

BMI Healthcare Limited

BMI Mount Alvernia Hospital

Quality Report

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

Ratings

Overall rating for this hospital

Medical care

Surgery

End of life care

Outpatients and diagnostic imaging

Summary of findings

Letter from the Chief Inspector of Hospitals

BMI Mount Alvernia hospital is an acute independent hospital that provides outpatient, daycare and inpatient services. The hospital is owned and managed by BMI Healthcare Limited.

A range of services such as physiotherapy and medical imaging are available on site. The hospital offers a range of surgical procedures and cancer care as well as rapid access to assessment and investigation. There are no critical care facilities which limits the scope of procedures that are available at the hospital.

Services are available to people with private or corporate health insurance or to those paying for one off treatment. Fixed prices, agreed in advance are available. The hospital also offers services to NHS patients on behalf of the NHS through local contractual arrangements.

We carried out a comprehensive inspection of BMI Mount Alvernia Hospital on 12 and 13 November 2014. The inspection formed part of a pilot programme of inspections in independent healthcare settings. The inspection reviewed how the hospital provided outpatient, medical care, surgical services and end of life care as these were the four core services provided by the hospital from the eight that are usually inspected by the Care Quality Commission (CQC) as part of its approach to hospital inspection.

As this was a pilot inspection and was undertaken to help develop the methodology we will use to inspect all independent healthcare providers, we have not given the hospital a rating.

The hospital has gone through a period of significant change and improvement over the past two years, with a new management team having been appointed by the organisation. Following a CQC inspection in January 2013, BMI Healthcare Limited had made a voluntary agreement with CQC to stop providing services for children; this agreement remains in force and children are not treated at the hospital.

Our key findings were as follows:

Are services safe?

- There were good Infection prevention and control procedures with staff having clear understanding of their own responsibilities.
- Pharmacy was well managed at the hospital with few medicines errors recorded. A dedicated inpatient pharmacist spends 90% of their working week on the wards meeting with patients to discuss their medication, reviewing all medicine charts daily and providing advice to ward staff and the RMO. Governance arrangements within the pharmacy department were good with a Medicines Management Committee that met bi-monthly and which fed into the Clinical Governance Committee. Pharmacists completed Continuing Professional Education in accordance with the requirement of the General Pharmaceutical Council.
- The level of senior medical and nursing input to patient care was limited overnight and at weekends. The hospital used an early warning scoring system (NEWS) to assist staff in identifying patients whose condition was worsening but these were not universally completed and the escalation policy was not always adhered to.
- The Resident Medical Officer (RMO) provided all medical cover over the 24 hour period and they could contact a consultant for advice, if they felt it necessary.
- We were not assured that patients were made fully aware of the limitations of care that could be provided at BMI Mount Alvernia Hospital in a systematic and consistent manner, such as the limitations in care that could be provided in the event of a deterioration in their condition. However, the hospital did have arrangements with a local NHS Trust to transfer patients should they be unable properly to care for any patient who unexpectedly deteriorated.
- The arrangements for handing over responsibility for patient care between consultants and for ensuring this was communicated effectively to staff were inconsistent and informal. Consequently, there had been an example where one consultant was not aware they were providing cover for another consultant.

Summary of findings

- The duty night matron held a file that contained the essential information for them to undertake the role safely. However, there was no information about which consultants were providing cover for absent colleagues within this folder, which had potential to cause delays in seeking senior medical and surgical advice in an emergency.
- The systems for the reporting, analysis and dissemination of learning from incidents were insufficiently robust and failed to ensure that the risk of recurrence was minimised.
- There was very good uptake and completion of mandatory training by staff employed at BMI Mount Alvernia hospital. This did not include consultants who worked under practicing privileges; it was unclear how consultants were consistently made aware of hospital policies and safe working practices in relation to subjects covered by mandatory training and the hospital incident reporting and investigation policies.
- There was a good theoretical understanding across the hospital in relation to adult safeguarding but this was not always followed robustly in practice.
- The management of the catering arrangements and food safety was very good with clear audit trails and governance records relating to the safe purchase, storage and handling of food provided to patients and staff.
- The facilities management was very good with attention to detail in the monitoring of water safety, electrical safety and fire safety. Records were readily available to demonstrate the provider met the requirements of the Control of Substances Hazardous to Health Regulations (2002).

Are services effective?

- Local policies and care pathways followed national guidance. We found that the guidance and policies were followed except in the radiology department where there was some inconsistency in local guidance being adhered to.
- There was no local end of life care pathway. However, the hospital was following the local NHS trust interim end of life care pathway and discussed with the inspectors a draft BMI pathway and the proposed piloting of that. The Hospital managed all patients requiring end of life care on an appropriate pathway and this was supported by robust multidisciplinary team review.
- Data collation and analysis was not as well developed, which meant it was not possible to consider the patient outcomes related to individual consultants or procedures to measure effectiveness in a systematic and consistent manner.
- Good Surgical Practice 2014 (RCS) says that surgeons should take part regularly in morbidity and mortality meetings. This was not happening because at the time of the inspection there were no morbidity and mortality meetings being held at BMI Mount Alvernia Hospital, although it is acknowledged that there were few unexpected deaths at the hospital. There was no comprehensive follow up where patients had been transferred out due to deterioration in their condition and this meant that the opportunity to learn and improve practice as a result of such meeting was missed.
- The hospital worked with a local NHS trust to ensure good multi-disciplinary review of patients receiving treatment at BMI Mount Alvernia hospital from consultants who also worked at the trust. We were less clear about the assurance that there was effective multi-disciplinary input where consultants did not also work at the trust as there were no MDT meetings held at the hospital.
- Some staff had a very limited awareness and understanding of the Mental Capacity Act 2005 and how this impacted on their role. The hospital dealt with very few people who lacked capacity and some records showed that some staff and consultants considered lack of capacity as an ongoing and overall assessment of the person's cognitive ability rather than being decision specific. Training in the care of people living with dementia was not offered to staff.

Are services caring?

- Without exception, patients reported a positive experience to us during our visit. Patient satisfaction surveys were benchmarked against other hospitals in the same ownership. The results for BMI Mount Alvernia showed high levels of patient satisfaction.
- Staff were caring and compassionate and treated patients with dignity and respect. They reported having sufficient time to provide good care based on individual needs and preferences.

Summary of findings

- Observed interactions between patients and staff were good, with clear warmth and kindness.

Are services responsive?

- Operations and treatments were rarely delayed or cancelled.
- The referral to treatment times were good and in line with national targets.
- The hospital provided some NHS funded care. There was no differentiation between NHS and private patients. Few NHS inpatients were being treated at the time of the inspection, although the hospital had contracts for NHS physiotherapy services.
- Within the practicing privileges contract for consultants there was a paragraph that required each consultant to review the management of each of their inpatients on a daily basis. Whilst the consultant physicians met this requirement some of the consultant surgeons did not and left the daily review of their patients to the RMO. The chair of the Medical Advisory Committee (MAC) advised the inspection team that they disagreed with this aspect of the organisational policy on practicing privileges and therefore the committee did not monitor or enforce the contractual agreement.
- The hospital did not provide critical care; patients who required elective high dependency or intensive care were not admitted to the hospital. Patients who experienced a sudden and unexpected deterioration in their condition such that they required higher level care were transferred to a local NHS hospital by emergency ambulance. There was, however, no scope of practice document nor mention within the practicing privileges contract of the range of treatments and surgery that could be provided at BMI Mount Alvernia and the decision as to whether to admit remained the decision of the consultant. There was a lack of structured and consistent governance processes in place which ensured that no patient could be admitted whose needs would in fact be more complex than those that can be met by the facilities and staff in the hospital.
- There was very limited advice or guidance on how staff would meet the wider needs of people with a learning disability. We were told that very few people with learning difficulties were admitted to the hospital; this is the reason there should be appropriate training and guidance for staff that are unfamiliar with this area of practice.

Are services well-led?

- We found that significant improvement had been made in areas of patient safety under the leadership of the current management team but more work needed to be done to improve some of the governance systems and processes, in particular learning from incidents.
- There were noticeable improvements in the organisational culture with staff reporting that they felt much more valued and respected under the current leadership than they had done previously.
- Complaints were not seen as a tool to drive service improvements, with learnings from complaints not being well shared. In addition, during the inspection there was little written information available to patients regarding how to complain.
- Specific activities were provided which allowed for increased inter departmental working. The introduction of 'Lunch and Learn' sessions allowed staff from across the hospital to come together to learn about specific topics such as pain management.
- The Resuscitation Committee operated in accordance with the recommendations made by the Resuscitation Council UK guidance. It was chaired by a senior clinician and had input from consultant anaesthetists and physicians. There were some documented concerns raised by the committee about the ability of the Resident Medical Officer (RMO) to respond to and lead resuscitation attempts identified during practice scenario during 2013; however no further concerns had been raised by the committee.
- There was a hospital Medical Advisory Committee (MAC) with consultant representation from across the specialities provided at the hospital. The Director of Nursing and Executive Director also attended. There were regular meetings with discussions around new applications for practicing privileges, hospital policies and complaints. We were told by senior staff that there was not a formal process for how information was communicated to consultants who did not sit on the committee.

Summary of findings

Was the hospital well-led?

- Staff of all grades reported a cultural change within the hospital and said they felt more empowered to challenge poor practice than they were prior to the current management team being appointed.
- The hospital's vision and strategy was that of BMI Healthcare Limited, the provider organisation. There were clear strategic objectives that were known to staff.
- There was a clinical governance structure but the post of Quality and Risk Manager was unfilled at the time of the inspection. Although we were told the Director of Nursing reviewed all incidents, we found in practice that the management and processes for review of incidents was not found to be robust or consistent, with some having not been reviewed and investigated. In addition, systematic learning from incidents and feedback to staff was not embedded across the hospital.
- Patient surveys were undertaken and used to benchmark the hospital against other hospitals within the same ownership. The Key Performance Indicators covered many aspects of the care people had received including the quality of catering, customer service, staff attitudes and pain management.
- We were told that there was an, "understanding" between consultants and the management team, which meant there was no need to formalise concerns that were identified in relation to individual consultants. Whilst there were route for more formal processes, there were isolated incidents reported of unacceptable behaviour by individual consultants that were managed informally by members of the management team rather than taking more formal and recorded action.
- Part of the strategic plan for BMI Mount Alvernia was to improve efficiency through cost reduction. Whilst the Hospital's strategy remained to recruit to permanent posts wherever appropriate, the Hospital also used bank staff to provide flexibility, particularly whilst occupancy levels were low.
- The hospital was operating below capacity. The strategic plan was addressing this and looking at ways to increase revenue through developing existing services and introducing new services.

