patients who pay for themselves, are insured, or are NHS-funded patients.

There were 6,191 visits to the operating theatre between January and December 2015. Between January 2015 and December 2015, 1,818 NHS patients were treated for inpatient and day case procedures compared with 3,021 patients funded from other sources. Between January 2015 and December 2015, 6,191 patients attended the hospital for a variety of surgical procedures. Surgical specialities offered include orthopaedics, ophthalmology, general surgery, gynaecology and cosmetic surgery. The five most common surgical procedures performed were injections into a joint; refractive eye surgery; diagnostic endoscopic examination of the bladder; diagnostic gastroscopy; and multiple arthroscopic operations on the knee.

The hospital also provides a small surgical service for children and young people. In the reporting year, there were 10 in-patient surgical admissions and 49 day case surgical procedures on children aged 3-15 years. There were 12 inpatient surgical admissions and 22 day case admissions carried out on young people aged 16-17 years in the same reporting period. Of these, approximately one third were funded by the NHS. There were no surgical procedures being carried out on children or young people at the time of our inspection.

There are five main theatres, three of which have laminar flow (a system of circulating filtered air to reduce the risk of airborne contamination). Three are general theatres. 'Coral' theatre is located on the ground floor, and 'Russet' and

'Amber' theatres on the first floor. There was also a cardiac catheter lab and an endoscopy suite, both of which are located on the second floor. The theatres are all accessible via a lift, and each has an adjacent recovery area.

The hospital has 41 beds in three wards for inpatient and day case care. At the time of our inspection there were 217 doctors and dentists with practicing privileges. There were 8.8 whole time equivalent (WTE) nurses in theatres and 19.4 WTE nurses in the in-patient departments. There were 5 WTE operating department practitioners (ODPs) employed and 4.8 WTE care assistants working in theatres.

During our inspection we visited theatres, the ward and the pre-assessment clinic. We spoke with four patients, one relative and 25 staff. These included managers, health care assistants, registered nurses, medical staff, theatre personnel, operating department assistants and administrative staff. We looked at the patient environment and observed patient care in all areas. We reviewed 18 patient records. Before, during and after our inspection we reviewed the provider's performance and quality information.

Surgery

Summary of findings

We rated this service as requires improvement overall. We rated safe as inadequate, well led as requires improvement and effective, caring and responsive as good.

The service failed to ensure that care and treatment was being provided in a safe way for service users. This was in breach of Regulation 12 of the Health and Social Care Act 2008. We issued a warning notice to the provider to take urgent action.

The theatre environments were in a poor state, with broken, torn and rusty equipment. We saw flaking paint on the walls, as well as loose plaster, torn flooring and skirting boards detaching from the walls. The building infrastructure had been temporarily redecorated many times over the eight years since being placed on the hospital's risk register but refurbishment had not been given sufficient priority. The hospital condemned over 100 items of theatre equipment including rusting trolleys, worn limb rests and gel pads after concerns were raised by the inspection team. The poor state of the environment and items of theatre equipment was an infection prevention and control risk as it prevented effective cleaning and decontamination.

The theatre environment was not consistently cleaned. We found areas of visible dirt and cleaning records showed gaps of up to two weeks in one month in cleaning being completed.

The wards we visited were visibly clean and systems were followed to ensure that cleanliness of the environment was maintained. Effective infection prevention and control measures routinely took place on the wards.

There were issues with the effectiveness of the laminar flow air system in all three of the theatres we inspected and maintenance records showed that action was required. However, this had not been addressed and was not detailed on the risk register.

Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and adequately. There were effective handovers and shift changes to

ensure staff managed risks to people who used services. Mandatory training compliance levels were 74% overall on 5 April 2016. This was below the hospital target of 85%. Only 78% of nursing staff had completed an annual appraisal against a hospital target of 85%.

Medicines were not always stored securely and records not routinely maintained appropriately in theatres.

Care and treatment took account of nationally-recognised evidence-based guidance. Policies and guidelines were developed to reflect national guidance.

Feedback from patients about their care and treatment was consistently positive. We observed that patients were treated with kindness and compassion throughout our visit. Patients told us they felt informed about their treatment and had been included in decisions about their care. The hospital was flexible and adaptable and ensured specific individual needs were met, including the needs of children and young people. Patients were able to choose their surgery date or appointment time to suit their needs.

Staff across the service described an open culture and felt well supported by their managers. They were passionate about the roles they performed in the hospital and felt they worked well as a team. Leadership in theatres focussed solely on day to day operational management. There was little strategic direction in the theatre department and the theatre manager lacked capacity and support to fulfil the full requirements of the role. There were risk, quality and governance structures, managed at departmental, hospital and corporate levels, and systems were used to share information and learning. The risk register did not highlight the severity of the risks in theatres and senior theatre staff could not accurately describe the risks within their own department. The resident medical officer was not included in the hospital's overall governance structure.

Surgery

Are surgery services safe?

Inadequate 

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

We rated safe as inadequate because:

- The three theatres we inspected (Russet, Coral and Amber) were in a poor state of repair, with flaking paint on the walls, loose ceiling tiles and broken flooring, a health and safety and infection control risk.
- The airflow system had been serviced in April 2016 and action needed to improve the air quality and cleanliness had not been taken.
- Equipment in theatres was not fit for purpose and an infection control risk, with visible rust and significant wear present on many items in use. Over 100 items of equipment were condemned by staff following concerns raised by the inspection team.
- Safety testing was out of date on many items of equipment in theatres, and staff had not had medical devices training.
- Infection prevention and control (IPC) practices were adhered to in the wards but not consistently in theatres and the recovery area.
- Mandatory training compliance was below the hospital target of 85%.
- Staff did not consistently follow infection control procedures. Staff were seen moving between theatres in scrubs, without changing personal protective equipment or washing their hands.
- The poor fabric of the theatre environment made cleaning difficult and there were significant gaps in cleaning schedule records in theatres.
- Medicines management was good in the ward area but systems were not robust in theatres and recovery. Intravenous drugs and fluids were not kept secure and records were not appropriately maintained in relation to the use of intravenous or controlled drugs.
- Medical records were overall well documented, but we found examples of illegible handwriting and missing signatures in some records.
- Five steps to safer surgery checklists were not completed for all patients during surgery.

However,

- Staffing on the wards and in theatres were as planned to support the delivery of safe care and treatment. Where there were vacancies, regular bank and agency staff were used to promote consistency of care.
- There was a positive incident reporting culture where feedback was given, and lessons learned were shared locally and across the Nuffield Health group.
- The ward environments were clean with effective systems to ensure cleanliness and infection prevention and control.

Incidents

- There had been no never events reported from January to December 2015. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The hospital had reported 269 clinical incidents between January 2015 and December 2015. The overall rate of clinical incidents had remained consistent during that period. There was no breakdown of these figures to detail how many related to surgical services. All staff we spoke with were aware of the electronic system for reporting incidents of harm or risk of harm and told us that they were encouraged to report incidents. Staff said the system was simple to use and accessible to all staff. Staff without access to the system (such as domestic and housekeeping staff) alerted the senior member of staff on duty to any areas of concern about the safety of patients who would report the safety concern or incident through the electronic system.
- Managers investigated incidents and fed back the findings to the clinical leads and staff. Ward and theatre staff said incidents were discussed and investigation findings fed back by clinical leads at meetings. Individual staff received information via email about the outcome of the incident they had reported.
- All incidents were discussed at monthly hospital governance meetings, which included the Medical Advisory Committee meeting and the quality and safety committee. The service monitored safety via the electronic incident reporting system. Information gathered through this system was reported in governance meetings and monitored through the quality dashboard.

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- There was shared learning and communication across the Nuffield Group on incidents and action posters were seen to alert staff to near misses or incidents at other sites to avoid them happening again.
- 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. All grades of nursing staff on the ward and in theatres explained how patients were to be informed if avoidable harm had occurred and recognised the need to be open and honest. Staff we spoke with were aware of the principles of DoC but could not recall incidences when it had been applied. Senior staff we spoke with were aware of the requirements of DoC following a moderate or severe incident of harm such as offering a written apology.

Safety thermometer or equivalent – how the service monitors safety and uses results

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. The surgical ward participated in the NHS Safety Thermometer for NHS patients. Senior staff conducted monthly audits of patient falls, pressure ulcers, and catheter related urinary tract infections. For the period March 2015 to March 2016, this showed there were no incidents of harm reported but staff advised us that this information was not displayed publically. This meant that patients, visitors and staff could not access this information.
- Information displayed in the hospital reception showed in April 2016 there had been no incidences of meticillin-resistant staphylococcus aureus (MRSA), Clostridium difficile or surgical site infections for hip or knee replacements.

Cleanliness, infection control and hygiene

- The hospital was not meeting the requirements of the Health and Social Care Act, 2008, Code of Practice for the prevention and control of infection and related guidance. Patients were not adequately protected and put at risk due to inadequate monitoring and provision of a clean, safe and hygienic environment.
- The walls in all areas, including the recovery rooms and theatres, were in a poor state of repair and included loose and broken plaster. We saw peeling paint from the

walls; skirting boards were coming away from the wall in some areas, and damaged flooring. We saw door frames were damaged with rubber seals hanging loose. The ceiling tiles above the recovery bays in Coral theatre had gaps ranging from 3mm to 1cm around the light panel. The overall state of repair in theatres and recovery areas prevented effective cleaning and decontamination, presented a risk to infection prevention and control.

- In Coral, Russet and Amber theatres we found many broken, damaged and/or rusty items of individual theatre equipment including surgical trolleys and drip stands that were rusty. This included theatre trolleys in Russet and Amber theatres, which staff confirmed were used for preparing equipment for surgery and used in the operating theatres. Rusty equipment posed an infection control risk as it could not be cleaned to prevent and control the spread of infection. We observed nine gel support pads that were torn, worn or split. This meant the integrity of the gel pads had been damaged so they could not be cleaned sufficiently for theatre use. These concerns were highlighted to the senior management team on the first day of our inspection and when we arrived on the second day we found 82 pieces of theatre equipment had been condemned as not fit for purpose. When we returned on 9 June 2016 a senior theatre staff member told us that a total of 122 items of individual equipment had been condemned as they posed an infection control risk.
- The recovery room in Coral theatre contained a large yellow bin, which staff confirmed was used for the disposal of clinical waste. This was sited in a clinical area, less than three metres from where patients were receiving pre and post-operative care, and posed an infection risk to these patients. The service had no risk assessment for the placement of the bin and no record for waste management in this area.
- We found soiled linen discarded on the floor in the recovery area of Coral theatre rather than being placed in a designated linen skip in accordance with Nuffield Health's own management of linen policy. Staff failed to minimise the risk of cross infection by placing and securing dirty linen in different colour-coded bags.
- In the Coral theatre there was no sluice within the theatre or recovery area. A sluice was located on the other side of the theatre, which meant it could not be accessed while surgery was taking place. If a recovering patient had used a bed pan or a vomit bowl, the contents were disposed of in the adjacent staff toilet.

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The alternative was staff carrying clinical waste through the main hospital corridor to the nearest sluice in the nearby outpatients department. This was contrary to guidance on the safe handling and disposal of waste as set out in Nuffield Health's Waste Management policy EM 02.

- Personal protective equipment (PPE) was available to all staff. We observed staff changing gloves and aprons in between patients to prevent the risk of cross infection. However, on three separate occasions we saw staff moving between theatres without removing their surgical mask. The same three staff members did not wash their hands. This was not in keeping with Nuffield Health's Standard Operating Procedure (SOP) regarding the use of PPE.
- We observed staff moving around the hospital site in the theatre scrubs. Limiting the numbers and movement of staff through the operating theatre environment minimises transfer of bacteria from one theatre to another. We observed three theatre staff in different areas of the hospital in their theatre scrubs. We also saw one clinical staff member walking across the car park in theatre scrubs. This was also in breach of Nuffield Health's own policy NHBH010; 'SOP for the use of theatre scrubs outside the theatre department'. Despite the inspection team raising this concern at the time of our inspection, at the unannounced inspection on 9 June 2016, we saw staff move in-between the first floor theatres (Amber and Russett) without washing their hands between each theatre.
- We saw that most staff were bare below the elbows in clinical areas and most staff observed were seen washing their hands and/or using hand gel appropriately. Hand hygiene gel was available in each of the patients' rooms and at the entrances to the ward and theatre departments. In theatres, we observed that while nursing staff were bare below the elbow, medical staff were not always. For example, we observed one doctor wearing a watch whilst in the operating theatre. Nursing staff on the wards we spoke with said that medical staff were not always bare below the elbows. Nurses told us they would prevent medical staff from entering a patient's room if they did not follow correct infection control procedures. If a patient had a known infection, a trolley with PPE was placed outside the room for staff and visitors to use before entering.
- We observed used theatre instruments on display on a trolley outside the first floor theatres. They were

contained in clear bags and awaiting collection by staff to move to the basement, where surgical equipment was stored. From there, collections were made twice daily and all instruments were taken to a neighbouring county facility for decontamination and sterilisation. They were then returned sterilised and ready for use. The dirty instruments were visible to patients and any passers-by in the main corridor could see them when the doors were opened. They were not kept secured in a closed cabinet that would safeguard any spread of infection and secure the transport of the instruments.