We saw several areas of outstanding practice including:

- We saw that the hospital had systems and processes in place that supported staff in providing a good service. For example allocating time for post discharge telephone calls to check that all was well once the patient returned home and having adequate staff on duty which gave them time to interact with patients and their families. Patients and their families were cared for by kind and compassionate staff who went out of their way to support them.

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

- Incident reporting and learning from incidents was insufficiently robust to assure us that all incidents were reported. The organisational and hospital governance was not sufficiently developed to ensure proper learning from incidents and from trend analysis.
- Consultant surgeons were not routinely adhering to the contractual arrangements of their practising privileges agreements and this was not being monitored or addressed by the MAC.
- There were gaps in the staff and consultant's understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and the staff understanding of the needs of people living with dementia.
- The arrangements for handing over responsibility for patient care between consultants and for ensuring staff are aware who holds responsibility at any time were unclear and informal.

Importantly, the provider must ensure that :

- The provider has not always notified CQC of serious incidents that have occurred. The provider must ensure that CQC is notified without delay if a patient receives an injury; Which has caused impairment, changes to the structure of a patient's body, caused prolonged pain, psychological harm or has shortened the patient's life expectancy; Or which requires treatment in order to prevent death or serious injury, any allegation of abuse or incident investigated by the police.

Summary of findings

- The investigation and reporting of incidents and systems for organisational and local learning was insufficiently robust. The provider must consider feedback mechanisms following the reporting of incidents, and should review the arrangements for monitoring the implementation and efficacy of mitigating actions.
- The provider must review the process for monitoring compliance with practicing privileges.
- The service does not provide Level two critical care. The provider must amend the Statement of Purpose to ensure it reflects the service provided and the range of patients' needs the service can meet.
- Mental capacity assessments were not always completed and recorded, when necessary, such as when considering consent or Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders. The provider must consider the formal arrangements required to support patients living with dementia or learning difficulties. This must include appropriate training and monitoring processes for the assessment of people who lack capacity to consent.
- The provider must ensure that the records relating to the safe use of lasers in theatre are updated and provide assurance that the consultants are trained in their use and the equipment is appropriately monitored following best practice guidelines.

In addition the provider should:

- The provider should develop clear antibiotic prescribing protocols as we were told, "Consultants like to do their own thing". This increased the risk of resistant bacteria developing which could affect the wider community as well as the patients at BMI Mount Alvernia.
- The provider should review the use of the NEWS to ensure that hospital protocols are followed and that emerging concerns are appropriately escalated.
- The provider should consider how it combines development plans and projects for oncology services into a coherent, strategic whole.
- The provider should ensure that where risk assessments identify a patient at risk from harm appropriate action is taken and recorded in the medical and care records.
- The provider should ensure that they have clear admission guidelines in place adhered to in practice to ensure the hospital only admits patients they are able to provide a safe level of care to.
- The provider should consider the practice in the Ambulatory Care Unit for caring for patients undertaking "clean" and "dirty" procedures in the same space.
- The provider should consider reviewing how complaints are managed to ensure that all complaints are captured and recorded, and then following investigation any action taken is feedback to staff to enable learning and prevent future reoccurrences.
- The provider should develop a more comprehensive policy around the care of the dying in areas such as the duties of the differing staff groups, withdrawal of active treatments, informing relatives and next of kin and organ donation would provide assurance that all patients were receiving the best possible care.
- Ward staff should be provided with training in the care of dying patients.
- The provider should maximise the opportunities to be more proactive in encouraging the development of all staff through regular appraisals and completion of competencies.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Medical care

Rating Why have we given this rating?

We found that medical care services were safe. There were systems to report and investigate incidents and changes were made to prevent recurrence. There were robust arrangements for ensuring that the risk of infection was minimised and that patient's medicines were managed safely and given as prescribed. There were arrangements to assess common healthcare associated risks to patients. There were adequate numbers of clinical staff from all disciplines to meet patient's needs. These staff had completed a mandatory training programme and held specialist qualifications. We found medical care services were effective. Patients' care and treatment met current guidance. However, there were no formal arrangements to compare patient outcomes with other similar hospitals. Patients received adequate pain relief and food and drink to meet their needs. Patients gave informed consent prior to treatment. There were arrangements for patients to access advice and support seven days per week. We found medical care services caring. Patients were overwhelming positive about their experience and said they were treated with courtesy and respect. Patients were given information about their care and treatment and were given options. Medical care services were responsive to patients' needs. The facilities were designed with the specific needs of the patients in mind, and they could access care and treatment when they needed it. Generally there were arrangements in place to meet individual needs, although in the case of needs arising from dementia or learning disability these were not formalised. We saw that the service learned from and acted on complaints and other patient feedback. We judged that medical care services were well-led. There was a local vision for the service which we saw was enacted by staff in their daily work. There were strategic plans and development projects although these were not unified into a single strategic plan. Staff felt supported to provide high quality care by their leaders who were visible and approachable. We noted a caring, patient centred culture that was open to change and challenge. Staff and patients were actively encouraged to be fully engaged with any developments.

Summary of findings

Surgery

Patients told us of the excellent care and attention they had received at the hospital. They told us they felt involved in their care and told us that staff listened to them and were very kind and caring. Staff at ward level and in theatres were proud of the service they offered. They were keen to tell us of successes they had achieved, and the changes that had been made to improve the patient experience. We found staffing levels were safe and staff had undertaken relevant training and development to enable them to provide effective care and treatment.

The hospital had risk management and clinical governance processes in place. However risk management was not effective as staff were not always recording incidents, and once reported there was little learning or feedback to staff to prevent the issue from happening again. Action was not always taken when a potential risk was identified as staff were not always following the policy guidance.

The hospital did not have the facilities to manage patients who required critical care support. This meant the hospital could not look after patients who developed complications following surgery or required enhanced post-operative care and would need to transfer patients out to the local NHS trust. Although patients were assessed to ensure the hospital could meet their needs, there were not robust and consistently used admission protocols or policies that set out the safe and agreed admission criteria. We found there was a risk of inappropriate patients being admitted as clear and specific guidelines were not available.

End of life care

Palliative and end of life care specialist input was via the Palliative Care medical consultants and the Palliative Care nurse. The end of life care delivered was a consultant led service with the Palliative care consultants reviewing patients daily as well as being contactable by telephone if staff required support. Out of hours and over the weekend the Palliative Care consultants provided on-call cover and undertook any reviews necessary. This meant that patients had access to specialist advice 24/7.

The care people receive at end of life was a whole team approach with the ward nursing and medical staff and the palliative care team all working together to deliver holistic care. Medicines were provided in line with the Adult Palliative Care Guidance 2nd edition 2006. The

Summary of findings

choice of medications at the end of life had been aligned to local community guidelines to support safe and consistent practice between care providers. A fast track process is in place to support patient's wishes and preferences to achieve their Preferred Place of Care.(PPC)

The nursing staff we spoke to on the wards had not received end of life training and no end of life care link nurses were present on the wards. At the time of the inspection BMI Mount Alvernia did not have an end of life pathway to support staff to identify and care for people at the end of life. End of life patients were placed on the generic medical pathway with specialist input from the palliative care consultants and nurse. Leadership of the specialist palliative care team was good and quality and patient experience was seen as a priority.

Outpatients and diagnostic imaging

The Outpatients Department was a calm and comfortable environment for patients. Patients we spoke with on the days of our inspection were very pleased with the care that they had received in the department. They told us that their care had been unhurried, caring, and that they felt well informed about their choices and treatment.

In the medical imaging department we saw evidence of systematic audit both clinical and safety which was used to inform practice. However, although nurses in the OPD were recording incidents they were not receiving feedback following the investigation into these incidents and were therefore unable to evidence that they were learning or making service improvements as a result of incident reporting.

Staff were mostly up to date with mandatory training. However, training over and above mandatory requirements was not being taken up by nursing staff and the appraisals that we looked at did not outline requirements for learning and development.

Patients had been satisfied with the waiting time for their appointments following their initial referral. We were told that patients waited around two weeks for an appointment and this was confirmed by patients we spoke with. The department did not audit the referral to treatment waiting times for private patients although

Summary of findings

they were able to evidence that NHS patients who had been booked through 'Choose and Book' had all been seen within the Referral to Treatment (RTT) waiting time 18 week target.

Although waiting times in clinics were recorded by patients completing patient surveys the department did not audit patient waiting times. We were told that staff were expected to keep patients updated of any delays and offer them a beverage. We could see from patient questionnaire results that the department was improving in keeping patients informed about waiting times.

The OPD did not have any systems in place to assist patients with a diagnosis of dementia through the department. The department did not have literature or communication tools available to assist patients with learning or other disabilities. Although the OPD could access translation services none of the staff were aware of this.

Staff were complimentary about their managers. Staff felt that the culture of the department had improved and they felt empowered to make positive changes to patient care. They also felt able to raise issues when they saw behaviours in other members of staff that did not support the department's values and vision.

BMI Mount Alvernia Hospital

Detailed findings

Services we looked at

Medical care; Surgery; End of life care; Outpatients and diagnostic imaging;

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Detailed findings

Background to BMI Mount Alvernia Hospital

BMI Mount Alvernia Hospital in Guildford, Surrey is part of BMI Healthcare Limited, the UK's largest provider of independent healthcare. The hospital has 76 inpatient and daycase beds, although at the time of the inspection these were not all in regular use. In addition, the hospital provides day services to oncology patients, outpatient and diagnostic services.

The hospital mainly services a catchment of Guildford and the surrounding area but also takes patients from

across Surrey, the south of London and sometimes nationally. Surrey has 1,098,200 resident adults with the borough of Guildford having the largest population. Compared to Great Britain as a whole, Surrey is heavily populated with the Guildford area being the most dense in the South East. There are high levels of employment with Surrey's 80% employment rate comparing favourably to the national average of 74.5%.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspection: Heidi Smoult, Care Quality Commission

The team of 14 included a CQC inspection manager and team of inspectors supported by a number of specialists

including: consultant gynaecologist, consultant oncologist, orthopaedic consultant, surgical nurse, oncologist nurse specialist, radiographer, physiotherapist and an expert by experience.

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 we held about the hospital and spoke to the local clinical commissioning group. Patients were invited to contact CQC with their feedback.

We visited the hospital to inspect on 12 and 13 November 2014 to undertake an announced inspection. We returned on 20 November to carry out an unannounced inspection.

As part of the inspection visit process we spoke with members of the executive management team and individual staff of all grades. We also met with groups of staff in structured focus groups.

We spoke with both inpatients and people attending the outpatient's clinics as well as those using day services such as the chemotherapy unit. We looked at comments made by patients who used the services of BMI Mount Alvernia Hospital when completing the hospital satisfaction survey and reviewed complaints that had been raised with the hospital.

We inspected all areas of the hospital over a two day period, looking at outpatients, medical care, surgical care and end of life care. We did not inspect the core areas of critical care, children's services or maternity as these services were not provided at BMI Mount Alvernia Hospital. Neither did we report on 'Well Led' as a core service as is usual when reporting on NHS trust inspections. This was because this inspection was part of a pilot inspection methodology of acute independent healthcare settings.

Detailed findings

Our inspectors and specialist advisors spent time observing care across the hospital, including in the operating theatres and the radiology department. We reviewed patient's records where necessary to help us understand the care that they had received.

We also reviewed maintenance, training, monitoring and other records held by the hospital.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experience of the quality of care and treatment at BMI Mount Alvernia Hospital.

Detailed findings

Facts and data about BMI Mount Alvernia Hospital

At the time of the inspection visit, there were 183 doctors and dentists working at the hospital under practicing privileges. There were no employed medical or dental staff.

There were 49.25 FTE registered nurses employed at the Hospital at the time of our inspection. 17 of these were allocated to the inpatient ward, 23.8 employed in the theatres and 8.36 worked in the outpatient department. The registered nurses were supported by 10.13 FTE care assistants working in both inpatient and outpatient areas of the hospital.

During the period July 2013 to June 2014 the hospital cared for 1117 patients overnight, a further 4,206 were admitted as inpatients for day case procedures. In total, there were 4055 patients taken to the operating theatres.

Pathology, emergency blood supplies and histopathology were outsourced to third party suppliers.

Children and young people under 18 years of age are not treated at the hospital. Maternity services and termination of Pregnancy services are not provided at the hospital.

Medical care

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Medical care services were mainly concerned with the provision of cancer services, although some general medical patients were admitted to the hospital. Patients were admitted for private medical treatment following a consultant referral. Medical care services were centred on St Martha's Oncology Centre, a day unit for the administration of chemotherapy. Patients requiring in-patient care were admitted to St Claire Ward, a general ward that cared for a mix of medical and surgical specialities. There was an endoscopy unit providing endoscopic investigations.

St Martha's provided about 350 episodes of chemo-therapy per month. There were fewer medical in-patients and during our inspection there were two medical in-patients. There were two endoscopy sessions scheduled per week.

We visited St Claire Ward, St Martha's Oncology Centre and the endoscopy unit during our inspection. We spoke with a range of staff including managers, consultants, nurses and support staff. In total we spoke with approximately 21 staff. We also spoke with seven patients and five relatives or friends. We observed care and treatment across medical care services and looked at a variety of records, including patients' treatment records, to help us understand the service and to judge standards of care and treatment.

Summary of findings

There were systems to report and investigate incidents and changes were made to prevent recurrence. There were robust arrangements for ensuring that the risk of infection was minimised and that patients' medicines were managed safely and given as prescribed. There were arrangements to assess common healthcare associated risks to patients. There were adequate numbers of clinical staff from all disciplines to meet patient's needs. These staff had completed a mandatory training programme and held specialist qualifications.

Patients' care and treatment met current guidance. However, there were no formal arrangements to compare patient outcomes with other similar hospitals. Patients received adequate pain relief and food and drink to meet their needs. Patients gave informed consent prior to treatment. There were arrangements for patients to access advice and support seven days per week.

Patients were overwhelming positive about their experience and said they were treated with courtesy and respect. Patients were given information about their care and treatment and were given options.

The facilities were designed with the specific needs of the patients in mind, and they could access care and treatment when they needed it. Generally there were arrangements in place to meet individual needs, although in the case of needs arising from dementia or learning disability these were not formalised. We saw that the service learned from and acted on complaints and other patient feedback.

Medical care

There was a local vision for the service which we saw was enacted by staff in their daily work. There were strategic plans and development projects although these were not unified into a single strategic plan. Staff felt supported to provide high quality care by their leaders who were visible and approachable. We noted a caring, patient centred culture that was open to change and challenge. Staff and patients were actively encouraged to be fully engaged with any developments.

Are medical care services safe?

We noted that there were systems for reporting and investigating incidents and that staff were aware of these. We saw examples of actions taken to mitigate recurrence of incidents. We found the number and type of incidents did not give cause for concern. However, we found that systems for feeding-back the outcome of incident investigations and arrangements for monitoring the implementation and efficacy of corrective actions were not robust.

Patients were cared for in a clean and hygienic environment that was well maintained. There were arrangements to prevent the spread of infection and compliance with these was monitored. There were no outbreaks of serious infection reported. There were adequate supplies of appropriate equipment that was properly maintained to deliver care and treatment and staff were competent in its use.

There were systems that ensured patient's medicines were given safely, on-time and according to the consultant prescription. Medicines were stored securely the majority of the time.

We found that patients' records were complete and accurate and were available to clinicians to support safe care and treatment. There were systems to identify patients whose condition may be deteriorating to allow early intervention. However, we found some examples where the hospital's protocol had not been fully followed with regard to monitoring patients' vital signs and escalating emerging concerns and that records did not fully reflect or evaluate the clinical situation. Patients were assessed for common healthcare associated risks using validated assessment tools.

We saw that staff had completed the provider's mandatory training programme which covered a wide range of topics tailored to job role. Staff were aware of their responsibilities with regard to the protection of people in vulnerable circumstances. There were adequate numbers of suitably qualified, skilled and experienced staff to meet patients' needs. There were arrangements to provide a resident medical presence, and to ensure patients' consultants were

Medical care

contactable, if the need arose. However, we found examples where this system had not been robust, and noted that it was not clear that a formal handover to a colleague prior to any absence occurred.

Incidents

- We found there was a system for reporting and recording clinical incidents. The system was a mix of paper based reporting by front-line staff, followed by an electronic system where all incidents were eventually logged.
- Staff we spoke with were aware of the system and could describe its use. We saw that copies of the incident reporting forms were available in clinical areas for staff to use. We were told that staff had received training in incident reporting.
- We found that incidents were reported and were shown the paper records of these.
- Although the majority of the medical services provided by the Hospital were oncology services, the oncology manager told us that there had been no serious incidents “For some time.” We did not discover any serious incidents that had not been reported. The hospital overall has an incident rate of 2-6 per 100 patient discharges per month with a fall in incidents reported in the last quarter. Serious incidents requiring investigation rates were stable at between 0.2 and 0 per 100 patient discharges.
- Medical care services had not reported any ‘never events’; never events are serious, largely preventable incidents that should not occur if the available preventative measures have been implemented.
- We saw documents that showed that incidents were investigated and that plans were drawn up to prevent recurrence. We reviewed the records of 14 clinical incidents. We found that all the incidents had been investigated and appropriate measures put in place to mitigate repetition. For example, a patient who had attended for chemotherapy which was not due on the day the patient had arrived. The patient had bloods taken and it was then noted that the patient had attended on the wrong day. Following this, more robust pre chemo checks were put into place.
- We saw two instances where an oncology patient had become unwell and had to be transferred back to NHS in-patient care. Statistical analysis showed the hospitals proportion of unplanned transfers was similar to that expected.

- We were told that the outcomes of investigations were discussed at ward meetings and we saw minutes of meetings which confirmed this. However, some staff told us that they were not informed individually of the outcome of any incidents they reported and they felt that this was an opportunity for learning lost. They also felt this did not act as an incentive to report incidents.
- Although incidents were investigated and actions planned, we did not see, and staff were not aware, of a robust system for managers to monitor the implementation of remedial actions, or to evaluate their efficacy.
- There was no formal system for discussing and analysing mortality and morbidity rates in medical care services. This meant that this method of reflecting and learning from patient incidents was not utilised.

Cleanliness, infection control and hygiene

- Overall we found that the Department of Health (DoH) guidance, “The Code of Practice on the prevention and control of infections and related guidance” was being complied with.
- We saw that staff washed their hands in compliance with World Health Organisation guidance “Five Moments of Hand Hygiene”. Hand hygiene audits were carried out and we saw the results for St Martha’s Oncology Centre which showed consistent results of 100% compliance; the rate for the hospital was reported as 95%. We also saw that staff were bare below the elbows and that this too was audited. The results obtained were consistently 100%.
- We saw that there were adequate supplies of Personal Protective Equipment (PPE) available and we observed staff using it appropriately.
- Housekeeping staff showed us their cleaning schedules which clearly set out the tasks to be performed and their frequency. They were required to sign when each task was completed and hand the sheets in at the end of the day. They told us that their supervisor checked their work.
- We were shown completed checklists that showed that nursing and medical equipment shared between patients was cleaned and decontaminated between patients. We saw that distinctive labels were used to indicate that equipment was clean and ready for use.

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- We observed that the clinical environment was clean hygienic and well maintained. There was an annual environmental audit and we saw that the last result for the oncology unit was 99.53%, with the storage of boxes on the floor being the only negative finding.
- We observed that clinical waste was segregated and appropriately managed in clinical areas. We saw that cytotoxic waste was disposed of in specific, colour coded receptacles to minimise risks to staff and contractors. We saw compliance with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 with all 'sharps' disposed of in suitable containers that were secure and appropriately labelled.
- Patients told us that they felt the hospital was clean and hygienic and that staff used PPE and washed their hands when required. A patient said, "I feel the place is safe and hygienic; staff wash their hands and wear gloves and have aprons."
- The 2014 Patient Led Assessment of the Care Environment (PLACE) achieved a score of 98.13% for the domain area of cleanliness which exceeded the national average of 97.25%. We looked at the raw data for the oncology unit and saw there were no specific issues identified.
- In line with the Department of Health's guidance "Saving Lives" the hospital used a system of care bundles to guide and manage the use of indwelling devices such as intravenous cannula. The use of these bundles ensures that such devices are cared for using a best-practice approach and that the risk of serious infection is minimised. We looked at two sets of records for medical patients on St Claire ward. We saw that the relevant care bundles were used but that all elements required were not recorded as completed. For example we saw a care bundle concerning the insertion of a cannula with key elements not recorded. We also saw that care bundles were not completed at the required frequency, for example one care bundle had only been completed twice rather than the specified three times the previous day. This meant that the safety benefits of using care bundles were not fully realised.
- On St Martha's Oncology unit we saw audit results for compliance with 'Saving Lives' care bundles. We noted that the results of these audits were consistently 100% which showed care reflected best practice.
- We visited the endoscopy unit and found the department to be clean and hygienic. We noted that there were completely separate clean and dirty areas for the preparation and cleaning of equipment which minimised the risks of infection to patients.
- In the endoscopy department we saw that there were adequate systems to ensure that endoscopes were safely decontaminated. We saw documentary evidence showing that the use of scopes was tracked and that the use of a specific endoscope was linked to each procedure. Staff we spoke with could explain the correct decontamination process. We saw that scopes were stored safely in a drying cabinet for up to three days, and that there was a process for ensuring that they were reprocessed at the appropriate time.
- In the endoscopy department we saw records that showed that the quality of the water supply was tested weekly to ensure it remained safe.
- We observed that chemotherapy was prepared in an aseptic pharmacy department to guard against the risk of infection being introduced when it was administered. We saw chemotherapy being prepared and noted it was compliant with relevant guidance. We were told that the oncology pharmacy department was subject to independent external inspection and audit.
- We saw records which showed patients were routinely screened for MRSA. We saw that where a treatable infection was identified appropriate antibiotics were administered.
- The hospital had reported no incidences of MRSA bloodstream infections, or cases of C Diff related diarrhoea since April 2014.