- We found gaps in the nursing cleaning records in all theatres. For example, the cleaning record in Coral theatre had not been completed for the third and fourth weeks of April 2016. We also saw a completed cleaning record on the first day of our inspection that confirmed by signature that Coral theatre had been cleaned. However, we observed visible dirt on a trolley in the scrub room with skin preparation liquid spilt down the side of it and the theatre had not been used since the cleaning should have occurred.
- In Coral theatre, the staff coffee room was also used as a changing room and we saw clean and dirty equipment was not segregated. There were dirty theatre shoes placed next to open boxes of clean surgical gloves and surgical hats.
- The ceilings in the theatres and recovery areas had ceiling tiles with gaps as the seals were broken, which meant that the airflow might not be effective. The laminar flow system in the three theatres equipped with it had been tested and validated on 2 April 2016 and showed the results were poor. The two first floor theatres were reported as 'poor' and the ground floor theatre as 'average' on servicing measures. This meant that a replacement or refurbishment of the airflow system was necessary to ensure that effective air flow was maintained. Senior managers were unable to give us evidence or assurances that any action had been taken or was planned. We viewed the 2015 reports where the overall results were average.
- At the unannounced inspection on 9 June, we found some improvements had been made. All operating theatre walls had been repainted and the walls, ceiling and skirting boards had been sealed. No improvements had been made to the pre-operative or post-operative areas within the theatres. More work needed to be done in the rest of the theatre department to address the damaged walls, floors and ceilings. We highlighted the

Surgery

unsatisfactory equipment to management on the first day of our inspection, and action had been taken by the time of our return on the second day. The ground floor theatre had been closed and more than 80 pieces of theatre equipment were condemned due to the rust and damage identified. The IPC lead and the finance manager had written a list of all the equipment and were planning to order replacements. Items removed included footstools, metal surgical trolleys, bins, drip stands, suction machines, and theatre gel pads that supported patients' body positioning during surgery. In the interim, equipment was borrowed from other acute hospitals and within the Nuffield Health group.

- At the unannounced inspection we saw paper dividing curtains between bays in the recovery area that were dated 23 March 2016. A senior theatre member of staff told us they thought they were changed every six months but could not describe the process which ensured this happened. Another member of recovery staff said they did not know the frequency that the curtains should be changed.
- A ward charge nurse was the lead for infection prevention and control (IPC) for two of their five shifts each week. There were IPC link nurses on the wards and theatres who supported the IPC lead in their role.
- We were told there was an IPC audit schedule, which was hospital wide, with hand hygiene audits that were completed quarterly. This was undertaken by staff performing IPC link roles in various departments. Areas of concern identified on the audits were the lack of patients' temperatures being monitored in theatres and the lack of asepsis training. We saw in the Director for Infection Prevention and Control's (DIPC) annual report for 2015 actions in place to address these areas of concern. The actions included improved compliance for asepsis training and ensuring patients' temperatures were appropriately monitored during surgery.
- Cleaning audits were completed monthly in conjunction with the domestic staff, and housekeeping staff completed mattress audits. The IPC lead told us that three mattresses were recently changed due to findings on the audit. We viewed hygiene certificates from a contracted company that confirmed all theatres and recovery areas had undergone a 'high degree clinical deep clean' between February 2015 and May 2016.
- The IPC lead told us they were not aware of the IPC concerns we raised surrounding theatres during our

inspection. They confirmed they did monthly walk-rounds of theatres but did not notice any unsuitable equipment in the theatres or recovery area, or concerns over the environment itself.

- Regular hygiene and infection control audits were completed, which included a quarterly asepsis audit. This contained information about the insertion and management of urinary catheters, and the prevention of surgical site infections. Results of the audits were reported to the monthly infection prevention and control meeting. We viewed the IPC action log for November/December 2015, which showed the hospital scored 71% against a hospital target of 95%.
- There were three surgical site infections recorded between January to December 2015. Two of three cases were under the care of the same surgeon and related to the same type of surgical procedure. Root cause analysis investigations were completed and found that in each case there had been no recording of the patients temperature during surgery. They also recommended standardising the use of skin preparation to Chlorhexidine.
- There was a service level agreement with a local NHS microbiologist, who could be contacted for advice if a patient had an infection.
- Ward areas were visibly clean. Staff were seen cleaning equipment after use. Staff used green "I am clean" stickers on the ward to notify all staff that the equipment was ready to use. Cleaning of equipment in between theatre cases was seen and surgical procedures identified as the highest infection risks were allocated at the end of theatre lists to reduce risks of cross infection.
- Ward staff attendance at infection control update training did not meet the hospital target of above 85%. At 5 April 2016, 70% of ward staff had completed the infection prevention training and 61% of staff on the wards had attended supporting practical IPC training. In theatres, 91% of staff had completed infection prevention training and 83% of theatre staff had completed the supporting practical IPC training. Only 46% of staff overall had completed asepsis training. Only 6% of theatre staff had completed asepsis training. We were told this was due to the IPC lead being out of date with the training so they were not able to deliver the training to other staff.

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- Patients were screened for MRSA at the pre-assessment stage before surgery. There were no reported incidents of MRSA or Clostridium difficile infections between January and December 2015.
- Patient Led Assessments of the Care Environment (PLACE) for February to June 2015 showed the hospital scored 100% for cleanliness, which was higher than the England average of 98%.
- The IPC committee met four times each year. Committee membership included attendees from pharmacy, pathology, microbiology and local departmental managers. However, the IPC committee meeting minutes for the whole of 2015 – 2016 did not detail any concerns with IPC practices or the theatre environments that we observed during inspection.
- The ward and theatres had portable resuscitation trolleys containing both adult and paediatric equipment and medicines to be used in the event of a cardiac arrest. We saw daily check sheets to record when trolleys had been checked to ensure equipment was available and in date. This was not consistently completed, with missing signatures on six days in the one month period prior to our inspection on the one trolley we checked. The resuscitation trolleys contained in theatres had tamper-evident tags to alert staff to any potential removal of equipment. However, we found one trolley was accessible to us at the time of inspection. Although the tag was present, it was not correctly applied, which meant we were still able to access the contents of the drawers and the trolley was not secure. The defibrillator was checked and working.
- There were anaesthetic machine check books in each of the anaesthetic rooms and operating theatres but they had not been consistently completed. There was no record of checks taking place between 12 and 23 May 2016. This meant there was no record to confirm the equipment was in good working order and able to be used for the planned surgical procedures.
- Equipment was not always labelled with the last service or maintenance check. Some equipment had not been safety tested (PAT) within the timescale agreed at the last PAT. For example, we saw a diathermy machine that was due for testing in December 2015 in the two first floor theatres that expired in April 2016. This meant equipment was at risk of being faulty as servicing and testing was out of date.
- The asset register of equipment was kept by the finance department and checked quarterly, but we saw that the asset register was not kept up to date.
- Patient Led Assessments of the Care Environment (PLACE) for February to June 2015 showed the overall hospital scored 97% for the condition, appearance and maintenance of the hospital, which was better than the England average of 92%. It was not clear whether the scores included theatres.
- We saw sharps bins were located in appropriate areas and secured. They had been correctly assembled and labelled.
- Surgical equipment was planned for in advance. Operating lists were checked six weeks ahead to ensure the availability of equipment. Further equipment could be ordered from a central supplies department that serviced all Nuffield hospitals in the area.

Environment and equipment

- Coral, Amber and Russet theatres had an adjoining anaesthetic room where patients were prepared for their operation. Separate lay-up rooms were available, which enabled equipment to be prepared for the next procedure.
- Individual recovery areas in each theatre were equipped to care for patients after surgery before they returned to the ward. However, the recovery areas were in poor state, with walls, floors and ceilings not fully sealed. In Coral theatre, the recovery area and the pre-operative area were in the same room.
- Several lights in Coral theatre recovery bay area were not working which meant there was no direct light from above in one of the recovery bays. There were other lights within the same room which provided some light into the recovery bay.
- We also saw some surgical sterile equipment was out of date. For example, we saw surgical needles ('Mayo's ½ circle trocar point 22mm'), which expired in January 2015.
- At the unannounced inspection, we found the patient transfer bag in Coral theatre was not fit for purpose. The opened and non-sterile packaging on the face mask showed a manufacturing date of 16 November 2001. A Guedel airway, size 3, within the bag had expired in January 2016. The Doppler machine was due for servicing in February 2016 and this had not taken place. The glucometer used to measure a patient's blood sugar levels had not been calibrated regularly. Calibration is a process of checking blood sugar readers to ensure they are giving accurate measurements.

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- Patients' bedrooms had undergone recent refurbishment and the environment was modern, clean, tidy and well stocked. All rooms and clinical areas had vinyl floors. Call bells were accessible for patients on the ward to enable them to call for assistance if required.
- Surgical staff ordered equipment required for surgery following the pre-assessment consultation on an individual basis. This meant surgical equipment was always available that was appropriate to age and size of each child or young person undergoing surgery.

Medicines

- Medicines were mostly stored correctly in locked cupboards. However, we found the ground floor theatre medicines fridge that contained injectable medicines was not secure and had been left unlocked. We brought this to the attention of the clinical lead, who agreed it should have been locked. At our unannounced inspection on 9 June, we saw the same fridge unlocked. This posed a risk as it meant drugs could have been accessed by non-theatre staff. This was not in line with the Misuse of Drugs (Safe Custody) Regulations 1973 in relation to storage of controlled drugs.
- Intravenous (IV) fluids in theatres were not kept secure. IV fluids were stored on an open and accessible shelf. This meant anyone walking into the three theatres were able to access IV fluids in the anaesthetic rooms. This was raised with the clinical lead at the time of our inspection but at the unannounced inspection the IV fluids were still not stored securely.
- At the unannounced inspection, we also found an unlocked cupboard in the Coral theatre which contained various medicines. This included IV antibiotics, IV Lidocaine and eye drops.
- Prescription charts were completed correctly and included detail about known allergies and missed doses.
- Controlled drugs (CDs) used for patients receiving post-surgical care on the wards were kept in secure cupboards within locked rooms. CDs are prescription medicines that are subject to stricter legal controls under The Misuse of Drugs Act, 2001. On the ward we saw accurate records which showed that CDs were routinely administered, and the CD stock counted, by two nurses.
- In theatres, the CD registers were not accurately maintained. Staff told us that the CDs were checked at the start and end on day's surgery took place. However, CD registers showed that CDs were only being checked once daily and the checks were signed by one nurse. This meant that there was not sufficient scrutiny of the CDs leaving a margin for error.
- During our unannounced inspection we saw that consultants were not signing each individual prescribed dose of CD for patients. Routinely, consultants were signing three or four doses given with one signature. For example, if a patient had different doses of a drug at varying intervals, the operating department assistant signed each entry but not the consultants. We also found that records of drugs that had been wasted were not countersigned.
- At the unannounced inspection, we found a patient had received Midazolam, which was an intravenous drug used in theatres. The CD register contained only one signature, and staff confirmed that the consultant had left the hospital before they realised the CD register had not been signed. Staff had failed to follow National Institute for Health and Care Excellence (NICE) guidelines 2016 to ensure that accurate records of controlled drugs were maintained. The NICE guidance sets out that the name and signature or initials of the person who administered the dose, as well as the name and signature of any witness to the administration should be clearly recorded.
- Medicines that required storage at low temperatures were kept in dedicated medicine fridges. The minimum, current and maximum room temperatures were monitored and recorded. We saw temperatures had been consistently and appropriately recorded on the wards but there were some missing temperatures noted in the Coral theatre anaesthetic room records for the medicines fridge. This meant medicines may have been stored at incorrect temperatures, which could affect their effectiveness and shelf life.
- There were piped medical gases on the ward and in the theatre suite. Portable oxygen cylinders were available for the transfer of patients from the theatre suite to the ward but these were not always kept securely. We saw three medical gas cylinders stored on a shelf on the side of the lobby area in the first floor theatres.
- Medicines to take home were available if a patient was discharged. This was appropriately packaged and labelled as medication for patients to take home after their surgery.

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- All registered nurses underwent medicine's administration assessment for the safe administration of oral and intravenous drugs before being able to administer medicines to patients.
- Nursing staff we spoke with said they routinely discussed potential side-effects of medicines with patients. On patient on the ward told us they were prescribed a new medicine and the clinical staff clearly explained the possible side effects to them.
- Pharmacy staff visited the ward daily and removed any out of date or unrequired controlled drugs. The pharmacy lead we spoke with said they aimed to complete medicines reconciliation for all admitted patients. Medicines reconciliation is the process of ensuring that patients receive the same medicines in hospital as they receive when at home. Patient records confirmed that medicines reconciliation was routinely happening for patients.