Environment and equipment

- We found that equipment was regularly checked and maintained. This included infusion devices, scalp coolers and patient monitoring equipment. We noted that stickers were present which clearly showed when equipment had been maintained in accordance with the manufacturers' recommendations.
- In endoscopy we saw that equipment was maintained by an external contractor and we saw that equipment was labelled to show that it had been maintained at the required frequencies. We saw that there were advanced plans to replace ageing equipment in this unit, and we were told that the arrival of new equipment was imminent. This meant that endoscopy equipment was maintained to ensure it remained fit for purpose.

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- We saw evidence in staff personal files which showed that staff had been instructed in the safe and proper use of equipment used on the oncology unit. Generally, this training was provided by the manufacturer.
- Mattresses and chairs were subject to six monthly checks in accordance with DoH Safety Action Bulletin 76 1991. On the oncology unit we saw the results of these checks for the past year and noted that all chairs and mattresses had passed the various tests required. This ensured they were fit for purpose and did not increase the risk of infection or contribute to the development of pressure damage to patients.
- The 2014 Patient Led Assessment of the Care Environment (PLACE) achieved a score of 92.03% for the domain area of condition, appearance and maintenance which exceeded the national average of 91.97%. We looked at the raw data for the oncology unit and saw there were no specific issues identified.
- When chemotherapy was prepared we saw that there was a checking system that ensured the accuracy of the prescription and dispensing of the treatment. There was a system in place that meant only one prescription was prepared at a time to minimise the risk of error.
- Chemotherapy drugs were delivered to the oncology unit in a sealed bag. These were then checked by the nurses before being transferred to colour coded trays prior to administration, reflecting current best practice. These medicines were not stored away as they were used almost immediately upon delivery.
- We observed nurses administering medication and found that it met the Nursing and Midwifery Council "Standards for medicines management." We observed two registered nurses checking chemotherapy prior to administration. The patient's identity was checked by a single nurse at the point of care, but this was in accordance with the local policy.
- We looked at medicine administration records and noted that no prescribed doses of medicines had been missed or omitted. This meant patients received their medicines when they were prescribed.
- Prescription charts were checked daily by a pharmacist to ensure safe and effective use of medicines. We saw charts were annotated by pharmacy staff which indicated this was happening.

Medicines

- We saw that medicines were kept in locked cupboards. Access was via a digital lock and we were advised that the number was changed every two months to minimise the risk of unauthorised access.
- We saw that there was a dedicated 'fridge for storing medicines when this was necessary and that the 'fridge temperature was monitored to ensure medicines were kept in optimal conditions.
- However, on several occasions during our visits we observed that the door to the Clinical Room where chemo-therapy supplied by pharmacy was kept for short periods awaiting administration was not locked. Access was via a digital lock and all staff we spoke with assured us that the room was kept secure, contrary to our observation. We brought this to the manager's attention who informed us this would be remedied. This meant that the medicines awaiting administration were not always securely stored.
- Dose banding for chemotherapy was routine and was an example of good cost-effective practice.
- Chemotherapy regimens reflected those in use at the local NHS cancer centre. If clinicians needed to treat people with regimes that deviated from these standard protocols they were required to complete an "Off protocol form" to provide rationale and an audit trail for this decision.

Records

- Overall we found that clinical records were complete, current and fit for purpose. We found we could navigate records although found some examples of where notes were not in a logical order. We found occasional lapses, such as the absence of an evaluation of a care plan, or a missing signature.
- Other records relevant to the running of the service were kept in paper and electronic formats. All records we requested could be produced were complete and supported efficient running and monitoring of medical care services.
- On St Martha's Oncology Centre we observed that confidential patient records were stored in an unlocked cupboard, located behind the nurses' desk, which was unmanned for short periods. We were told the cupboard was kept locked when not in use and no medical records were kept in the cupboard when the department was closed. This arrangement meant that unauthorised access to these records was possible.

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Safeguarding

- All staff had completed training in the safeguarding of adults at risk as part of the mandatory training programme.
- There had been no safeguarding referrals made in the past year. Statistical analysis showed that the hospital's rate of notifications regarding allegations of abuse was lower than expected with an observed value of 0 against an expected one of 0.26.
- The hospital had a designated safeguarding lead that had completed training at level 3, and staff could name this person.
- All staff we spoke with, including non-clinical staff could describe factors that would arouse suspicions of abuse. They could also describe the actions they would take. The oncology manager described a situation where initially there had been potential safeguarding concerns. When the situation was probed further this was found not to be the case. This meant staff were aware of their responsibilities in relation to the safeguarding of adults at risk and were alert to the possibility of abuse.

Mandatory training

- The provider had a comprehensive mandatory training programme, which was tailored to each staff job role. Most training was electronic based and included a knowledge check and required updating annually. Staff told us they had no problems completing on-line training. We viewed the mandatory training programme and noted it was comprehensive and contained all the training subjects that would be expected.
- We saw training records that indicated all staff (excluding medical staff) were up to date with their mandatory training. A new staff member was required to complete the programme in their first four months of employment; we saw that after a month they had completed the bulk of their training.
- We saw there was an electronic monitoring system that flagged when staff's mandatory training was due to expire. The oncology manager described how they used this system to ensure staff remained up to date with mandatory training.

Assessing and responding to patient risk

- Guidance from the National Institute of Health and Care Excellence (NICE) - CG50 "Acutely Ill Patients in Hospital"

recommends the use of an early warning scoring system to identify patients whose condition may be deteriorating. Mount Alvernia used the National Early Warning System (NEWS) and we saw this was routinely used. However, on St Claire ward we looked at two medical patients notes and found instances where the NEWS score was not calculated when physiological observations were recorded. We found instances where the NEWS score was elevated but where there were no records of any review by registered nurses or of actions taken to comply with the protocols written on the observation charts. This meant that the safety benefits of the NEWS system were not being fully realised.

- We saw an example where a consultant had requested that a patient at risk of infection had their temperature recorded two-hourly during the day. The records indicated that this was not done at the required frequency which meant that the recognition of the onset of serious infection, and the commencement of treatment could have been delayed.
- At St Martha's Oncology Centre the NEWS score was used selectively as the tool is intended for in-patient use. In this unit the tool was used to quantify the risk and inform the escalation of care for patients that nurses had identified as a concern. This meant that there was a system to ensure that appropriate actions were taken when concerns were identified
- We looked at the records of medical in-patients and saw that a range of risk assessments were carried out using nationally recognised and validated tools. These included assessments for risk of pressure ulcers (the Waterlow score) and malnutrition (the Malnutrition Universal Screening Tool). We saw that these assessments were reviewed daily as required by the hospital's care pathway. Other risk assessments included those concerned with, falls, manual handling and the use of bed-rails.
- We saw that the risks of Venous Thromboembolism (VTE) were assessed for each patient and that appropriate prophylactic measures were put in place as a result of this, for example the use of anti-coagulant medication. We saw the assessment rate for the hospital stood at 95%, the rate expected for NHS contracts, and that there had been no reported VTE in the previous six months. This showed there were effective processes for managing the risk of VTE to patients.
- We saw that there was adequate resuscitation equipment, that it was easily accessible and that staff

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knew where it was located. We looked at records which showed that the equipment was checked daily to ensure it remained ready for immediate use. Additional supplies of medicines used in resuscitation were kept in pharmacy so that if one set was used there was always a replacement.

- We saw that there was an extravasation kit available so this emergency situation could be dealt with promptly minimising harm to patients. We looked at the extravasation policy and found it covered all areas necessary. Staff we spoke with were able to describe the procedure including the assessment of a patient's veins prior to commencing treatment. They also reported that they could access the consultant and a consultant in plastic surgery quickly in the event of an extravasation episode if needed.
- We also saw a cytotoxic spillage kit to ensure any spillages could be managed in a way that reduced risks. We also saw a body fluid spillage kit was in place.
- We found that medicines items for dealing with the medical emergency of sepsis were not co-located as part of a kit; this could result in delays in appropriate treatment being given when needed.

Nursing staffing

- The provider had an electronic system for calculating and recording nursing staffing requirements and actual hours used. We looked at the reports generated for St Martha's Oncology Centre.
- We found that 97.2% of the nursing hours calculated as required were filled in in August 2014 and 99.3% in October 2014. The oncology manager told us that although there was a very small shortfall this was due to tolerances within the methodology.
- Nurses we spoke with told us that they considered there were sufficient nursing staff to meet the needs of patients. Patients echoed this view and told us that any requests for help or care were responded to promptly.
- The oncology unit was actively recruiting into vacant nursing posts. Out of an establishment of seven registered nurses (including the manager) there were two vacancies (28.5%) and from an establishment of two Health Care Assistants there was one vacancy (50%).
- Shortfalls in nursing staff were filled using staff from the provider's bank or from an agency. We noted that bank and agency staff were used on a regular basis. This provided continuity of care for patients, and ensured

these staff could work safely as they were familiar with the systems and processes of the unit. In August 2013 Bank staff accounted for 21.8% of nursing hours and agency staff 16.9%. In October 2014 these figures were 0.3% and 10.8%. The manager told us that this was because a vacant post had been recruited into.

Medical staffing

- Medical staffing was consultant led. Consultants were supported by an on-site Resident Medical Officer (RMO) who provided a 24 hour medical presence.
- We saw there were arrangements to ensure that that when consultants were absent nursing staff and the RMO knew who to contact. There was a failsafe, although informal system that the consultant on-call at the local NHS cancer would provide cover should the patient's own consultant was unobtainable, and if this person did not undertake private practice they had a 'buddy' who would do so. We saw that consultant absences were notified and noted in a record on the oncology unit for staff to reference easily.
- Although we were told the system worked well on the oncology unit, the system was not as robust on St Clare Ward where we were given examples of consultants being contacted when they were out of the country. However, an alternative consultant had been available to provide appropriate clinical input to ensure safe care.
- Despite some arrangements being informal, staff told us that out of hours contact with consultants was not a problem and they were amenable to being called.
- It was not clear if consultants were providing a formal handover to other consultants temporarily supervising the care and treatment of their patients as required by the conditions of their practicing privileges agreement prior to any absence
- On St Claire Ward we saw that medical patients received a daily consultant review, in compliance with the conditions of their practicing privileges agreement.
- Oncology patients received a consultant review before each cycle of chemotherapy and we saw these recorded in patient records.

Major incident awareness and training

- Staff had not attended major incident or business continuity training, or attended any simulation exercises.
- The hospital had a business continuity plan but staff did not know of its existence. However, in our discussions

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with them staff could articulate what they would do in the event of an event that adversely affected business continuity. This meant although the policy was poorly disseminated staff would manage any untoward incident to minimise risks to patients.

Are medical care services effective?

We found that care and treatment reflected current expert guidance. There were no formal systems for collecting comparative data regarding patient outcomes.

Patients received adequate pain relief although we found that in some cases the way in which pain relief was documented and evaluated was incomplete. Patients' nutritional status was adequately assessed and patients received food and drink that met their needs in sufficient quantities.

Patients were cared for by staff who had undergone specialist training for the role, and who had their competency reviewed. Patients had access to the full range of medical specialists involved in cancer care via multi-disciplinary meeting held at the local NHS cancer centre. They also had access to relevant allied health professionals if their care and treatment required this. Staff involved in treating and caring for patients had access to adequate and current clinical information to enable them to do this effectively.

There were arrangements that enabled patients to access advice and support seven days a week, 24 hours per day. Patients provided informed, written consent before commencing their treatment. Where patients lacked capacity to make decisions, staff knew what steps to take to ensure relevant legal requirements were met.

Evidence-based care and treatment

- We saw that general patient management was compliant with NICE guidance. For example, CG 161 – Preventing falls in older people, QS24 – Nutrition Support in Adults and QS3 - VTE and bleeding risk assessment. We observed that patient records demonstrated compliance with this guidance.
- We reviewed a range of clinical policies and found that all expected topics were covered by a policy framework. We noted that most policies and clinical guidelines were based on those used by the local NHS cancer centre and reflected guidance from the recently disbanded Cancer

Care Networks. Although based on NHS models these policies and guidelines had been reviewed and ratified by the provider. We noted that some guidelines were available for procedures we were told were not carried out at the hospital, such as intra-theal administration of chemotherapy.

- We reviewed patient care records and found the care they received was congruent with the guidelines and protocols in use at the hospital.
- We found that there were two policies regarding extravasation. One was owned by the provider while the other by the local NHS cancer centre. The manager agreed that the NHS one should be removed as this could cause confusion.
- There were policies in place describing the management of neutropenic sepsis which were compliant with NICE guidelines (CG 151-Neutropenic sepsis: prevention and management of neutropenic sepsis in cancer patients). We were advised by staff that after 6pm patients were advised to attend an A&E department as there were no laboratory facilities on site if the triage assessment indicated a risk of sepsis. Staff we spoke with were aware of the need to get patients to a facility that would enable the commencement of antibiotics within the hour and described how traveling times was factored into the advice they gave and that the receiving unit was contacted in advance to enable the patient to be fast tracked on arrival.
- Staff told us that although they waited for blood results before commencing antibiotics, results were usually available in 15 minutes which still enabled the target of commencing antibiotics within an hour to be met. However, there were no audits in place to monitor 'door to needle times' in the event of patients presenting with sepsis.
- We saw that patients were monitored for signs of toxicity while undergoing chemotherapy. We looked at a patient's records and saw an example of doses being adjusted as the patient had experienced some toxicity.
- St Martha's Oncology Centre had undergone an external assessment to become accredited BUPA cancer unit for the treatment of breast and bowel cancer. The unit had also been awarded the MacMillan Quality Environment Mark (MQEM) following an external assessment. This demonstrated that the standards of care and treatment met national guidelines.

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Pain relief

- Patients we spoke with told us that they received adequate pain relief. One patient reported, “I am asked about pain relief and the pharmacist checks it weekly too.”
- When patients experienced pain we found that actions were taken to address the issue. A patient told us, I spoke to the nurse today about my pain and she’s sorting it with the consultants I’ll have stronger pain killers before I go home.” We observed a situation where a patient attending the hospital had developed sciatic pain so had been kept on the ward. The patient was seen by the pain management consultant and a plan had been put in place to enable the patients discharge.
- St Martha’s Oncology Centre did not keep controlled drugs as a stock item. If patients required strong opiate analgesia during their treatment there was a system for accessing this medicine from the ward. However, in order to comply with legal requirements this process required nurses from each area checking and recording the administration which meant that patients could experience a delay in receiving pain relief. We were told that resident medical officers (RMO) could prescribe controlled drugs, but were sometimes reluctant to do so without the authorisation of a consultant. This could result in a delay in patients receiving pain relief. We witnessed a situation where this occurred as the RMO organised pain relief with the pharmacist.
- We looked at the records of two medical patients on St Claire Ward. We found the assessment and recording of pain was not comprehensive. We saw that there was a system for assessing the reported levels of pain using a score and that these were regularly recorded. However, we found that when patients reported an elevation in pain, there were no additional records that explained the circumstances of this, the actions taken or any evaluation of the effectiveness of any action. For example, in one record a patient’s pain score was showing that pain relief was adequate; the prescription showed that four doses of strong, opiate analgesia had been given in the previous 24 hours, but the nursing records contained no entries regarding this. In the other patients notes we saw that the pain score had been recorded as elevated some hours earlier, but that the patient had not been prescribed, and therefore not given, any pain-relief. The nursing records did not refer to or address this issue.

- There were no systems or tools used for assessing pain in patients with a cognitive impairment, for example dementia.
- The Cancer Patient Survey (March 2014) showed that 100% of patients felt they received adequate pain relief advice.

Nutrition and hydration

- We saw that in-patients were weighed and the risk of malnutrition was assessed using a nationally validated tool. Day case patients at St Martha’s Oncology Centre were regularly weighed and their nutritional status was assessed and any emerging problems or concerns were discussed with them.
- We found that patients and those supporting them had access to hot drinks at all times. We saw that drinks machines were available in waiting areas and we noted that patients always had a drink within reach. Ice-lollies were available to patients undergoing treatment to comfort and hydrate any oral discomfort caused by their treatment.
- There were robust arrangements to ensure good food hygiene. Process were all monitored for example, storage and holding temperatures and we saw catering staff testing the temperature of food. The hospital received a five-star award from Guildford Borough Council’s Environmental Health Department for food hygiene.
- Cultural and therapeutic diets were all available. For example, gluten-free, Kosher or Hal-al.
- The catering department was open until 8pm to enable patients to obtain food outside of mealtimes. Out of hours sandwiches, toast and soup could be provided. This meant that patients could access a variety of food and drink to meet their needs at all times.
- Patients reported that they were satisfied with the food and drink available. A typical comment received was, “The food is lovely, good choices.” Patients gave us examples of how there was flexibility around nutrition. One patient said, “This morning I just needed a bacon sandwich so they made me one.” Another patient reported, “They are helpful in the kitchen, I didn’t fancy rice-crispies so I had porridge, or I ask for hot milk in the night.”
- The 2014 Patient Led Assessment of the Care Environment (PLACE) achieved a score of 88.79% for the

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domain area of food, which was slightly above the national average of 87.73%. We looked at the raw data for the oncology unit and saw there were no specific issues identified.

Patient outcomes

- There were few unexpected deaths at the hospital with only one being reported in the past year.
- We were told that there was no comparative data regarding patient outcomes available. The hospital had recently started to report death within 30 days of chemotherapy to the NCEPOD, but had not had any such deaths to report since they had joined the scheme.
- Emergency readmissions to the hospital were rated better than expected with a rate of 0.1 readmissions per 100 patient discharges.
- There were no current arrangements for external peer review of services. However, we were told there were plans to introduce this based on the same model as NHS reviews. We saw the results of a pilot review that had been undertaken. We noted that where the review had highlighted areas where the expected systems, policies or arrangements were not in place, remedial actions had been put in place.

Competent staff

- All nursing staff working at St Martha's Oncology Centre were trained in all aspects of chemo-therapy administration and treatment having attended a recognised course at the Royal Marsden hospital. We saw evidence of this in personal files. Staff underwent an annual competency assessment in relation to chemotherapy and we saw from staff files and training records these were all completed and in date. This meant staff had the specialist skill they required to effectively treat and care for patients.
- However, we spoke with a staff nurse on St Claire Ward who told us that they had received no training in oncology related problems, including sepsis, or palliative care. This had been discussed at their performance review and they understood training would be available, "soon." We spoke with the ward manager who had received training in the management of oncology emergencies. We were told that only one other band 6 nurse on the ward had received this specific training. This meant that staff working with oncology patients in this area had yet to undergo

specialised training although they had been identified as requiring this. This meant there was a risk they may come across clinical situations they were not competent to deal with.

- Agency staff who worked on the oncology unit completed a comprehensive induction and competency assessment and we saw checklists that demonstrated this had occurred. The manager told us that CVs were checked to ensure they had completed specialised training in chemotherapy.
- All staff had received an appraisal within the last year, except the manager who had not had an appraisal in the past two-half years. Appraisals generated development plans which were reviewed at least every six months. We saw appraisal documents, development plans and reviews in staff personal files.
- There were no arrangements or policy in place for clinical supervision for the staff.
- Overall, patient expressed confidence in the abilities of the staff. One patient said, "It's been wonderful across the board. All are well trained and there's great camaraderie. The agency staff are equal to the permanent girls, they too are competent and you feel confidence in them."
- Consultant staff were all employed by a local NHS trust as oncology specialists or physicians. Their appraisal and revalidation with the General Medical Council was managed by this NHS trust.

Multidisciplinary working

- Oncology patients being treated at the hospital were discussed at the multi-disciplinary meeting at the local to NHS cancer centre to ensure that their care and treatment was co-ordinated and reflected current treatment guidance and best practice. Concern had been expressed that private patients were not being discussed at this forum and we saw meeting minutes from the hospital's Medical Advisory Committee where this was raised. We were assured that all patients were discussed and we saw documentary evidence that demonstrated this was occurring and that the results of these discussions were fed back to St Martha's staff and recorded in patients' notes.
- In-house physiotherapy services were available to patients. We were told that physiotherapists had

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undergone specialist training to enable them to meet the needs of oncology patients. We observed physiotherapists treating patients on St Martha's Oncology centre and on the ward.