Records

- The care records reflected the clinical pathways at the hospital. For example, there were separate records kept for the following clinical pathways: day case surgery without general anaesthetic, day and overnight stay surgery (a stay of less than 24 hours), and long-stay surgery.
- The care records contained pre-operative assessments, records from the surgical procedure, recovery observations, nursing notes and discharge checklists and assessments which were appropriate to the patient's clinical pathway. Pre-operative assessments routinely included risk assessment of the risk of venous thromboembolism (VTE), manual handling and the risk of the patient developing a pressure ulcer. Staff we spoke with said that patients required to stay more than 24 hours had a nutritional risk assessment completed.
- Fluid and food charts were not routinely completed thoroughly. There were gaps in the records that meant we could not identify what the patient had eaten or drunk in a 12-hour period. At the unannounced inspection, we saw that in one case charts were missing for the previous 48 hours. This was raised with the nurse in charge, who confirmed that the patient should have had their fluid and food intake monitored and said immediate action would be taken. The recording of fluid

was not consistent as some staff had recorded the volume of fluids in millilitres, while others had recorded cups or glasses of fluids. The nurse in charge confirmed that these should all be recorded in millilitres

- Pre-operative checklists were seen and venous thromboembolism (VTE) assessments were recorded on checklists. At the unannounced inspection, we viewed nine patient records and found assessments were routinely completed. In particular, orthopaedic patients were well documented.
- Records made by doctors and nurses were signed and dated. We reviewed nine records and found that handwriting was not always legible and in four records we found that the name and designation of the recording individual was not printed clearly, if at all.
- We reviewed nine surgical patient records and saw that some relevant assessments had not been completed in all of the records. There were incomplete records for assessment of pressure areas and nutritional status. On one ward, the patient notes did not contain any information on the anaesthetic record sheet and the date and times were not clear.
- At the unannounced inspection we saw that a notice board opposite the nurse's desk on Purbeck ward that could be seen by visitors had pinned to it a theatre list containing confidential details of patients. Clinical details included the type of surgery being performed and any known risk factors. This was highlighted to the nurse in charge.
- The hospital did not audit record keeping.

Safeguarding

- Staff were required to attend safeguarding training with a hospital target of at least 85% of all staff. At 5 April 2016, 87% of theatre staff had attended training on safeguarding vulnerable adults and safeguarding children and young people at level 1 which was required by all staff. 100 % of eligible staff had attended level two training which was required for staff with direct contact with patients. Ward staff were 79% compliant with safeguarding vulnerable adults training and 85% of ward staff had attended safeguarding children and young people level one training, 95% level two training. The paediatric nurses had all received level three safeguarding children training. Training was completed online each year.
- All of the staff we spoke with on the wards and in theatres were clear about their roles and responsibilities

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and what action they should take if they suspect a person is at risk of avoidable harm or abuse. All staff knew how to raise a safeguarding concern and knew the matron of the hospital was the safeguarding lead.

- The paediatric nurses had compiled safeguarding information folders, which were placed on each ward and department. The folders contained the names and contact details of the local authority safeguarding teams in Dorset.
- Clinical staff gave us examples of safeguarding concerns they had reported appropriately. These included a concern for a child's welfare and the reporting of an emotionally abusive relationship.
- Children were appropriately safeguarding during their episode of care. Children were cared for by a paediatric nurses and separate theatre lists took place for children. This meant children were able to recover from surgery in a safe area where there were no adults also receiving care.

Mandatory training

- All staff who worked at Nuffield Health Bournemouth Hospital were required to attend mandatory training to ensure they had suitable skills to care for patients safely. However, the hospital's overall mandatory training figure at 5 April 2016 was 74% against a hospital target of 85%.
- Mandatory training at the hospital included consent, fire safety, Mental Capacity Act 2005, and health record-keeping. Staff were able to access training online. Face-to-face training was available for basic life support, intermediate life support (including paediatric), manual handling and aseptic technique.
- Mandatory training records showed that both ward and theatre staff were not routinely completing mandatory training. For example in theatres, attendance at safer blood transfusions 1 & 2 was 47%; medical devices in practice was 57% and Mental Capacity Act and VTE assessments training was 71%. Only 33% of theatre staff had completed in date intermediate life support training. We saw attendance for Deprivation of Liberty Safeguards training was 63%; paediatric basic life support 67% and manual handling practical training was 74% for ward staff.
- The human resources manager oversaw staff training records and ensure staff were booked onto training

where required. Staff were provided with a monthly electronic copy of their training record. Department managers were able to access a spreadsheet that would inform them of their staff's compliance rate.

Assessing and responding to patient risk

- Patients were required to complete a comprehensive pre-admission questionnaire to assess if there were any health risks that might compromise their treatment. The health questionnaires were discussed with patients in the pre-admission clinics. If the pre-assessment clinic nurses identified any increased risk factors they would discuss with the responsible anaesthetist who could revise the surgical treatment plan if required.
- Anaesthetists assessed patients requiring surgery under the American Society of Anaesthesiologists (ASA) grading system for preoperative health of surgical patients. This is a system to record the overall health status of a patient prior to surgery. The system enabled anaesthetists to plan specific post-operative care for patients if required.
- Staff completed a modified early warning score (MEWS) to assess patients' observations. This was a system that enabled staff to record observations and gave protocols to follow if the observations were outside the expected range, showing that their condition was deteriorating. We saw evidence that these charts had been completed on the wards. However, the staff we spoke with could not recall a recent patient who had needed additional care because their condition had worsened. Staff completed a specific paediatric early warning score (PEWS) for children.
- At the unannounced inspection we saw where a diabetic patient did not receive appropriate dietary consideration or care. The patient records from the pre-assessment clinic indicated the patient was a diet controlled diabetic. However, the patient's record on admission showed they were taking oral diabetic medication to control their diabetes, which they held in their room and self-administered. The patient had fasted from the previous night and had no breakfast, yet took their medication in the morning. This had not been noticed by clinical staff and may have impacted upon the patient's diabetic control.
- In the event that a patient's condition deteriorated, the hospital had service level agreements for transfer of the patient to the local NHS trust by ambulance. The hospital did not provide care for level 2 or 3 patients

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who require closer monitoring due to the nature of their condition. There were strict guidelines for staff to follow, which described processes for stabilising a critically ill patient before transfer to another hospital. There was a file available for all staff, which gave guidance about the processes to follow and a grab bag with equipment that might be needed before and during transfer. The staff we spoke with could describe their understanding of the escalation process.

- The RMO described how they would escalate concerns if a patient became unwell. After stabilising the patient, they would contact the consultant, make handover notes, photocopy medical and nursing notes, and arrange an ambulance and nurse escort for hospital transfer. The patient would be given a minimum of one-to-one care until the ambulance arrived. Nursing staff contacted the RMO via pager if they had concerns about a patient's worsening condition. The RMO also detailed the process if their emergency pager sounded and the action they would take. They reported that there had been no emergency cases (including cardiac arrests) during their last eight months of employment. We were given an example of a patient complaining of chest pain, who was promptly transferred to the local acute trust's cardiac care team.
- Risk assessments were completed to ensure patients were suitable to receive care and treatment at Nuffield Health Hospital Bournemouth. These included pressure ulcer risk and assessments for venous thromboembolism (VTE). However, the preventative treatment of wearing surgical stockings post-operatively was not always prescribed on the patient's drug chart, nor was the instruction documented clearly in the patient's records. Rates for screening patients for the risk of VTE were between 98% and 99% for January 2015 to December 2015, which was above the hospital's target of 95%.
- Patients were discharged with contact information to ring the ward if necessary should they have any concerns, such as a wound infection. The nurses would ask them to visit the ward if they lived locally so their wound could be assessed or treated. If necessary, this would then be flagged to the consultant. If the patient did not live locally, they would attend their local GP.

Five Steps to Safer Surgery Checklist

- Staff followed the five steps to safer surgery. This is a nationally recognised system of checks designed to

prevent avoidable harm and mistakes during surgical procedures. These checks included a team safety brief at the beginning of each theatre list, signing in and out, scheduled time out and de-briefing and completion of the five steps safety checklist.

- We reviewed nine surgical records and found that in two cases there was no evidence of the checklist being completed.
- Ward staff told us that they would not accept a patient back from theatres if the surgical checklist had not been completed or was missing in the patient's notes. They said they would contact the consultant if a limb had not been marked when it should have been or the consent form not completed. This suggested that the five steps were not always followed during surgical practice.

Nursing staffing

- Ward staff rotated between the three wards in the hospital. They used a daily workload analysis tool to calculate staffing levels. Ward staff told us staffing levels were adapted to meet the needs of the patients and the type of surgery they had received.
- At the time of our inspection, there were several staffing vacancies on the ward. However, staff had been successfully recruited and were due to start employment at the end of May 2016, which would result in the service being fully staffed. Agency staff had been employed at times to increase staffing numbers if there was a clinical need.
- There were vacancies in theatres and recovery for clinical staff, including a band 6 deputy theatre manager vacancy. Some posts had already been filled but new staff were still going through the recruitment process and start dates were not set. Agency staff were often employed in theatres due to the shortage of theatre staff. Shortfalls were also covered by bank nurses, or permanent staff who worked overtime. Senior staff told us they often block booked bank and agency staff to ensure there was continuity of care for patients. Figures for January 2015 to December 2015 showed there was moderate use of agency staff in theatres throughout this period, between 20% and 39%.
- Staffing levels in theatre met the recommendations from the Association for Perioperative Practice (AfPP).

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The AfPP guidance states that two scrub practitioners, one circulating practitioner, one registered anaesthetic practitioner and one recovery practitioner is the minimum requirement for safe elective surgical care.

- Nursing staff on the wards conducted handovers of care when new staff arrived on duty. Staff used handover sheets updated with any change to a patient's care and plans for discharge. Ward staff felt they obtained enough information at handovers to enable them to care for patients effectively.
- Nuffield Health Hospital Bournemouth employed three registered children's nurses who covered shifts when children were admitted as inpatients for surgery. They worked across the hospital in outpatients, the wards and in recovery to ensure the needs of children were met. They confirmed that a child would not be admitted if there was no paediatric nurses on shift, and that they swap working rotas if necessary to ensure adequate cover. This information was verified with other staff in the hospital and the management team. Paediatric nurses would provide care to the child during their surgical procedure and throughout recovery.

Surgical staffing

- The hospital employed two resident medical officers (RMO), who worked alternate weeks in one-week blocks from Monday to Sunday. The role of the RMO was to review patients daily, prescribe additional medication and liaise with the consultants responsible for individual patients' care. The RMO was based on site and was available 24 hours a day, seven days a week. They were employed via a locum agency that supplied the hospital with the RMOs on alternate week rotation. If the need arose, the agency would provide cover for the RMOs for holiday or sick leave.
- Consultants and anaesthetists worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work at the hospital. Nuffield Health followed processes to that ensure all medical staff who worked at the hospital had the appropriate skills and competencies, which included regular managerial supervision and appraisals of their work performance.
- Surgeons undertaking surgical procedures or anaesthetising children and young people were required to provide evidence of their competence,

qualifications and experience before they were granted practicing privileges. We saw evidence that this was routinely happening in the MAC and Senior Management Team (SMT) meeting minutes.

- All nursing staff we spoke with said consultants were available outside normal working hours via the telephone for further advice and support. Nurses said consultants always visited their patients before leaving the building. Emergency medical cover was provided by the RMO, who told us they were always able to contact consultants if required. The Matron and other clinical staff confirmed that surgeons would return to re-assess their patient if necessary.
- Consultants were required to organise cover if they were unavailable. Surgery was scheduled according to the surgeon's availability so cover was rarely required.
- The anaesthetist on call rota ensured an anaesthetist was available to the surgical team at all times if required.

Major incident awareness and training

- Senior ward staff told us they had received training in the form of table top exercises, which enabled them to develop contingency plans for potential major incidents.
- All of the other staff we spoke with were aware of where to find local guidance and procedures to follow in the event of a major incident.

Are surgery services effective?

Good 

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

We rated effective as good because:

- Care and treatment took account of current legislation and nationally-recognised evidence-based guidance. Policies and guidelines were developed to reflect national guidance.
- We found that National Institute for Health and Care Excellence (NICE) guidelines were followed in theatres, and patient outcomes were monitored.

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- Patients undergoing joint replacement surgery were able to participate in national data collection which included Patient Rated Outcome Measures (PROMS) to compare outcomes on a national level.
- With the exception of patients having knee replacements, the readmission rate post-surgical procedure at this hospital was similar to, or better than, similar independent hospitals when compared nationally.
- Patients had access to a variety of methods for pain relief. Patients' pain levels were monitored and responded to appropriately.
- Patients mostly had a comprehensive assessment of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs.
- Staff were clear about their roles and responsibilities regarding the Mental Capacity Act (2005).
- There was good multidisciplinary team working across all staff, with a high consultant presence and 24-hour resident medical officer cover.

However,

- There was no pre-operative fasting policy, which meant surgeons' preferences dictated how long patients fasted before their surgery. This practice did not follow national guidance.
- Consent forms had been signed on the day of surgery which did not take account of the Royal College of Surgeons best practice guidance.
- Only 78% of nurses working theatres had received an annual appraisal of their practice.
- food and fluid charts were not consistently maintained.

Evidence-based care and treatment

- Care and treatment took account of current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed in line with the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE) guidelines. For example, modified early warning scores (MEWS) were used to assess and respond to any change in a patient's condition. This was in line with NICE guidance CG50.
- There was an ongoing audit programme to evaluate care and review clinical practice. The audits were undertaken monthly and the results were either

displayed on the provider's quality dashboard or discussed at governance meetings. We saw that most of the areas audited had achieved the targets set locally or nationally.

- Adherence to policies and national guidelines was discussed at management and departmental meetings to ensure care and treatment offered was up to date. Policies were available on the Nuffield Health hospital's intranet for staff to have use when needed.

Pain relief

- Clinical staff used a 1-5 scored pain scale as an assessment tool to assess a patient's pain levels, and pain control was prescribed and recorded on the patient's drug chart. In the recovery area, we saw diagrams on the wall used to assess patients' pain. It was a range of five faces showing a happy to a sad face, rated as 1-5. This method was also used for assessing pain in children and young people.
- Nuffield Health followed policy to support the management of children's pain, called 'Analgesics to Manage Paediatric Acute Pain' V1.0. Children were prescribed and administered anaesthetic cream prior to insertion of an intravenous cannula or before they had bloods taken.
- Patients on the wards said they received pain relief in a timely manner. Patients told us clinical staff asked about any pain they might have and gave pain relief promptly if necessary. However, at the unannounced inspection, we found that pain assessment and treatment was inconsistent. We viewed the records of a patient receiving regular pain relief but it was not always documented that the pain assessment scoring had taken place. We saw that the patient's pain was recorded as 6 out of 10 at 2.40pm but by 4pm the patient had still not received any pain-relieving medication though they appeared to be in visible pain.
- Patients had access to a variety of pain relief appropriate to their operation. This included epidural and patient-controlled analgesia (PCA). Staff assessed patients who required this type of pain relief before their operation and gave them information to ensure that they understood how the delivery of the medication worked. Staff completed regular assessments when this pain relief was being used to ensure that patients' pain levels were controlled, the equipment worked appropriately and to monitor for any unwanted side effects.

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- Patient records showed that pre-operative assessments included details of post-operative pain relief options available to the patient. This ensured that patients were aware of the type of medication available to them and could make choices about their analgesic treatment before surgery.

Nutrition and hydration

- Patients received written instructions before admission to advise them about how long to go without food before their operations. Information included when they could have their last meal and for how long they were able to drink water before their operation.
- Staff monitored and recorded fluid intake and output on a fluid balance chart post surgery. This was to ensure that patients were sufficiently hydrated after their operation. However, we saw inconsistency in recording of fluids..
- Surgical patients were not fasted prior to surgery for the recommended time as set by national guidelines. The European Society of Anaesthesiology, 2011, recommend that adults and children should be encouraged to drink clear fluids for up to two hours prior to elective surgery and to eat solid food up to six hours before surgery. The theatre clinical lead confirmed that the guidance was not been followed and explained that individual consultants recommended their preferred starving times to patients pre-surgery. We spoke with a post-operative patient, who said that he had been starved for an extended period of time of more than 14 hours without clear fluids without explanation or apology. Extended starving periods may cause undue discomfort to patients prior to their surgery.
- Day surgery patients were offered drinks and snacks after their procedures before being discharged. Patients we spoke with said the food was good and that they had a choice of food and drink options available to them. .
- A patient with lactose intolerance told us they had been admitted to the hospital on several occasions, and that there had previously been difficulty in the hospital supplying non-dairy milk. However, on this admission, the appropriate milk had been supplied along with a bowl of fresh fruit.
- There were no dietitians on site but nurses could make a referral through service level agreement with a local NHS trust if the consultant requested it.

Patient outcomes

- Between January 2015 and December 2015, there were five unplanned readmissions to theatre. The standardised readmission rate for the reporting period October 2013 to September 2014 showed that readmission rates for cataract, hernia and hip replacement procedures were similar to other similar hospitals, tending towards better than expected or much better than expected. However, the readmission rates for knee replacement procedures were worse than expected. We were not made aware of any action taken to investigate or improve this position.
- Patients were offered opportunities to participate in data collection to measure outcomes of treatment. All patients who were booked for joint replacement were asked for consent to be registered on the National Joint Registry (NJR), which monitor how well different implants, surgeons and hospitals perform on a national level. We saw that 99% of patients had consented to participate in the register, which ensured their care and joint replacements were monitored at a national level.
- Patients were offered the opportunity to participate in the Patient Reported Outcome Measures (PROMS) data collection if they had received treatment for hip and knee replacement, inguinal hernia repair and varicose veins. PROMS measures the quality of care and health gain received from the patients' perspective. Between April 2014 and May 2015 data from PROMS showed that the hospital was within the expected range for knee replacement surgery relating to the Oxford knee score (a patient-reported outcome measurement, which contains 12 questions on activities of daily living that assess function and pain in patients undergoing total knee replacement).

Competent staff

- Nursing staff across the service told us that they did not have formal line management or clinical supervision but felt they were able to contact senior members of staff for help and guidance at any time.
- The hospital quality dashboard confirmed staff received annual appraisals. It showed that between January 2015 and December 2015, 100% of ODPs and healthcare assistants in theatre had received an appraisal, which enabled them to have an opportunity to discuss areas for improvement or further development of their role. However, only 78% of nursing staff had received an appraisal of their performance.

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- Surgeons operated under practising privileges. Practising privileges give consultants the right to practice within an independent hospital following approval by the Medical Advisory Committee (MAC). The hospital followed robust procedures to ensure that surgeons who worked under practising privileges had the necessary skills and competencies. Checks undertaken ensured that surgeons performed only the procedures they carried out in the NHS.
- The surgeons received managerial supervision and appraisals of their work performance. Senior managers ensured the relevant checks were made against professional registers, and that information was obtained from the Disclosure and Barring Service (DBS).
- The RMO had appropriate advanced adult and paediatric life support training and skills, and had attended a week-long induction programme at the start of their employment to cover all mandatory training requirements. This included clinical skills testing and an English proficiency test. The MAC was involved in the selection of appropriately skilled RMOs.
- Nursing staff undertook further competency-based training to ensure they had the relevant skills to care for patients (for example, epidural and patient-controlled analgesia training).
- Some nurses had undertaken further training as 'link' nurses (for example, medicines management, infection control and dementia care). The nurses attended regular meetings and updated ward and theatre staff about any changes to practice that were required.
- Staff were positive about access to further training and development courses. Courses were available externally or online via the Nuffield Academy.
- Healthcare assistants had opportunities to develop their skills and knowledge. A ward healthcare assistant told us they were undertaking a programme from the Nuffield Health academy on the new care standards. There were nine units in total and they had just completed level 3 and had a mentor allocated to them.
- Scrub staff had been assessed through the Nuffield Health competency framework to be surgical assistants. Support staff either performed the role of the surgical assistant or assisted with passing instruments and swabs.
- Operating department practitioner's (ODP) are required to register with the Health and Care Professions Council (HCPC) every two years. The human resources team ensured that the ODPs had in date registration with HCPC.
- Nursing staff were required to demonstrate competency before they were able to administer medicines. We were told by senior staff that there was a list of nursing staff who had completed competency assessments ensuring they were safe to administer medicines. However, staff were unable to locate this list and a senior staff member acknowledged that this was an area they needed to take a more robust approach to.
- New staff were supernumerary (treated as additional staff) for two weeks and went through a probationary period and induction process. New staff induction included orientation to the environment, policies and guidance and mandatory training completion.
- Paediatric nurses were employed by the hospital to provide care to children and young people. The paediatric nurses had received appropriate training in safeguarding and paediatric life support. The paediatric nurses were directly supervised by the deputy matron meaning they could access additional training as needed.

Multidisciplinary working (in relation to this core service only)

- Our review of records confirmed that there were effective multidisciplinary team (MDT) working practices involving nurses, doctors, pharmacists and physiotherapists. For example, we saw excellent MDT working in the surgical safety briefings during theatre.
- The RMO told us that there was good MDT working with individual consultants and that cover was well provided. There was good support provided to RMOs and we were told that consultants were helpful, approachable and supportive.
- Theatre staff multidisciplinary handovers were observed at both the announced and unannounced inspection for ophthalmic and orthopaedic surgery. They were found to be comprehensive, with the consultant discussing their cases and the plan ahead. All clinical staff were involved, including the anaesthetist, and staff from different disciplines contributed positively to the discussions.

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- Staff could access specialist services for patients such as dietetic, speech and language therapy, pain team through service level agreement with the local NHS trust.
- Physiotherapy was provided at this hospital to all surgical patients. Physiotherapists attended handovers and working within the multidisciplinary team to formulate effective discharge plans.

Seven-day services

- The majority of surgical procedures were completed between Monday and Friday with occasional weekend surgery if there was sufficient demand.
- A resident medical officer (RMO) was based on site 24 hours a day, seven days a week.
- Consultants were contactable by phone outside normal working hours. Staff said consultants were easy to contact if required.
- The RMO gave us a clear example of when they needed to contact a consultant out of hours regarding a post-operative patient who was bleeding. The consultant attended and reviewed the patient within 20 minutes and dealt with the situation promptly.
- The pharmacy was accessible outside normal working hours. The nurse in charge and the resident medical officer (RMO) each had a separate key to the pharmacy (which needed to both be used to access medicines) to ensure medication was available at all times. In the event that additional controlled medication was required outside normal working hours, it could be obtained from one of two local acute NHS trusts through a service level agreement.
- Radiological services were not routinely provided outside normal working hours. However, there was a radiographer always on call if urgent x-rays or scans were required.

Access to information

- The patient, on discharge, received a letter that included the reason for their surgical procedure, findings, medication and any changes, potential concerns and what to do and details of any follow up. The nurse sent a copy of this letter to the GP and placed a copy in the patient's medical records at the hospital. This also included the ward telephone number and a patient's medical care notes number, so if the patient had a problem out of hours they could contact the ward for advice.

- Staff were able to access information on their local intranet, which included clinical policies and standard operating procedures. There was also information such as patient information leaflets to support a patient giving informed consent, which staff could print for the intranet. For example information about joint replacement was available.
- The doctors were able to access patient information, including scan results and blood tests using the hospitals information technology systems.
- The hospital kept records on site for two years after which they were sent to an offsite storage facility. Staff could access paper records stored offsite within 24 hours. This meant staff could access past clinical information about patients previously treated at this hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Throughout our visit, staff we spoke with were clear about their roles and responsibilities regarding the Mental Capacity Act (2005). They were clear about processes to follow if they thought a patient lacked capacity to make decisions about their care. They would not carry out treatment and would discuss with a senior member of staff. Nuffield Health had a specific consent form used for patients who lacked capacity to consent to treatment. Although many staff we spoke with had not used this form, they were aware of it and the criteria to use one, including for patients with early stages of dementia. An example was given to us by a staff nurse that used this specific form. It related to a patient who needed to return to theatre due to bleeding after surgery. The consultant and anaesthetist both signed the form for the best interest of the patient to return them to theatre. The patient was deemed not to have capacity to consent and this was reported on the online reporting system.
- A pocket sized guide was provided to all staff called the 'Mental Capacity Act Principles'. It was two sided and provided quick reference guidelines on assessing capacity and advice on good practice.
- Staff were required to attend training about the Mental Capacity Act. The target for attendance was over 85%. We found that at 5 April 2015 71% of theatre staff and 85% of ward staff had attended the training.
- Surgeons gained consent from patients prior to surgery. Information about the procedure was given to patients

Surgery

at their initial visit for assessment. Once admitted, on the day of the procedure, formal consent was recorded by the surgeon conducting the procedure. We saw that the consent forms had been completed correctly and detailed the risks and benefits of the procedure.

However, the Royal College of Surgeons considers it is best practice for patients to sign consent forms before the day of surgery, to allow patients a 'cooling off' period and to consider further treatment options.

- At the unannounced inspection we viewed nine clinical records. We found consent forms were signed before any treatment was provided to the patients, although two were not dated when signed by patients. We observed in patients' records that the risks and benefits of treatment were clearly explained to people before their consent to treatment was obtained.
- Surgical staff we spoke with were clear they would not perform any procedure on a child without their parent or legal guardian's consent. Staff were aware of the principles of Gillick competence and said that young people who refused to have their procedure with their parent or guardian present were always accompanied by a chaperone but would still require parental consent.

Are surgery services caring?

Good



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

We rated caring as good because:

- Feedback from patients about their care and treatment was consistently positive. We observed that patients were treated with kindness, compassion and dignity throughout our visit. Staff were consistently reported as being kind and caring.
- Patients told us they felt they had sufficient information to enable them to be involved with their care and had their wishes respected and understood. Patients and their relatives were fully involved in decisions made about their care and treatment.
- Flexible visiting hours enabled patients to maintain supportive relationships with those close to them.

Compassionate care

- Patients we spoke with were positive about the care and treatment they received.
- We observed throughout our visit that patients were treated with respect and dignity. Staff were seen knocking on doors and waiting for permission to enter and patients told us that they were called by their preferred name. We observed compassionate and caring interactions from all staff.
- Measures to preserve patient's privacy and dignity were mostly observed throughout surgical procedures. However, at the unannounced inspection we saw a patient in the recovery bay after surgery and staff had not pulled the curtain around the bay. This resulted in the patient being in full view of anyone entering the operating department, including preoperative patients. When the doors opened, the patient was visible to people walking along the main hospital corridor. This meant their privacy and dignity were not being maintained.
- In the Patient-Led Assessments of the Care Environment (PLACE) privacy, dignity and well-being scored 88% compared to an England average of 87%.
- The hospital participated in the Friends and Family Test. For the reporting period July 2014 to June 2015 the hospital reported consistently high levels (between 96% and 98%) of patients who would recommend the hospital to their friends and families. The proportion of patients who responded to the test was low to moderate (between 21% to 41%). The results were for across the whole hospital, not just surgical services. The results were not displayed at the hospital for view by patients, relatives and staff.
- Post-operative patients on the wards told us that they could not fault care they received, and that the nurses and doctors were excellent. Staff were described as being, 'lovely' and 'polite' and several patients told us call bells were always answered promptly.

Understanding and involvement of patients and those close to them

- Patients on the surgical ward told us they were given enough time to ask questions and had enough information about their care. Patients felt well informed about their care.