- Patients could also be referred to the full range of allied health professionals including occupational therapist, speech and language therapist and dietician. These staff worked at the local NHS cancer centre and were therefore skilled and experienced in assessing and treating the patients using medical care services at the hospital. This arrangement ensured there were good links between the services, and specialist input and continuity of care for patients.
- At St Martha's Oncology centre patients could experience a range of complimentary therapies. These included Indian head massage, reflexology and acupuncture. We saw these therapies being provided and patients and staff we spoke valued them and felt they were of great therapeutic benefit. These services were provided in partnership with the Fountain Centre, a local cancer charity.

Seven-day services

- Patients undergoing chemotherapy had access to phone advice 24 hours per day, seven days a week. During St Martha's Oncology Centre working hours these calls were taken by an appropriately trained nurse. At night these calls were taken by the night sister. Patients were assessed using the UK Oncology Nursing Society (UKONS) triage tool to ensure that the assessment was comprehensive and of reasonable quality. We looked at these triage forms for out of hours and found that they were appropriately completed. However, when we looked at the in-hours triage forms on the oncology unit we found that only 28 were fully completed and 56 were not. We were told that this was because the nurses on the oncology unit knew the patients so well. This notwithstanding, it did present a risk that some vital component of the triage assessment could be missed.
- The unit has advanced plans to develop the acute oncology service within the hospital. A chemotherapy trained nurse will receive and deal with all telephone calls from patients experiencing chemotherapy related toxicities at any time. This development was expected within the next few weeks. Staff we spoke with were all

aware of this plan and were supportive of it. We saw documentary evidence showing plans were well advanced. This means that when implemented patients will have access to specialist advice at all times.

- Staff told us they could access advice from the oncology manager by telephone at any time, although this was not a formal arrangement. Staff told us that out of hours contact with consultants was not a problem and they were amenable to being called.
- We found that patients attended St Claire Ward at the weekend for the disconnection of completed chemotherapy pumps. Whilst the nurse performing the intervention was trained in the care of central venous access devices nursing staff involved have not received any oncology training. This meant that if the patient was experiencing any therapy related difficulties these might not be recognised, or managed appropriately.

Access to information

- At St Martha's Oncology Centre we saw that there was an up-to date schedule of patients to be treated that day displayed on a whiteboard. This schedule contained vital information to ensure patients received appropriate care and that all staff were aware of what was required, for example it contained information about counselling services that were due, or the times that interventions such as the use of a scalp cooler were due to commence or finish. During our visit we saw the nursing team using this information to inform their work. This meant that there was access to current, accurate information to ensure patients received effective care.
- On St Clare Ward we saw that medical patients contained adequate referral information. We saw that a patient transferred from another hospital had a nursing assessment from the referring hospital and a transfer letter on file. We also saw that another patient had correspondence from the consultant detailing the reason for admission and proposed treatment.
- We were told that the prescription charts for chemotherapy were kept in pharmacy when the patient was not receiving treatment with a photocopy kept in the patient's regular notes for reference. This duplication presents a potential risk that the information could become muddled. The hospital is moving towards Electronic Prescribing with a scheduled implementation date of 2015 which will obviate this risk.

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- A patient told us, “My GP is always kept informed; communication is good and I’m copied into letters.”

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients signed consent to chemotherapy agreements and we saw these in patients’ records. We noted that they outlined the expected benefits and risks of treatment so patients could make an informed decision.
- 100% of staff at St Martha’s Oncology Centre had completed training in the Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS) as part of the provider’s mandatory training programme.
- We spoke with a range of clinical staff who could all clearly articulate their responsibilities in ensuring patients consented when they had capacity to do so or that decisions were taken in their best interests. Staff discussed with us the availability of, and need to use separate consent forms that ensured the MCA code of practice was complied with.
- No DoLS applications had been made by the hospital.

Are medical care services caring?

Patients and their supporters were overwhelmingly positive about their experience and told us that they found the all staff friendly, kind and that caring, patient-centred ethos prevailed. This view was reflected in patients’ surveys and assessments. Patients told they were treated with respect and their privacy was maintained. Our observations of care confirmed this.

Patients told us they felt involved in their care and that they had been given adequate information for them to consider all the treatment options open to them. Patients were encouraged to be supported by friends and relatives during their treatment although patients were not always explicitly asked if there was someone to support them.

Compassionate care

- We spoke with patients and their supporters on St Martha’s Oncology Centre. Patients were overwhelmingly positive about their experience. A typical comment received was, “Treatment is amazing and they’re all lovely.” Another patient reported, “Its first class, everybody’s lovely and they smile at you. They have really looked after me and I can’t fault it.”

- During our visit we noted that staff treated patients and their supporters with courtesy and respect. We saw that all staff displayed a friendly, approachable and caring demeanour. We observed that patients’ privacy was considered and maintained. We saw sensitive conversations were carried out in private, that curtains were used or doors closed, and that staff knocked before entering rooms.
- The 2014 Patient Led Assessment of the Care Environment (PLACE) achieved a score of 88.4% for the domain area of privacy, dignity and wellbeing which exceeded the national average of 87.73%. We looked at the raw data for the oncology unit and saw there were no specific issues identified.
- The Cancer Patient Survey (March 2014) showed that 100% of patients felt they were given enough privacy when discussing treatment or diagnosis, and were treated with dignity and respect.

Understanding and involvement of patients and those close to them

- Patients attending St Martha’s Oncology centre told us that they were well informed about their care and treatment. One patient said, “You’re not left wondering what’s happening and they explain at every stage during the full range of treatment.” Another told us, “They’ve been very welcoming, warm and friendly. We’ve had lovely conversations, no lectures. I’ve been fully informed and given lots of information. So far it’s a huge relief.”
- Patients told us that that their families and supporters were involved in their care too. A patient told us, “I always have someone with me and she feels part of it all too.” Another patient said, “They’re all lovely and welcoming to visitors as well. They know our names and give us teas and coffees.”
- We observed nurses interacting with patients and their supporters and saw that they explained what they intended to do before they commenced their interventions in such a way as to involve patients in their care. One patient reported, “I have a fear of needles which they know about so they spend time making sure I’m calm.”
- Patients told us they were not specifically asked about who might accompany them and support them during their treatment. There was an assumption that there would be a family member or friend to do this. A patient

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said, “They haven’t asked me but just assume she’ll be with me every time I think.” Another patient commented, “No-one has asked if I need someone with me, they just know I’m never alone.” However, the patients and supporters we spoke with did not view this negatively.

- In the Patient Cancer Survey (March 2014) 100% of patients said they received written information about their diagnosis. All respondents to this survey said they were given choices regarding their treatment options and that side effects were explained to them.

Emotional support

- Patients had access to a palliative care nurse. We spoke with a patient who told us that they had found this nurse to be very supportive emotionally and practically with issues such as accessing attendance allowance and a wig.
- Psychological support, including peer support, for patients was available. It was provided by the Fountain Centre, a local charity with which the oncology unit had developed close working links.
- We were told that consultants worked closely with psychologists and Macmillan Nurses. There had been an issue with these nurses attending private patients but we saw evidence that this was being progressed by the provider at a corporate level.
- Staff could access emotional support from a confidential counselling service provided by the hospital. Staff also told us that they found their team particularly helpful and valued the way in which staff were enabled to provide peer support. This included a weekly, informal de-brief session held each Friday.
- The Cancer Patient Survey (March 2014) showed that 100% of patients felt they received adequate emotional support. 100% of patients said they received adequate advice regarding to community support and the vast majority were offered access to join a support group relevant to their diagnosis.

Are medical care services responsive?

We found that services operated at times that allowed patients to access care and treatment when they needed it. We found that there were a variety of mechanisms to provide psychological support to patients and their supporters. This range of services meant that each patient

could access a service that was relevant to their particular needs although there were no formal arrangements to support people living with dementia or learning disabilities.

There were systems to ensure that patient complaints and other feedback was investigated, reviewed and appropriate changes made to improve treatment care and the experience of patients and their supporters.

Service planning and delivery to meet the needs of local people

- St Martha’s Oncology Centre was open until 8pm to enable people with work or other commitments to attend appointments at a convenient time.
- The Cancer Patient Survey (March 2014) showed that 93% of patients thought the flexibility for booking appointments was good or very good. Eighty eight percent found consultant appointments flexibility was good or very good.
- The facilities were designed to meet the specific needs of oncology patients. There were pleasant, comfortable waiting areas, treatment areas and single rooms. All rooms offered en-suite accommodation. There were televisions available and internet connections for patients to use.

Access and flow

- The service provided about 350 episodes of chemotherapy per month, and this capacity met the current demand.
- Times from referral to admission or commencement of treatment were not formally monitored, although there was a consensus from both staff and patients that there were no untimely delays. The Cancer Patient Survey (March 2014) asserted that most respondents saw a consultant “very quickly” with a range of 1-22 days.
- Most patients had their treatment initiated within two hours of the commencement of their attendance with all treatment commenced within three hours. The main reasons for any delay were attributable to pharmacy and pathology services and were connected with waits for blood results or the availability of medicines.
- We saw that the care pathways in use directed staff to consider all aspects of discharge planning. We saw that sections had been completed which meant that patients were protected from the risks associated with poorly planned discharge from the hospital.

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Meeting people's individual needs

- We found that staff were knowledgeable about the individual needs of the patients in their care and could discuss these easily.
- We saw that St Martha's Oncology Centre had a comprehensive range of patient information of different types of cancer and chemo-therapy. Most of these were produced by national charities and therefore, could be regarded as of high quality. No leaflets were displayed in other languages, although the manager told us the need for this was limited given the local demography but that these could be procured from the charity, or on-line should they be needed.
- Training in the care of people living with dementia was not offered to staff. We were told that the hospital rarely treated this patient group and there was an expectation that existing carers would provide care. However, we were given an example of a patient who had some memory difficulties who was supported by an enhanced care pathway which included close liaison with the GP and community services to benefit from day-case chemotherapy.
- We asked staff about any arrangements to support people with learning difficulties and it was apparent that there were no systems or resources to do this specifically. We were told that very few people with learning disabilities used medical care services.
- We saw that there were arrangements to support people with sensory impairments, and these were identified as part of the assessment process. One patient told us, "I have a hearing loss that they all know about and they all know to speak up and clearly to me. They know me so well."
- Staff could tell us how they would access professional translation services for people who needed them. However, we were told these were rarely needed.
- The hospital provided a pastoral care worker whose role was to provide spiritual support to patients regardless of their religious denomination. We saw leaflets had been produced and were available that explained this service to patients. Staff were aware of how to make contact with the relevant worker.
- Patients had access to a range of specialist nurses who worked at the local NHS cancer centre. These included clinical nurse specialists for gynaecology and brain cancer, a stoma nurse and a breast care nurse. The hospital employed a palliative care nurse whose role

was being redefined to provide a robust navigation service through the health and social care system. This development is being championed by the provider's oncology lead nurse. This meant that patients could access a range of professionals with specialist knowledge to support them and their families and friends.