Surgery

- Two ward patients told us that they were given sufficient information about their care and treatment. One patient told us that when discharged at the end of a previous stay, they were given all the information they needed to feel confident about leaving hospital care.
- We observed that nurses explained care and involved patients in plans for discharge.
- Information was given to patients about their procedures at their pre-admission appointments to enable patients to make decisions about their care and treatment. All of the patients we spoke with told us they felt they had been given sufficient information before their operations to prepare them for the procedure and their recovery.
- We saw evidence in patients' records that relatives were involved in decisions made about patient care where appropriate. One relative we spoke with said they felt involved in all aspect of their loved ones care and treatment and felt the nurses took time to listen to and respond to any concerns they had.
- Staff asked patients to complete satisfaction surveys about the quality of care provided. Figures for December 2015 to May 2015 were positive, with ratings of 94% of patients happy with their care. The results of the surveys were discussed at governance meetings but were not shared widely with all staff or with patients.

Emotional support

- There was open visiting on the wards to enable patients to have support from family and friends.
- Patients were able to contact the ward after they had been discharged for further help and emotional support if required.
- If 'sensitive' discussions were needed after the operation or procedure, these were held in the patient's private room. These discussions were led by the consultant with support from nursing staff.
- When children and young people were admitted for surgery, their parents were encouraged to stay with them to provide ongoing emotional support.

Are surgery services responsive?

Good 

By responsive, we mean that services are organised so that they meet people's needs.

We rated responsive as good because:

- Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility and choice was reflected in the service. The service met national waiting times for NHS patients to wait no longer than 18 weeks for treatment after referral.
- The needs of different people were taken into account when services were planned and delivered. There were good examples where staff adapted procedures and worked flexibly to meet individual requirements.
- Complaints and concerns were taken seriously, and responded to in a timely way. Learning from complaints was disseminated through the clinical governance group and used to improve the quality of care.
- Staff could describe adjustments they would make if required to provide care for individuals with specific needs such as a learning disability or patients living with dementia.

Service planning and delivery to meet the needs of local people

- Surgical lists were routinely planned between Monday and Friday. Occasionally, extra operating lists ran on a Saturday to meet demand. Patients were offered a choice of dates to best suit their needs. Surgical lists for children were separate to adult lists and young people aged 16-17 years would be placed onto the most appropriate list depending on their individual needs.
- Nuffield Health Hospital Bournemouth provided planned surgery to NHS and privately funded patients for a variety of specialities, including orthopaedics, ophthalmology, general surgery, gynaecology and cosmetic surgery.
- Senior managers reported having regular meeting with local commissioners to ensure they were responding to local need.
- All patients had their own rooms and facilities allowed for visitors, including parents of children and young people, to stay overnight if they wished to.

Access and flow

- Consultants saw patients referred by their GP as an outpatient before elective surgery was booked. This appointment was to check the patient met the admission criteria, assess the patient, and discuss a plan of treatment. This meant that staff could plan for the flow of patients.

Surgery

- The surgical service met national waiting times for NHS patients to wait no longer than 18 weeks for treatment after referral. The service was responsive to patients in the admission criteria with average waiting times of one to four weeks. No admissions or discharges occurred out of normal working hours.
- Surgeons only undertook planned, non-emergency procedures. A named hospital consultant surgeon, following accepting a patient, listed them for the appropriate procedure. The consultant or secretary would then send a booking request to the hospital booking team

Meeting people's individual needs

- Dates for surgery were discussed with patients at their initial outpatient appointment. Patients were able to choose to have their operations at times suitable for them
- Menu options were available for patients who required special diets for religious or cultural reasons. A snack menu was also available for meals outside normal food service times. Food allergy alerts were noted in the kitchen and in the patients' record. In the Patient-Led Assessments of the Care Environment (PLACE) for February to June 2015 the hospital scored 99% for organisational food and 96% for ward food.
- Patients' requirements were identified during the pre-assessment appointment and services were planned to meet their individual needs. Staff told us they rarely treated patients living with dementia or people with learning disabilities. However, they were able to describe adjustments they would make for specific individual needs if required such as additional staffing, simplified written documents and greater collaboration with carers.
- Staff planned surgical lists to take account of the needs of individuals. For example, we were told that patients who were very anxious, or patients with dementia would be placed at the start of the surgical list to avoid unnecessary waiting.
- When children and young people were admitted resources were planned to meet their individual needs. For example, toys and bedding were organised by the paediatric leads which were appropriate to child or young person's age, gender and preferences.

- In the Patient-Led Assessments of the Care Environment (PLACE) for February to June 2015 the hospital scored 85% for the care environment for patients living with dementia. The England average was 81%.
- For patients whose first language was not English, telephone and/or face to face translation facilities were available. We observed a poster in the main reception which welcomed patients in a variety of languages and allowed patients and their relatives to highlight their first language so an interpreter could be arranged.

Learning from complaints and concerns

- In each patient bedroom, there was a booklet, which contained information about how to raise a concern or complaint.
- The hospital received 33 complaints from January 2015 to December 2015. Two complaints were raised to the Care Quality Commission in the same period. The two most frequent themes were clinical care of consultants and communication by varying hospital staff.
- The monthly quality and safety committee meeting, attended by the theatre manager, discussed complaints and lessons shared. For example, we heard from staff how communication between nurses on the ward and administrative staff had improved following a complaint raised by a patient.
- Complaints and concerns (percentage of patients attending our hospital who made a formal complaint) was 0.8% during the period January 2016 to March 2016.
- Complaints were discussed with consultants at the quarterly Medical Advisory Committee meetings.
- All complaints were monitored by the hospital director and responded to in line with Nuffield hospital's policy. Complaints were investigated by the relevant head of department with involvement from consultants and nurses if required.

Are surgery services well-led?

Requires improvement 

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

Surgery

We rated well-led as requires improvement because:

- There was a leadership focus on customer experience which distracted from meeting clinical standards in theatres.
- There was insufficient assessment, identification and mitigation of risks. The risk register did not reflect the severity of risks within theatres and a low priority and rating had been recorded. This meant that the environmental and infection control risks within surgery were not given sufficient priority for action.
- There was insufficient monitoring and action to improve quality and safety, particularly in the operating department.
- The senior leadership team, including the infection prevention and control (IPC) lead, did not demonstrate sufficient knowledge or understanding of the IPC risks present within the theatre environment.
- The theatre manager was not sufficiently supported to fulfil the requirements of the role. They were unable to accurately describe the risks within the surgical department.
- There was not a clear strategy for surgical services.
- The resident medical officer was not part of the overall governance structure, so had little opportunity to contribute to service development.

However

- The corporate vision and values were understood by staff.
- Staff across the service described an open culture and felt well supported by their managers. All grades of staff we spoke with were passionate about their jobs and wanted to make a difference.
- The MAC was well attended by all surgical specialities and included paediatric representation.

Leadership / culture of service related to this core service

- Surgical services at this hospital were managed by the theatre manager. The theatre manager reported directly to the matron.
- The theatre manager was passionate about the team they managed and wanted to make improvements. However, the senior team had not been successful in recruiting to the role of deputy theatre manager which meant the theatre manager did not have sufficient capacity or support to undertake the role. The theatre

manager was able to manage the day to day operation within theatres but lacked capacity or support to develop the service strategically. The theatre manager was also temporarily leading the endoscopy service which made further demands on the role.

- All staff we spoke with were passionate about the service they provided and said they consistently put the patient first.
- Staff told us they felt cared about and listened to. They spoke positively about the management team, telling us they were visible and approachable. A registered nurse told us they felt well supported by management when compassionate leave was needed.
- A bank nurse told us they were happy to work at the hospital as they were afforded sufficient time to care for patients. They said that the management team recognised the importance of spending time with patients which was reflected in the overall staffing.
- We spoke with a urology consultant who gave positive feedback of working at the hospital. They felt that the staff were knowledgeable about urology and they liked working at this hospital due to the theatre staff's knowledge and skill.

Vision and strategy for this this core service

- Staff were clear about the corporate vision for the service, which was 'to improve the health of the nation'. Staff were aware of the provider values, which were to be enterprising, passionate, independent and caring. The newly built cardiac catheter lab and endoscopy suite were seen as valuable assets to the hospital. Several staff we spoke with said they hoped funds raised through this new provision would secure additional revenue to improve the theatre environment.
- There was no specific strategy for the surgical department. Staff were aware of tentative plans for a rebuild of theatres but said that had been consistently not prioritised. Some senior staff we spoke with expressed frustration by this.

Governance, risk management and quality measurement for this core service

- There was a governance structure for the surgical service. Service-wide meetings were held on a quarterly basis, these oversaw local quality, audit and risk activity performance.

Surgery

- The RMOs were not included in formal meetings or governance processes. They did not attend handovers, ward or departmental meetings and had no consistent opportunity to raise areas of concern.
- All service-wide meetings reported to the quality and safety committee and the medical advisory committee (MAC). Consultants from a variety of surgical specialities, including paediatric surgery, attended the MAC meetings quarterly. We saw from records that a variety of topics were discussed, including incidents, complaints, practising privileges, and NICE guidance. Action plans were identified and monitored at the meetings. The MAC was consistently well attended by all disciplines.
- Staff raised concerns to the matron and the quality group would decide what needed escalation and placing on the risk register.
- There was one hospital-wide risk register. The register detailed 11 potential risks to the hospital as a whole. These included moderate ratings such as; facilities maintenance, the lack of suitably trained theatre staff and surgical first assistants, the cardiology service, and the security and safeguarding of vulnerable children and adults. Action taken to mitigate identified risks were detailed, with named individuals and time plans for review. However, 'theatre facilities' were given a low rating of six.
- We were informed the concerns around the infrastructure of the theatre and recovery environment had been on the risk register for eight years but no refurbishment had taken place. Management told us numerous plans for refurbishment had been submitted and initially approved but then funding had been retracted before the start of the work. It appeared that the theatre environment had been temporarily improved through deep cleans and decorating many times but it remained an unsafe environment.
- The theatre manager told us there was no annual audit plan for the theatres due to the lack of theatre lead's capacity to implement. This had not been placed on the risk register or seen as a concern.
- Senior staff in theatres did not demonstrate understanding of the risks within the surgical department. The theatre manager was unable to give details on the five unplanned returns to theatre within the last 12 months, and the three unplanned re-admissions. There were also three surgical site infections reported, and they were unaware of the information about these. They were unaware of the risks detailed on the risk register.
- The senior leadership team, including the IPC lead did not demonstrate sufficient understanding of the potential risks to patients presented within the theatre environment. Additionally, the risks had not been identified by Nuffield's corporate wide governance team who we were told had completed regular inspections of the hospital.
- The senior management team demonstrated a commitment to providing a positive customer experience for patients at the hospital. However, there was a lack of focus on meeting clinical standards. This was evidenced in the clinical governance group meeting minutes and during our discussions with senior staff.






Public and staff engagement

- The hospital asked staff to complete yearly staff surveys. The results for the hospital as a whole exceeded the Nuffield Health average. For example, 96% of staff would recommend the hospital to friends and family compared to 91% for Nuffield Health as a whole.
- Staff said Nuffield Health kept them updated by sending emails regarding policy changes, incidents, or new legislation. This was both internal from the Bournemouth hospital management team, and from the rest of the wider Nuffield group.

Innovation, improvement and sustainability

- Several staff we spoke with said they hoped that revenue from the new cardiac catheter suite would provide funding to improve the theatre environments.

Outpatients and diagnostic imaging

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

Information about the service

Outpatient services at Nuffield Health Bournemouth Hospital cover a wide range of specialities. These include ENT (Ear Nose and Throat), urology, general surgery, orthopaedics, gynaecology, ophthalmology, pain management, cardiology, dermatology, gastroenterology, neurology, respiratory medicine and rheumatology. Diagnostic imaging facilities provided by Nuffield Health Bournemouth Hospital include x-rays and ultrasound, dual-energy X-ray absorptiometry (DXA), computerised tomography (CT), fluoroscopy, mammography and magnetic resonance imaging (MRI). The hospital also provides outpatient physiotherapy services.

The outpatient clinic has 13 consulting rooms, one treatment room, two ophthalmic rooms, two minor operation treatment rooms, two phlebotomy rooms, one treatment room. Any specialty can use the consultation rooms. Clinics are all consultant led.

The physiotherapy department comprised of one physiotherapy gym, two treatment rooms, and a hydrotherapy pool.

In the period January 2015 to December 2015, there were 21,599 outpatient appointments, 10,887 of which were new appointments and 7,565 were follow-up appointments. The hospital provided a service for NHS patients though block NHS contracts. A total of 3,247 NHS patients were seen in outpatient clinics, 2,241 of these being first appointments and 906 being follow-up appointments

In the same reporting period, there were 183 new outpatient appointments and 89 follow up appointments for infants aged 0-2 years. There were 519 new outpatient appointments and 201 outpatient follow up appointments

for children aged 3-15 years. There were 141 new outpatient cases and 62 follow up appointments for young people aged 16-17 years. None of the outpatient care and treatment episodes for children and young people had been funded by the NHS. Patients were either self-pay or covered by insurance or other means.

During our inspection, we visited the outpatients, physiotherapy and diagnostic imaging services. We spoke with six patients and 18 staff, including nurses, medical staff, healthcare assistants, physiotherapists, administrators, receptionists and managers. We reviewed information provided on CQC feedback cards from patients using the service. We reviewed patient records and staff training records. We observed care being provided. Before, during and after our inspection we reviewed the provider's performance and quality information.