Learning from complaints and concerns

- We did not see any information displayed advising patients on how to make a complaint. Patients told us that this was not something that was specifically discussed with them. However, all the patients we spoke with were aware of how to raise a complaint or concern should it be necessary.
- Services were developed following patient feedback. We saw that there was a suggestion box at reception for patients to make comments. For example, a system had been developed whereby a special rubber bracelet had been commercially produced that alerted staff to the presence of lymphoedema in the arm. The bracelet was worn reminding them certain procedures should be avoided on this side. Patients had commented that they did not like having to constantly remember to tell staff about their affected arm and now valued that this simple system addressed this issue.

Are medical care services well-led?

There was an explicit vision/philosophy for the oncology service which staff demonstrated in their daily work. There were number of projects and developments in progress showing a strategic awareness but these were not drawn together as a coherent plan. Staff and patients told us that senior hospital staff were visible and approachable. We observed a culture in medical care services that was centred on meeting the needs of individual patients and noted that there was an exceptional sense of team work.

We saw examples of events that engaged patients and the wider community. Patients were actively involved in the design of the care environment. We saw that medical care services worked collaboratively with local NHS services, and national and local charities. There were systems to ensure staff remained engaged in the running and development of the oncology unit.

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Vision and strategy for this service

- We saw that the corporate mission statement was displayed. The staff at St Martha's Oncology Centre had produced their mission statement together. We viewed this document and noted that the values described in this mission statements, for example dealings with patients and their families being "conducted with courtesy, professionalism, integrity, openness and respect" were evident in staff's daily work. We spoke with staff who told us they had helped develop the unit vision and could describe the contents.
- We found that St Claire Ward had devised a strategy for the improvement of oncology patient management. We saw that the strategic actions were clearly articulated in the plan and progress against these was monitored.
- At St Martha's Oncology Centre we saw that there were various projects and plans to develop and improve the service. For example, plans for the Acute Oncology Service and external peer review were well developed and planning for the launch of a "Living Well" programme that supported patients following completion of chemotherapy issues like with managing on-going side effects and returning to normal activities, had commenced. This showed that there was a strategic vision for the service. However, these various strands were not brought together to form a coherent, overall strategy for the service.

Governance, risk management and quality measurement

- Medical care services were represented by the oncology manager at various fora that formed part of the hospital's overarching governance structure. These included the medical Advisory Committee, Senior Management Team and Clinical Governance Committee. We saw meeting minutes which showed that matters concerning the speciality were highlighted to these governance groups.
- The oncology manager attended the provider's national Cancer Nursing Steering Group. We saw documentation that showed that this group ensured that the provider reviewed policies and procedures, set work-stream milestones and objectives and monitored quality outputs.
- The hospital had carried out a Cancer Patient Survey in 2014 to obtain feedback about the services it offered. We saw the report of the feedback and noted that

concerns had been raised in relation to the responsiveness of the service outside of working hours. The planned Acuity Oncology Service project was developed partly in response to this feedback.

- We found that staff were kept informed of governance issues at formal staff meetings and saw minutes that confirmed this. Staff we spoke with told us that they felt they were kept updated on any quality and safety issues.

Leadership of service

- Nursing staff and consultants we spoke with told us they felt the oncology manager provided strong leadership that focussed on the needs of patients. The manager was visible on the unit and patients could recognise them and appreciate their role.
- The Hospital Executive Director was also visible on the unit and we observed him talking to patients about their experience. Staff told us that this was a usual practice. They also told us that he frequently spoke with them and showed a keen interest in their work.
- We found that the leaders encouraged collaborative working across departments at the hospital. For example, we saw how pharmacists and therapists were integrated into the clinical areas and saw how their contribution was valued.
- We saw that the leadership had fostered a collaborative working relationship with a local cancer charity to expand the range of services available to patients.
- When we spoke with patients and their supports we received comments that told us they felt that the service was efficient, caring and centred around their needs.

Culture within the service

- We noted that there was an exceptional sense of team work and mutual support. Staff we spoke with told us that they valued the supportive ethos. They felt supported by their colleagues and leaders to provide high quality patient care.
- The workforce was stable; 73% nurses, 88% of allied health professionals and 82% of administration staff had worked at the hospital for more than a year in July 2014.
- Staff we spoke with told us how they would raise any concerns and said they felt empowered to do so. They said that when they voiced any ideas or concerns these were well received and given due regard.

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- Staff told us they felt fully involved in the on-going service developments and that their ideas and opinions were actively sought. They were able to tell us the details of current projects which showed that they were engaged with these developments.
- We saw that staff sickness levels at St Martha's Oncology Centre were low. We looked at the reasons for sickness and did not see patterns of sickness absence that indicated staff were working in stressful circumstances.
- The contribution of all staff was recognised by unit leaders. The catering assistants on the oncology unit had been nominated for and had received an 'Above and beyond' award in recognition of their contribution to the provision of a quality service, and the role development they had undertaken to achieve this. This showed that there was a culture where achievement was recognised and acknowledged.

Public and staff engagement

- We found that the oncology centre carried out activities to engage with their patients and the wider community. We saw publicity material, and staff told us, about a fundraising coffee morning held for the Macmillan cancer charity. We also saw evidence of "The Big Health Pledge" event held in July 2014 with the aim of supporting oncology patients to be as healthy as possible. During this event physiotherapist's demonstrated gentle exercise to prevent DVT and retain muscle strength, a dietician discussed healthy eating and the catering team demonstrated a wide range of uses for dietary supplements. A beauty therapist also gave advice on sun protection and skin care. This event

produced positive feedback from patients and staff and showed that the unit was committed to supporting patients through engagement that went beyond clinical care.

- We saw evidence that demonstrated that patients had been involved in all stages of the design process for the oncology centre. This helped ensure that it was a pleasant but effective environment for them to receive in.
- The Patient Led Assessment of the Care Environment team included a representative who was an oncology patient. This ensured that views of this patient group were included in these assessments.
- There were formal staff meetings and we saw the minutes of these. We noted these meeting provided a forum for communication to flow up and down through the various levels within the organisation.
- Staff told us they there were informal staff meetings held each week which were not minuted. They valued these meetings as a way of communicating current and pressing issues, and for providing and receiving support from their peers.

Innovation, improvement and sustainability

- The provider was currently engaged in a cost-improvement programme. We spoke to clinical staff who felt they had been fully involved in the development of this plan and were kept informed of its implementation and progress. It was stressed to us that the programme had been designed not to impact on clinical care and staff were confident that safety or clinical standards were not being compromised.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

BMI Mount Alvernia Hospital was last inspected in 2013 to follow up on concerns identified at a previous inspection. This inspection was planned as part of a new system of inspecting independent hospitals and to assess if the hospital had continued to make improvements to the quality of care and treatment provided.

The hospital currently has two 12 bedded surgical in-patients wards in use. St. Clare Ward, an acute general surgical and orthopaedic ward and St. Ethelbert Ward, an acute general short stay and day case surgical ward. There is no provision for surgical procedures requiring level two critical care at this hospital. St. Joseph Ward is currently used to undertake pre-assessment clinics.

The hospital has three main theatres, with eight patient recovery bays. There is also an Ambulatory Care Unit which provides two endoscopy or minor ops theatres, six recovery bays, a consulting room, treatment room, reception and waiting room.

During our inspection we visited all of these areas. We spoke with over 40 members of staff, five consultants, eleven patients and a relative who were in the hospital during our inspection. We listened to what staff told us in focus groups and took into account staff feedback from our website. We also collected the views of patients through feedback comment cards and feedback on our website. We also looked at nine sets of patient records both in theatre and on the wards. We looked at various documents the hospital kept and reviewed the way the hospital monitored its surgical function.

Summary of findings

Patients told us of the excellent care and attention they had received at the hospital. They told us they felt involved in their care and told us that staff listened to them and were very kind and caring. Staff at ward level and in theatres were proud of the service they offered. They were keen to tell us of successes they had achieved, and the changes that had been made to improve the patient experience. We found staffing levels were safe and staff had undertaken relevant training and development to enable them to provide effective care and treatment.

The hospital had risk management and clinical governance processes in place. However risk management was not effective as staff were not always recording incidents, and once reported there was little learning or feedback to staff to prevent the issue from happening again. Action was not always taken when a potential risk was identified as staff were not always following the policy guidance.

The hospital did not have the facilities to manage patients who required critical care support. This meant the hospital could not look after patients who developed complications following surgery or required enhanced post-operative care and would need to transfer patients out to the local NHS trust. Although patients were assessed to ensure the hospital could meet their needs, there were not robust and consistently used admission protocols or policies that set out the safe and agreed admission criteria. Consequently, there was a risk of inappropriate patients being admitted as clear and specific guidelines were not available.

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Are surgery services safe?

We found BMI Mount Alvernia Hospital had quality assurance systems in place to manage risk, report incidents and monitor safety. However learning from safety incidents was not effective as staff told us they rarely received feedback or learning from any incidents. We had concerns that not all incidents were being reported and the provider had not always notified CQC when serious incidents occurred. This included gathering information on falls, pressure ulcers, catheter and urinary tract infections together with an early warning system to alert staff of a patients deteriorating condition. However in the records we reviewed no action was recorded when a patient was identified at risk or if their condition deteriorated. Although the theatres had systems in place to identify where an operating list had been altered during our inspection an operating list was altered by hand, which was not best practice and identified as a potential risk. We found that the surgical consultants did not always visit their patients daily as required in the hospital's practicing privileges contract. We identified that although there were systems in place staff were not always following the correct procedure which put both staff and patients at risk.

The hospital did not have the facilities to manage patients who required critical care support. This meant the hospital could not look after patients who developed complications following surgery or required enhanced post-operative care. Although patients were assessed to ensure the hospital could meet their needs, there were not robust and consistently used admission protocols or policies that set out the safe and agreed admission criteria. Consequently, there was a risk of inappropriate patients being admitted as clear and specific guidelines were not available.

There were robust infection prevention and control procedures in place and the hospital facilities were clean, tidy and appropriately equipped to undertake surgical interventions. However we queried having 'clean' procedures recovering in the same locations as patients undergoing 'dirty' procedures in the Ambulatory Care Unit.

Although the hospital was using a high number of agency staff we found they were well inducted into the hospital and meant that the wards and theatres were operating fully staffed. There were systems in place to enable staff to maintain and develop skills relevant to their area of work.

The hospital used integrated surgical care pathways, a paper based records system, which gave an easily accessible record of the patients' journey through the hospital including the procedures and the interventions undertaken. This meant that patients were kept safe through having adequate numbers of staff available who were using a single multidisciplinary set of records.