Outpatients and diagnostic imaging

Summary of findings

Overall this core service was rated as 'good'.

There were appropriate systems in place to keep patients safe. Staff reported incidents and shared learning of these incidents. Outpatient areas were clean and equipment was well maintained. Staffing levels were appropriate without any use of agency staff. Patient records were available for appointments and the department had timely access to test results. However, nurses who were responsible for decontamination of nasendoscopes were not trained to undertake the decontamination of that equipment. They had received training in general decontamination of equipment. There was good multidisciplinary team working. Staff told us there was good training and support in their role, with appropriate opportunities to develop their skills further.

Staff were caring, compassionate, and treated patients with dignity and respect. Patients told us they felt informed about their treatment and had been involved in decisions about their care.

Hospital staff, together with consultant private secretaries, managed and scheduled clinics appropriately. This ensured good availability of appointments for patients across all specialities.

Staff worked effectively in teams and were generally positive about the leadership of the service at both a local and senior level. There was an open culture and staff were encouraged to make suggestions to improve services for patients. The hospital used different methods to gather feedback from patients about their experience.

Are outpatients and diagnostic imaging services safe?

Good 

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

We rated safe as 'good'.

- Staff had a good understanding of how to report incidents. There was learning from incidents.
- Staff carried out appropriate mandatory training for their role. Staff told us they had support to keep this up-to-date.
- Clinical areas and waiting rooms were all visibly clean and tidy. Infection prevention and control practices were followed, and regularly monitored, to prevent the unnecessary spread of infections.
- Appropriate equipment was available for patient procedures and tests. Equipment was well maintained and tested in-line with manufacturer's guidance. Staff managed medicines safely and securely.
- Records were stored securely. Staff told us that patient records were available before appointments.
- In diagnostic imaging, local rules and safe systems of work were in place. There was appropriate signage on X-Ray doors to show when in use and to prevent people entering.
- Staff could demonstrate the procedures in the event of a medical emergency. There was a call bell system in clinical areas and an on-call team within the hospital who were advanced life support (ALS) trained.
- There was a nominated radiation protection supervisor (RPS). Patients received good communication and support from across the radiation team.

However,

- Nurses who were responsible for decontamination of nasendoscopes were not trained to undertake the decontamination process for those particular nasendoscopes. They had received training in general decontamination of equipment.
- There was also no formal checking of daily maintenance of this equipment.

Outpatients and diagnostic imaging

- Audits showed compliance with infection control practice had not been above 87%.

Incidents

- The hospital reported 269 clinical incidents in the period January 2015 to December 2015. The hospital reported there were no serious incidents requiring investigation in outpatients during the period January 2015 to December 2015.
- There were no never events in the period January 2015 to December 2015.
- All staff knew their responsibility to report incidents. The clinical manager ensured staff received regular updates on incident reporting. Staff reported incidents on an electronic incident reporting system, All staff spoken with knew how to log an incident.
- In the diagnostic imaging department, there were clear processes for reporting incidents about the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).
- There were systems and processes in place for post incident feedback.
- Monthly departmental meetings had incident reporting as a standing item on the agenda. A random sample of meeting minutes confirmed this. There was evidence of shared learning of incidents across the department and also incidents across the hospital.
- Safety alerts, for example about medical devices, medicines or infections, were received by the hospital and communicated to heads of department.

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 to that person.
- Senior staff told us they received information and training on the duty of candour. However, not all staff we spoke with knew about the duty of candour. Senior staff were aware of the requirements of duty of candour and could provide examples of when they had been applied. We saw where patients had been offered a written apology and the opportunity to be involved in any resulting investigations following an incident of avoidable harm.

Cleanliness, infection control and hygiene

- Outpatient, physiotherapy and diagnostic imaging departments were visibly clean and tidy.
- The hospital had an infection control lead nurse, who maintained links with the local NHS infection control team. The lead nurse monitored audit activity, provided guidance at senior nurse meetings and managed the infection prevention programme. This included training and supporting link nurses in each department of the hospital.
- The results of the audits showed compliance with infection prevention had been inconsistent. During 2015, compliance had not risen above 87%, lowest level of compliance 78% from April 2015 to June 2015. From January to March 2016, the compliance was 82%. The matron had discussed this with heads of department during quality and safety meetings.
- Hospital wide staff training compliance with infection control was at 90% against a hospital target of 85%. Staff were also expected to attend practical infection prevention and control training. Only 65% of staff overall had completed the practical training but this included 100% of all clinical staff.
- We reviewed cleaning records for outpatient clinic rooms. The rooms showed cleaning had taken place regularly.
- Hand sanitisers were widely available throughout the outpatient, physiotherapy and imaging departments to encourage hand hygiene.
- Personal protective equipment (PPE), such as gloves and aprons, was readily available for staff in all clinical areas. The equipment helped to ensure staff safety and reduce risks of cross infection when staff performed procedures.
- Physiotherapy department cleaning records showed that cleaning took place in accordance with a fixed schedule.
- The physiotherapy team checked the hydrotherapy pool twice daily. We saw paper records in the physiotherapy department confirming this practice. The team took a sample of water and checked for temperature, pH and chlorine levels. They also sent samples to the microbiology for testing for further analysis.
- The diagnostic and imaging department overall was clean. Staff were responsible for maintaining the cleanliness of the equipment in accordance with infection prevention and control (IPC) standards. Cleaning records for all areas were checked. They were complete with no historical gaps. However, signatures

Outpatients and diagnostic imaging

were against dates only. The cleaning schedule for each area was not available. This was highlighted to the radiology manager who took appropriate actions. The department introduced printed copies of the detailed cleaning schedules for staff to work against and sign each element.

- All six items inspected on the cleaning tick list were clean.
- In the diagnostic and imaging department, PPE equipment including lead coats were checked every six months and were clean and of good condition.
- Nursing staff and other healthcare workers adhered to the 'bare below the elbow' guidance to allow thorough hand washing and reduce risk of cross infection.
- The hospital's patient-led assessment of the care environment (PLACE) scores were the same or higher than England average for all domain.
- The hospital had no incidences of clostridium difficile, meticillin-resistant staphylococcus aureus (MRSA) or meticillin-sensitive staphylococcus aureus (MSSA) in the period January 2015 to December 2015.

Environment and equipment

- All of the items of equipment checked were labelled with the last service and review date. All had an asset number to allow easy tracking if they needed servicing or maintenance.
- The appointed Radiation Protection Adviser was provided through a service level agreement (SLA) with an acute NHS Trust based in London. There was an appointed and trained Radiation Protection Supervisor. Their role was to oversee equipment safety and quality checks, and ionising radiation procedures, in accordance with national guidance and local procedures.
- Signs in the diagnostic imaging department identified when x-rays were being taken and not to enter the room.
- During the course of our inspection we observed that specialised personal protective equipment was available for use within radiation areas. Staff were wearing personal radiation dose monitors.
- There had been no significant incidents of over exposure readings on the film badges. A small reading for a medical staff that was part of an audit to measure eye dose. The film badge was subsequently positioned on the external face of the lead coats.

- There were patient alarms in the patient cubicles. The radiographer confirmed they were tested every Friday at 10am by the maintenance team.
- A list of all equipment including model, make, age and serial numbers was available in the department.
- The diagnostic and imaging department had business continuity plans in place should there be significant equipment failures. The local NHS hospital provided services when required.
- Resuscitation equipment, including equipment for resuscitation of children, was located in outpatient department on a trolley. The trolley was sealed with tamper-evident tags. We saw a daily check sheet which recorded the trolley had been checked to ensure equipment was available and in date.
- Lead coats were visually inspected and x-rayed very six months. Records inspected on the day of the inspection confirmed this.
- During the inspection, we found that nurses who were responsible for decontamination of nasendoscopes were not trained to undertake the decontamination process for those particular nasendoscopes. They had received training in general decontamination of equipment. There was also no competency framework for the training of staff to decontaminate this specific equipment. Hence staff were not fully aware of how to decontaminate the equipment. There was also no formal checking of daily maintenance of this equipment.
- Housekeeping team managed the waste disposal. There was clear labelling of all clinical waste bins in clinical rooms.
- **Medicines**
- Medicines in outpatient department were stored safely. All medicines cupboards were locked and the keys held by the lead nurse on duty. Staff we spoke with knew who held the keys. Fridges were locked and temperatures checked daily and logged, to check medicines were stored at the correct temperature. We checked a random sample of medicines in outpatient department and radiology, all of which were in date.
- The medicine cabinet was temperature controlled. Up to date records were seen and temperature were within the correct range (3-38 degree Celsius).
- Contrast media is a substance introduced into a part of the body in order to improve the visibility of internal structures during radiography. These materials were safely stored in the diagnostic imaging department.

Outpatients and diagnostic imaging

Medicines in the diagnostics and imaging department were stored in a medicines cabinet. There were good security systems in place. The medicine cabinet was locked and sited in a cabinet which was also locked. Keys for both were in a different room in a lockable cabinet. The keys were kept at the reception.

- There were no controlled drugs in the departments.
- Pharmacy staff undertook monthly audits to establish the expected stock levels against the number of prescriptions each month.
- The resident medical officer (RMO) prescribed any drugs if required in the absence of a consultant radiologist.
- Some contrast media was stored in a warmer, so ready for use. Temperatures were recorded daily-acceptable range was 36-38 degrees. Records were up to date and there were no exceptional temperatures.

Records

- All the hospital's own records were kept on site, or recalled from a medical records store in time for their outpatient appointment. The consultants' secretaries, whether internal or external, provided the consultant's own notes prior to any outpatient appointment being undertaken. All consultant secretaries had completed a training programme in information governance.
- All patients attending outpatients had a GP referral letter or their current medical records from a previous appointment or admission.
- Radiology admin staff knew that the patients should have all previous images available and they check with the patients as to whether they have received x-rays or scans before when making the appointment; and request any previous images from source in preparation. Such requests were documented and images were made available according to the clinic lists daily.
- The hospital used the picture archiving and communications system (PACS). This was a nationally recognised system used to report and store patient images.
- The imaging department had access to an image exchange portal for images held on other systems. This access meant staff could view patients' existing x-rays instead of exposing them to unnecessary repeat x-ray procedures.
- Staff said records were always available for scheduled appointments.

Safeguarding

- The safeguarding training for vulnerable adults and children was mandatory for all staff. All the staff we spoke with were aware when to raise a concern and the process they should follow. At the time of the inspection, compliance with safeguarding training level 1 was 100% in outpatients and 90% compliance with level 2. In the diagnostic and imaging department, compliance with safeguarding training level 1 and 2 was both at 78%. This was below the target set by the hospital. This was due to a member of staff on sick leave. Two members of staff were trained at level 3.
- Staff that we spoke with demonstrated a good understanding about safeguarding processes. There were internal processes to flag any concerns of children who did not attend any outpatient appointment. Nurses were familiar with these processes, they knew what actions they needed to take if they suspected a patient or a visitor to the hospital had been subject to abuse. We heard examples of when appropriate action had been taken to safeguard individuals from abuse or avoidable harm. For example, we heard how a safeguarding concern about a child who was assaulted by a parent on hospital premises was reported to the local authority safeguarding team. The annual safeguarding report for 2015 confirmed this incident occurred in September 2015

Mandatory training

- The Nuffield Health Bournemouth Hospital mandatory training matrix included training requirements for staff, dependent on their role. For example, information governance, health safety and welfare, and fire safety was applicable to all staff whereas infection prevention training was only for staff working with patients who required the necessary skills in these areas.
- Most training was done by e learning with the Nuffield on-line academy, in some cases followed by workshops and assessments. Staff completed their training during their work time when possible or they could access their e learning accounts from home if they preferred.
- The mandatory training target for the outpatient department was 85%. The department was exceeding this target for all training except aseptic technique (40% staff had completed this training) and safe blood transfusion level 1 and level 2 (60% of staff had completed this training). The senior sister for the service

Outpatients and diagnostic imaging

was aware of the need to ensure all staff were appropriately trained. An automated system alerted managers and individual staff members when they were due for training.

- Staff in the diagnostics and imaging department received on-going mandatory training and they were responsible for ensuring they kept up to date.
- Training for the radiation protection supervisor (RPS) and her deputy RPS was provided by a trust in London. There were up to date records and certificates for completion of the programme.
- The mandatory training target for the diagnostic and imaging training was 85%. The department was not meeting this target for 12 areas. The following were all completed by 78% of the staff: basic life support, business ethics, fire safety, incident reporting, information governance, infection prevention, practical, managing stress and whistleblowing. The following was completed by only 67% of the staff: infection control. These low numbers were due to a member of staff off on sick leave.

Assessing and responding to patient risk

- There was always a registered medical officer (RMO) on duty, who was trained in advanced life support. They provided support to the outpatient staff if a patient became unwell. Patients who became medically unwell in outpatients were transferred to the inpatient ward or to the local acute NHS Trust in line with the emergency transfer policy.
- There were service level agreements with the local acute NHS Trust, for support services to the hospital. This included processing and reporting on radiology, radiology monitoring, and support with life support training including the provision of emergency scenarios.
- Staff in outpatients were clear about how to respond to patients who became unwell and how to obtain additional help from colleagues in caring for a deteriorating patient. All radiographers and registered nurses in the outpatients and diagnostic imaging departments had received training in immediate life support and paediatric basic life support, with all other staff trained in basic life support.
- Staff in all outpatient departments had training in basic life support, with some staff trained in intermediate life support.
- The principal function of the Radiation Safety Committee was to ensure that clinical radiation

procedures and supporting activities were undertaken in compliance with ionising and non-ionising radiation legislation. The committee met annually and the Radiation Protection Supervisor (RPS) received minutes and actions.

- There were two appointed and trained RPS whose role was to ensure equipment safety and quality checks and ionising radiation procedures were carried out in accordance with national guidance and local procedures.
- The signage on the x-ray doors were clear and appropriate in the general x-ray rooms for staff, visitors and patients informing where radiation exposure took place.
- There was a pregnancy status check policy in place and the status of all women of child bearing age was checked by radiographers prior to examination. There was also clear signage within the department waiting areas and changing cubicles to ask patients to let staff know if there was a possibility that they were pregnant.
- The diagnostic and imaging department had a patient identity check process in place. This was audited monthly. The target was set at 100% and the last audit in April achieved 96% compliance.

Nursing staffing

- Outpatient, diagnostic imaging and physiotherapy departments reported they had sufficient numbers of staff to meet the workflow and patient needs in a safe manner.
- Consultants could contact the outpatient services at any time requesting an ad hoc clinic. This was agreed if there was an available consulting room and sufficient nursing staff.
- The OPD did not use any agency staff.
- A paediatric nurse was present when children were seen in outpatient clinics.

Medical staffing

- The hospital at the time of the inspection employed 217 medical staff working under rules or practising privileges. The granting of practising privileges is an established process whereby a medical practitioner was granted permission to work within the independent hospital.
- The hospital completed relevant checks against the Disclosure and Barring Service (DBS). The registered manager and MAC chair liaised appropriately with the

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General Medical Council and local NHS trusts to check for any concerns and restrictions on practice for individual consultants. The General Medical Council is a public body that maintains the official register of medical practitioners within the United Kingdom.

- Where consultants were providing care and treatment to children and young people they were required to provide evidence of their qualifications, experience and training to demonstrate their competence in doing so. We saw evidence this was routinely happening in the minutes of the MAC and Senior Management Team (SMT) meetings.
- There was sufficient consultant staffing to cover outpatient clinics, including Saturday clinics. Consultants agreed clinic dates and times directly with the hospital OPD and administration team.
- Staff told us that medical staff were supportive and advice could be sought when needed.

Major incident awareness and training

- The hospital had a business continuity plan in place for use in the event of disruption caused by total or partial shutdown of the hospital due to one or more major failures of equipment, systems and/or services, fire damage, or due to external circumstances beyond the control of the hospital (e.g., bomb threat).
- A hospital-wide fire alarm test took place on a weekly basis and staff knew when this was planned. All staff understood their responsibilities if there was a fire within the building.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate 

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

We inspected but did not rate effective as we do not currently collate sufficient evidence to rate this.

- National guidelines were used, there was evidence that clinical audits were being undertaken in all outpatient areas, including recording of patient reported outcomes.

- Staff were supported in their role through appraisals. All staff were appraised or had appraisals booked with their managers. Staff were encouraged to participate in training and development to allow them to deliver good quality care.
- There was evidence of multidisciplinary team working across the hospital and with the local NHS acute trust. There was good sharing of information for example sharing of radiology images electronically between the hospital and local NHS trusts.
- Consent forms were completed for all minor surgical procedures.
- Patients pain needs were met appropriately during a procedure or investigation that was carried out in clinic.
- The hospital had a process for checking competency and granting and reviewing practising privileges for consultants. Radiology staff were aware of competencies of consultants for procedures and use of equipment.

Evidence-based care and treatment

- In the diagnostic imaging department, there was good evidence that compliance with national guidelines was audited; Nuffield Health Bournemouth Hospital had an IR(ME)R audit proforma in place, which the lead radiographer completed as part of clinical self-audit against procedures on an annual basis. The outcomes were shared with staff and any non-compliance was addressed with an action plan.
- Staff followed Royal College of Radiology (RCR) guidelines for administration of contrast media. These guidelines were available in folders in the viewing room and interventional rooms.
- Radiation Exposure/diagnostic reference levels (DRL) were audited every six months and evidence of these were seen during inspection.
- Clinical audits were undertaken in diagnostic imaging. For example, an audit was carried out to measure eye dose using film badges on the lead coats during screening. As a result of this audit, eye glasses were now provided.
- All radiology reports were checked and verified by the radiologist, before the report was sent to the referrer.
- Radiographers checked all referrals to ensure patients were booked for the correct imaging tests and the requesting information was fully completed.

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- Staff in outpatient department reported they followed national or local guidelines and standards to ensure patients received effective and safe care.

Pain relief

- In outpatient department, staff discussed options for pain relief with the patient, during their consultation before any procedure being performed. Many procedures could be performed with the use of local anaesthetic, enabling the patient to go home the same day. The hospital used the corporate Nuffield patient management tool.
- Patients received written advice on any pain relief medicines they may need to use at home, during their recovery from their outpatient procedure.
- Patient records evidenced pain relief was discussed and local anaesthesia was used for minor procedures.
- Nuffield Health followed policy to support the management of children's pain, called 'Analgesics to Manage Paediatric Acute Pain' V1.0. Children were prescribed and administered anaesthetic cream prior to insertion of an intravenous cannula or before they had bloods taken.

Patient outcomes

- Nuffield Health produced an audit tool to measure compliance with the policy for prevention and management of venous thromboembolism (VTE). We saw evidence of compliance with this annual audit.
- Patients were offered opportunities to participate in data collection to measure outcomes of treatment. All patients who were booked for joint replacement were asked for consent to be registered on the National Joint Registry (NJR), which monitors infection and revision rates. We saw in medical records that we reviewed, patients had consented to participate in the register which ensured their care and joint replacements were monitored nationally.

Competent staff

- Practising privileges is authority granted to a physician by a hospital governing board to allow them to provide patient care and treatment within that hospital. There were appropriate systems in place to ensure that all consultants' practising privileges were regularly reviewed. The hospital Medical Advisory Committee followed a process to ensure all consultants who had

practising privileges had the relevant competencies and skills to undertake the treatment they were performing at the hospital. This included the review of competencies, outcomes, appraisal and revalidation.

- Appraisal rates for the year January 2015 to December 2015 were 100% both for nursing staff in outpatient department and for healthcare assistants.
- All new staff completed an induction programme. Staff told us the induction process was comprehensive including department tours and introductions to heads of department and colleagues.
- Staff confirmed they were well supported to maintain and further develop their professional skills and experience.
- Patients told us that they felt staff were appropriately trained and competent to provide the care they needed.
- Staff appraisals were up to date. Staff spoken with felt their appraisal was positive with development plans for the future. Each appraisal had two elements- "Looking back" And "Looking forward."
- All permanent staff except the member of staff who had just returned after long term sickness, were up to date with their appraisal. Bank staff do not receive annual appraisal.
- All radiographer staff had received training on cannulation. Staff could therefore cannulate patients for CT scanning. This ensured patients were not waiting for the RMO to cannulate.
- Staff felt that they had access to continuous professional development training and shared details of the recent training courses attended. For example, a radiographer attended the annual mammographic symposium.
- Consultant radiologists signed competency forms detailing which procedures they could carry out and which equipment they could use. Sample signatures were kept within the imaging department so that x-ray referrals could be checked.
- There was training for radiology helpers to gain professional qualifications. Basic radiographers developed extended skills in magnetic resonance imaging (MRI).

Multidisciplinary working (related to this core service)

- From the care we observed, there was effective team working, with strong working relationships between all staff groups.

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- If there were unexpected findings following a radiology imaging, the radiologists contacted the referring clinician and the radiographers follow up on the results to ensure if any further actions need to be taken.

Seven-day services

- OPD ran clinics Monday to Friday from 8am until 8pm, there were occasional Saturday clinics.
- The diagnostic imaging department ran from 8am until 8pm, with an on-call service available at the weekend.

Access to information

- Patient notes were always available to ensure continuity of care.
- Staff we spoke with reported timely access to blood test results and diagnostic imaging. This enabled prompt discussion with the patient on the findings and treatment plan. Results were reported electronically, accessible by the clinician at the hospital.
- X-rays were available electronically for consultants to view in the clinic.
- There were appropriate systems in place to ensure safe transfer and accessibility of patient records if a patient needed to be transferred to another provider for their treatment. Medical staff we spoke with confirmed the transfer methods used and understood the required security aspects of data transfer.
- Doctors dictated clinic letters and they were typed by their private secretaries. GP's were sent the clinic letter and a copy was retained on the patient records. A copy of the letter was in the patients' record.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Information about the Mental Capacity Act 2008 and associated Deprivation of Liberty Safeguards was covered in the mandatory safeguarding training. Staff demonstrated in conversations a good understanding about their role with regard to the Mental Capacity Act.
- The consent process for patients was well-structured, with written information provided before consent being given.
- Verbal consent was given for x-rays, outpatient procedures and physiotherapy treatments carried out.
- Staff we spoke with said they would not carry out any procedures on children without parental consent.

Are outpatients and diagnostic imaging services caring?

Good 

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

We rated caring as 'good'.

- Staff in all outpatient areas were caring and compassionate. Patients commented positively about the care provided from all of the outpatient staff. Staff treated patients courteously and respectfully.
- Staff maintained patient privacy and dignity.
- Patients could make informed decisions about the treatment they received. Staff listened and responded to patients' questions positively.
- Staff demonstrated they were passionate about caring for patients and clearly put the patient's needs first, including their emotional needs.

However,

- Patients received explanation of their medicines without consideration of privacy.
- **Compassionate care**
- We observed that staff mostly took all possible steps to promote patients' dignity and they were afforded privacy. We observed staff ensured doors were closed and curtains pulled. Patients that were required to change into a hospital gown for their examination when undergoing x-rays and other diagnostic examinations were asked to change in a cubicle and wait in the waiting area. Even though they also wear a dressing gown, patients may still feel vulnerable.
- Pharmacy staff gave patients their medicine near the outpatient reception area. Explanation of the medicine that had been prescribed to the patient was given without consideration of privacy as people nearby could overhear the content of the conversation.
- Throughout the inspection, we saw staff speaking in a calm and relaxed way to patients. Patients told us staff were helpful and supportive.
- The Friends and Family test demonstrated that on average, over 97% of patients recommended the hospital between July and December 2015.

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- In the Patient Led Assessments of the Care Environment (PLACE) between February 2015 and June 2015 privacy, dignity, and wellbeing scored 99% compared to an England average of 87%.
- We spoke with two patients who told us that staff were polite, caring and friendly. There were no negative comments. One patient had been contacted previously to say that the appointment had been changed. They were very happy with how the change to their visit had been handled.

Understanding and involvement of patients and those close to them

- Patients received relevant information, both verbal and written, to make informed decisions about their care and treatment. There had been sufficient time at their appointment for them to discuss any concerns they had.
- Patients felt fully informed about their care and treatment. All the patients we spoke with had a good understanding of their condition and proposed treatment plan, as well as where to find further information.
- The diagnostic and imaging department undertook their own patient satisfaction survey. Results were posted in public areas. The latest survey results (February 2016) showed over 99% of patients were satisfied with the service.

Emotional support

- When having conversations with staff it was clear, they were passionate about caring for patients and clearly put the patient's needs first, including their emotional needs.
- Staff told us that they always offered to chaperone patients undergoing examinations. We saw medical staff requesting chaperones for their patients.

Are outpatients and diagnostic imaging services responsive?

Good 

By responsive, we mean that services are organised so that they meet people's needs.

We rated responsive as 'good'.

- Services were planned and delivered in way that met the needs of patients. The hospital environment was designed and maintained to support the individual needs of patients and to support privacy.
- Patients told us that there was good access to appointments and at times that suited their needs.
- Waiting times, delays and cancellations were minimal. Physiotherapy and X-ray appointments were on time and patients were kept informed of any delays in outpatient clinics.
- There was information on specific procedures, conditions and hospital charges in the waiting area. This was in English and not in other languages or formats, such as braille. The hospital reported that they had minimal numbers of patients who could not understand English.
- Staff always listened to complaints, concerns, and lessons learnt. Staff were knowledgeable about the complaints process and confident that complaints were investigated. However, they did not always receive feedback about the outcome of complaints.

Service planning and delivery to meet the needs of local people

- Services were planned around the needs and demands of patients. OPD clinics were arranged in line with the demand for each speciality. If consulting space was available, consultants could arrange unscheduled appointments to meet patient needs.
- The hospital was a provider of Choose and Book which is an E-Booking software application for the National Health Service (NHS) in England which allows patients needing an outpatient appointment or surgical procedure to choose which hospital they are referred to by their GP, and to book a convenient date and time for their appointment.
- Clinics were held Monday to Friday, 830am to 8pm, with occasional outpatient clinics held at weekends to meet patient's needs.
- Reception desks were sufficiently away from waiting areas so patients could speak to receptionists and staff, without their conversation being overheard.
- OPD had 13 treatment rooms. They were general treatment rooms used for minor procedures such as removal of sutures, wound dressings and removal of skin lesions.
- The diagnostic and imaging department provided same day x-ray service for outpatients and the wards.

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- The diagnostic and imaging department opening times were flexible to meet the needs of for outpatients department. Extended evening and weekend sessions were provided when necessary. Radiographers remained until the outpatient clinic list had been completed.
- Children and young people's appointments were scheduled according to available resources to ensure that a paediatric nurses was present if required and that child friendly reading material, equipment and toys could be provided.
- The hospital's own administration team managed the NHS patients who used Choose & Book and were subject to NHS waiting time criteria. All referral to treatment (RTT) waiting times for every month were above or met the target of 95% for 18 weeks for the reporting period (Jan 15 to Dec 15). RTT measured the total period waited by each patient from referral to treatment and helped managed each patient's journey in a timely and efficient manner.
- Staff told us that physiotherapy and X-ray clinics usually ran to time.
- There was no formal system in place to inform patients if a clinic was running behind schedule. OPD staff would advise the reception team who would, in turn, advise patients as they arrived for their appointment. Information regarding how long patients waited was not captured and could therefore not be analysed to identify any concerns.

Access and flow

- The diagnostic and imaging department accommodated non-medical requirements when booking appointments. Clinical needs were always taken into consideration when booking appointments. During the inspection, the process of booking patients was discussed and observed. All patients were telephoned to arrange their appointments. The exception to this was the appointments made for the walk-in x-ray services.
- The diagnostics and imaging department introduced blood tests that can be done immediately prior to a scan to measure how well the patient's kidneys worked. The device gave result immediately. Prior to this test, patients had to go for their blood test and then wait for at least one hour or the results.
- Do not attend (DNA) rates were not audited. However, admin staff followed up every patient, including NHS patients, who did not attend on the day of the appointment and for a number of days after. Patients were also sent a letter to contact the department. The nurse in charge of the outpatient department told us they always ensured appointments were given to any cancellation and as such did not need to monitor those cancellations.
- To minimise the risk of ward patients waiting in a public wait area, porters were requested to fetch ward patients when there was an x-ray or CT room is available.
- The consultants' secretaries arranged patients' appointments with the outpatient reception team.
- The hospital's own administration team managed the NHS patients who used Choose & Book and were subject to NHS waiting time criteria.
- For NHS patients the hospital consistently met the six-week diagnosis targets.

Meeting people's individual needs

- The department had a portable device which was used for children particularly in the fluoroscopy room where patients underwent longer procedures. Children's programmes were downloaded onto the portable device to entertain/distract the patient. This had proved to be a very useful tool for this group of patients.
- Translation services were requested at the point of booking appointments
- Staff recognised the need to support people with complex or additional needs and made adjustments wherever possible. For example, arrangements were in place for wheel-chair access.
- The reduce the number of visits made to the hospital, the OPD organised appointments to ensure other needed procedures such as X-rays or ultrasounds or scans took place at the same time as the patient's OPD visit.
- Signs offering patients a chaperone were clearly displayed in waiting areas and clinical rooms.
- There was ample seating in the waiting area. There was access to tea and coffee in the waiting area.
- All written information, including pre-appointment information and signs were in English. Language line provided hard copies of patient information on request. The radiology team knew how to access this when required. Large print copies were available as patient information was accessible by the radiology department.

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- Staff described there were rarely patients whose first language was not English. There were policies for accessing translation services and the OPD considered those when arranging the length of patient appointments. There was an induction loop at the outpatient reception area.

Learning from complaints and concerns

- The hospital director monitored all complaints and responded to in-line with the hospitals policy. Patients who complained received an acknowledgement of within two working days and a full response within 20 working days. The relevant head of department with the involvement from consultants and nurses if needed, investigated these complaints. There were no complaints about the outpatient department for the period January 2015 to December 2015..
- All staff received information about the complaints procedure as part of their induction. The staff we spoke with were clear on the process and procedure.
- During our inspection, we found leaflets for patients instructing them on how to make a complaint.
- There were very few complaints in the diagnostic and imaging department. There were examples of learning from such complaints. For example, one patient had complained about the lack of choice of size of hospital gowns in the cubicles and insisted on the day to speak with the hospital manager. The incident itself was handled well, The hospital director came to talk to the patient. As a result, a range of sizes were now made available. During our inspection, patients confirmed to the availability of different sizes of hospital gowns.

Are outpatients and diagnostic imaging services well-led?

Good 

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

We rated well-led as 'good'.

- There was a corporate vision that most staff knew about. They exhibited the ethos of the strategy in their commitment to provide quality and compassionate care for patients in an effective and efficient manner.
- Staff had confidence in their immediate managers. Staff reported that senior management within the hospital were visible and always approachable.
- Though a small service, children and young peoples' care and treatment was given sufficient leadership priority.

However,

- Individual departments did not maintain their own risk registers.

Vision and strategy for this core service

- All staff demonstrated a commitment to providing quality and compassionate care for patients in an effective and efficient manner. Staff spoke passionately about the service they provided and the care they offered to patients. Staff were aware of the provider values, which were to be enterprising, passionate, independent and caring. Provider values were embedded amongst the staff, which were to be enterprising, passionate, independent and caring.
- The corporate mission was "for the love of life." Staff we spoke with were aware of the corporate mission and departmental vision.

Governance, risk management and quality measurement for this core service

- There was defined governance and reporting structure in the hospital, which fed into the organisations governance processes. Departments held their own team meetings, in which information was fed back from hospital clinical governance meetings, operational leads and senior nurse meetings. These meetings discuss learning from incidents, safety and quality issues and improvements that need to be made.
- There was a quarterly children and young people's governance committee meeting. This was attended by the lead paediatric nurse, the lead paediatricians and the matron. Senior staff also routinely discussed service provision for children and young people at the MAC and the Quality and Safety committee, as well as at Senior Management Team (SMT) meetings.

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- In the diagnostic and imaging department, there were clear governance structures and clear defined reporting structures in the department to senior management.
- There was an overall corporate register and the department fed this through the management structures. There was no outpatient department risk register. In the diagnostics and imaging department risks were identified and risk assessment documented. For example, we found there had been no lone working policy.
- Individual departments did not maintain their own departmental risk registers. The registered manager explained it was corporate policy to keep hospital risk registers to high level issues. For example, the corporate risk register contained risk identified in the outpatient department regarding the call bell facilities. At the time of the inspection we found the hospital had corrected the call bells in the outpatient department and the pre-assessment clinic.
- However, staff in the outpatient department were not aware of the content of the corporate risk register nor how to place items onto the corporate risk register.
- The medical advisory committee met quarterly. The meeting notes included incidents, complaints, quarterly audit results, patient satisfaction survey and approvals, renewals and removals regarding consultants holding practising privileges at the hospital.

Leadership / culture of service

- A senior nurse was the overall head of outpatient department. Managers in the outpatient, radiology and physiotherapy departments had clinical roles and were easily accessible. Staff reported good support and guidance from their managers. Managers were passionate about their teams and caring for their patients.
- The executive team were highly visible within the hospital. Staff told us their names were known by the hospital director. They felt very much part of the hospital team.

- Medical staff we spoke with confirmed a positive relationship with the executive director.
- In the diagnostic and imaging department, staff were happy working for the hospital. Staff also spoke highly of the manager. Staff found them very supportive, inclusive and there was an open door policy in place. Staff had previously identified stress as a risk to poor leadership. This had now been resolved.
- All staff said they felt listened to and respected. They felt they could raise concerns and they would be investigated.
- All staff we spoke with, were happy working at the hospital. The diagnostic and imaging department had an overall good staff retention rate. There was a good team culture with shared principles on the quality of the service delivered. There was evidence of good communication across all staff.

Public and staff engagement

- Patients were encouraged to leave feedback about their experience by the use of a patient satisfaction questionnaire and for NHS patients by the Friends and Family Test.
- Staff told us that they were able to meet with the hospital director who was very visible in the organisation.
- There were a number of examples of local patient satisfaction surveys. The results of the patient survey were not always shared with the outpatient department members of staff.

Innovation, improvement and sustainability

- The diagnostics and imaging department introduced blood tests that can be done immediately prior to a scan to measure how well the patients' kidneys worked. The device gave result immediately. Prior to this test, patients would have had to go for their blood test and then wait for at least one hour for the results.
- The diagnostics and imaging department anticipated the changing demands on the service and ensured all radiographers trained in CT scanning and cannulation.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

There were areas where the provider needs to make improvements.

Importantly, the provider MUST ensure that:

- Theatre environments are safe and follow infection prevention and control procedures in line with the Health and Social Care Act, 2008, Code of Practice on the prevention and control of infections and related guidance.
- Staff complied with bare below the elbows guidance and adhere to best practice and Nuffield's own policies in relation to infection prevention and control.
- Linen is safely stored and handled in theatres.
- Clinical waste is safely stored away from areas of direct patient care until disposal.
- Equipment is safe for use and that the condition of equipment allows for efficient cleaning.
- An effective system is implemented to ensure that worn, torn, broken or rusty equipment is identified, withdrawn from use and replaced in a timely manner.
- Cleaning schedules and effectiveness of cleaning are monitored to ensure that cleaning occurs at agreed intervals.
- All staff receive mandatory training in line with the hospital set minimum target of 85%.
- All staff complete an annual appraisal
- There is an effective and monitored system for the tracking and tracing of endoscopes.
- Staff working in endoscopy are trained and assessed against an identified competency framework that is specific to their role.
- All patients have a documented risk assessment for venous thromboembolism.
- The five steps to safer surgery checklist (WHO) is always appropriately completed.

- The storage and management of medicines including controlled drugs meet the requirements of current legislation, Nuffield policy and standard operating procedures.
- Verbal orders for medicine prescribing are not used when undertaking planned procedures.
- Departments should maintain their own risk registers and ensure staff are fully aware how to raise matters and place them on the risk register.
- There are robust systems and processes for assessment, identification and mitigation of risks across all services and departments of the hospital.
- Risk register includes all risks that may adversely affect patient safety and is shared with and understood by staff across all departments.
- Patient records of care and treatment, including nutritional monitoring, are legible and complete.

Action the provider **SHOULD** take to improve

In addition the provider SHOULD ensure that:

- Learning from incidents is consistently shared across all hospital departments.
- Ensure pharmacy staff discuss medicines with patients in a manner that maintains patients' privacy.
- Medicines are stored at the appropriate temperature and there are clearer recording systems so there is assurance that medicines in endoscopy department have been stored within the correct temperature range.
- Relevant staffs receive appropriate training for decontamination of nasendoscopes.
- Ensure there are systems in place to check daily maintenance of nasendoscopic equipment.
- Implement formal systems to inform patients of waiting times of clinic.
- Ensure results of patient satisfaction surveys are shared with staff and displayed publicly.
- That consultants are capturing data after carrying out endoscopy procedures at the hospital, and plan how this data can be used to improve patient outcomes.

Outstanding practice and areas for improvement

- All resuscitation trolleys are checked at agreed intervals and this is reflected in the recording of such checks.
- Boxes are not stored on the floor in the cardiac catheter suite storeroom to enable effective cleaning of the storeroom.
- The theatre manager is afforded capacity and support to fulfil the requirements of the role.
- Develop a pre-operative fasting policy in line with national guidance.
- Consent forms are signed by patients on the day of their procedure to allow a 'cooling off' period in line with national guidance.
- The Resident Medical Officer is part of handover and team meetings.
- A strategy for surgical services is developed.

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

Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

How the regulation was not being met:

- In endoscopy suite local standard operating processes were not in place to support systems and processes. We found an inconsistent approach to the tracking and tracing of endoscopes.
- Risk assessments such as assessment for the risk of venous thromboembolism and the WHO safer surgical checklist were not always fully completed.
- Medicines, including controlled drugs, were not always stored securely and records were not appropriately maintained in all areas. Verbal orders were routinely being used to prescribe medicines in the cardiac catheter suite.
- Records were not always fully or consistently completed.

Regulated activity

Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met;

- Departments did not maintain their own risk registers and staff were not fully aware how to raise matters and place them on the risk register.

This section is primarily information for the provider

Requirement notices

- Risks in theatres and endoscopy had not been accurately identified or responded to.

Regulated activity

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met;

- Mandatory training overall compliance at the hospital was 84% against a hospital target of 85%. Training compliance was particularly low in theatres with overall compliance of 74%.
- There was no competency framework or training plan for staff working in endoscopy meaning there was no assurance that they were safe to undertake specific procedures.

Enforcement actions

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
Surgical procedures	<p>Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control</p> <p>A warning notice was served under Regulation 12, 1,2 (d) (h) (g).</p> <ul style="list-style-type: none">• Soiled linen was not safely discarded of in designated linen skips in Coral theatre recovery area.• The clinical waste bin in Coral theatre was placed within 3 metres of patients receiving pre and post-operative care.• There was no separate sluice in Coral theatre so staff were disposing of bodily fluid such as urine, vomit and faeces in the staff toilet.• The theatre environments were in a poor state of repair with loose plaster, gaps in the ceiling tiles, worn flooring and detaching skirting boards. There were faults with the laminar air flow system in theatres which we would not assured had not been actioned.• The transfer bag used in Coral theatre contained old, non-sterile and out of date equipment.• Many (at least 100) items of equipment used in theatres were worn, torn or rusty meaning they could not be effectively cleaned to prevent or control the spread of infection.• Medicines including controlled drugs were not routinely stored or managed safely in theatres.• Staff did not always change or remove Personal Protective Equipment (PPE) when moving between theatres. Staff were not consistently bare below the elbows in theatres.