Incidents

- The hospital had in place policies and procedures for dealing with untoward incidents. The policies were readily available for staff to access on the hospital's intranet.
- We noted that there were few reported surgical incidents on the hospital's incident reporting system and the hospital had not reported any serious surgical incidents to the commission over the past year. However the number of reported incidents was increasing and was similar to other providers offering a similar service.
- Never Events are serious and largely preventable events that should never occur. From the data supplied by the hospital we noted that there were no reported Never Events.
- We queried the hospital's policies and procedures for informing the commission about serious untoward incidents as we were aware of a surgical incident that had occurred but had not been reported to us as required under legislation.
- Staff in theatres and on the wards told us they were confident they knew how to report incidents.
- They told us that incident reporting had improved as the culture of the organisation improved. They told us that previously they would have hesitated to report incidents but were now actively encouraged to record untoward occurrences. This was reflected in the increased number of reported clinical incidents.
- We found that there were few formal systems in place to learn from incidents. Managers received little feedback about any investigation unless they were part of the investigating team. Staff told us that feedback was sometimes given at team meetings about what had happened, but there was little learning about what to do in order to prevent something similar happening again.
- The theatre manager told us that he did not have access to the electronic incident reporting system so was unable to tell us how many incidents or return to theatre

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occurrences had happened in theatre over the past year or what the learning or actions from such events were. He told us that he was reliant on feedback from the Quality and Risk manager who collated the data and provided monthly reports.

- However although a person had been recently appointed to the post of Quality and Risk Manager, the position had been vacant for some time with the Director of Nursing covering the role and responsibilities.
- Managers we spoke with were aware that incident reporting was an area which needed to be strengthened and improved and we were told that the hospital was actively addressing this through raising staff awareness and looking at the reporting systems as a whole.

Safety thermometer

- BMI Mount Alvernia was starting to use the NHS Patient Safety Thermometer as this was part of the information required when treating NHS patients. We saw that notice boards for displaying the information had been purchased but had not yet been installed.
- The information gathered as part of the NHS Patient Safety Thermometer initiative was available for all patients seen and treated in the hospital; for example any falls, pressure ulcers, catheter and urinary tract infections.
- At the time of our inspection this information was recorded and reported to the hospital's Quality and Risk Committee.
- The patient integrated care records included a range of risk assessments to identify patients at risk and identified measures to reduce the incidence of pressure ulcers or falls such as pressure relieving mattresses or bed rails.

Cleanliness, infection control and hygiene

- BMI Mount Alvernia Hospital had policies and procedures in place to manage infection control. This included infection prevention, decontamination and waste disposal. The policies were readily available on the hospital's intranet and the staff we spoke with knew how to access them if needed.
- A weekly infection, prevention and control link group meeting took place chaired by a lead external advisor. The theatre manager told us the infection control link nurse attended these meetings and fed back any relevant issues to the theatre team.

- Managers told us that infection control was routinely monitored and gave us examples of the infection control audits that took place on a regular basis such as hand hygiene, catheters, surgical incision sites and intravenous cannulation sites.
- We were told that the hospital's Clinical Governance Committee received the monthly reports of any infection control surveillance, outbreak or audits that had taken place.
- There were no reported infections over the past 12 months. This indicated that the hospital's policies and procedures for managing infection control were effective.
- We spoke with the hospital's infection control leads and noted that although site specific infection rates were monitored there was little trend analysis undertaken as there were so few reported incidents. We noted that in the past week two infections had been reported on catheterisation procedures undertaken by the same surgeon. Although investigations had taken place no cause had been found and it was unknown if this would be reported at the Medical Advisory Committee (MAC). The hospital could not provide the infection rates for the individual consultants.
- We found there were systems in place to monitor infection prevention and control within the hospital although this did not include the individual consultants.
- During our inspection we observed staff complying with the hospital's infection control policies such as hand hygiene and the use of personal protective equipment (PPE). We noted hand sanitizer gel was in place at the entrance to clinical areas and on the wards.
- All public areas of the hospital including the wards and theatres were clean and tidy.
- We noted that the areas not accessed by patients such as the clinical treatment rooms, linen cupboards and sluice areas were also kept clean and tidy. For example the surfaces in the treatment rooms were kept clear of clutter and in the linen cupboards floors were kept clear to make cleaning easier and prevent contamination. Clinical waste was appropriately bagged, labelled, stored and disposed of through an approved waste collector.
- We saw that cleaning checklists were in place throughout the hospital. This provided assurance that all areas were maintained and cleaned appropriately on a regular basis.

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- There was little public health information available regarding infection prevention control measures although infection control featured prominently on the company website and in the Patient Guide.
- Throughout the hospital the general environment was in good repair which reduced the risks of infection. We spoke with the Director of Nursing who informed us there was a rolling programme to replace carpeted areas in clinical areas with floor coverings that were easier to keep clean.
- We saw ancillary staff undertaking thorough cleaning of the bedroom areas between patients.
- Patients we spoke with told us the hospital was always kept to a high standard. They told us staff were always washing their hands and wearing gloves and aprons.
- During the surgical pre-assessment appointment all patients due to be admitted for surgery were swabbed for potential infections such as MRSA and C Diff. Patients were not admitted for surgery if an infection was identified.
- The hospital used outsourced sterile supplies services which collected used equipment and delivered sterile sets back to the hospital. We saw that there was an appropriate flow of dirty equipment to the dirty sluice area where the used equipment was packed and taken outside for collection. This reduced the risk of contamination.

Environment and equipment

- Resuscitation equipment was readily available on the wards and in theatre.
- We saw that the resuscitation equipment was checked daily and following use in line with professional guidance.
- Staff told us that the resuscitation equipment and layout now mirrored the local NHS Trust. This was instigated as consultants and staff often worked across the two sites and it was felt to be safer having familiar systems in place.
- There was suitable and sufficient equipment available in theatres to support the type of surgery undertaken. We saw there was equipment available to deal with surgical emergencies such as resuscitation, difficult intubation, malignant hyperthermia, haemorrhage and emergency tracheostomy.
- The integrated surgical care included a detailed record and a clear audit trail of the equipment used in theatre.

- In theatre and the recovery room we saw that checklists were completed to identify that equipment was clean, functioning and ready to be used. This included daily checks on the oxygen, suction and blood monitoring machines. This meant that there were systems in place to ensure theatre equipment was safe to use.
- We visited the Ambulatory Care Unit which included endoscopy and minor operations theatre suites. The unit was clean and provided suitable facilities for the procedures undertaken there.
- We noted there were appropriate tracking and traceability systems in place. This ensured that the endoscopes used could be traced back to the individual patients and demonstrated they were decontaminated according to best practice guidelines.
- We saw that weekly water testing took place with replacing of equipment where indicated.
- The unit had dedicated trained endoscopy staff that were fully aware of decontamination issues.

Medicines

- The hospital had policies and procedures in place to support safe medicine management in the hospital. This included a Medicines Management Committee which met bi-monthly and fed into the Clinical Governance Committee.
- A pharmacist was employed to oversee medicines management and we observed them reviewing drugs on the ward and in discussion with the Resident Medical Officer (RMO) over medicine issues. The pharmacist undertook periodic audits of medicines on the wards.
- Although medicine management was not reviewed in depth we noted that the management and storage of medication was generally to a good standard. Medicines were held secure in locked cupboards and in theatre drugs were only drawn up when needed. Fridge and room temperatures were recorded daily with the current temperature and range.
- We noted that on the wards medicines records were clear, well maintained and generally well completed.
- However we saw where patients were undergoing injections for pain in theatre the lot numbers and expiry dates of the drugs used were not recorded in the patients care plan, except where unlicensed products were being used. Staff we spoke with told us there was

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insufficient space in the day case care plan to record the information. They told us this had been raised with the hospital management but there had been no action taken to date.

- Theatre medicine records were of a good standard and the surgical care pathway documents clearly recorded the drugs given and the medical and anaesthetists input.
- The local microbiology protocols for the administration of antibiotics were the same as used in the local NHS Trust. Staff told us that although they used the same protocols as the local NHS Trust there were variations between individual consultants.
- The infection control leads told us that although there were BMI protocols in place each consultant “Did their own thing”.
- Antibiotic audits were undertaken by the pharmacy department who reported anomalies through the Medicine Management Committee. We were told that if there were prescribing concerns the pharmacist would raise this with the individual consultant in the first instance and escalate through the medicines Management Committee and the Medical Advisory Committee (MAC) for action.

Records

- The hospital used BMI integrated surgical care pathways, a paper based records system. These were documents that covered the patients’ journey from admission through the surgery to discharge.
- We noted that medical records were also kept which contained correspondence between consultants and GP’s, clinical notes made during consultation and investigation requests.
- We looked at the pre-assessment information and saw that any tests and investigations undertaken were clearly documented and the patients’ medical and social history was recorded prior to them being admitted for surgery.
- Risk assessments were available and completed during pre-assessment and then followed up on the ward.
- On the wards we queried what action was taken following a risk being identified as we noted patients identified as having a higher risk of pressure area damage. It was not clear from the records what action

had been taken either on the wards or in theatre to prevent the patient coming to harm. Staff on the wards and in theatre talked through the actions taken but this had not been recorded in the notes.

- There were different care pathways available for the different types of surgery undertaken at the hospital for example gynaecology, hip and knee replacement.
- We examined eleven sets of patient records during our inspection. The records gave an easily accessible record of the patients’ journey through the hospital including the procedures and the interventions undertaken. The records we examined were stored securely and clearly showed the input of the various specialisms including the anaesthetists and physiotherapists.
- The hospital conducted periodic records audits. The most recent medical records audit demonstrated 93% compliance against best practice standards.
- We noted theatre records were fully completed and included completed World Health Organization (WHO) surgical safety checklists.

Safeguarding

- The hospital had safeguarding policies and procedures readily available for staff on the intranet.
- Over the past year CQC had not received any formal notification from BMI Mount Alvernia of any safeguarding allegations or incidents. However over the same period of time CQC were invited to two local authority safeguarding strategy meetings in relation to allegations of abuse. Senior members of the hospital had attended these meetings but CQC had not been notified as required under legislation.
- At the time of our inspection all safeguarding investigations had been concluded and action plans were in place to address the issues identified.
- We spoke with the Director of Nursing about how safeguarding was managed in the hospital.
- The Director of Nursing was a trainer with current Level 3 safeguarding training and provided the hospital’s in house safeguarding training.
- Managers told us that each Monday a list was circulated of those staff that required update training and they then chased up the members of staff concerned.
- We spoke with staff on the wards and in theatre. They told us that they had received recent training on safeguarding vulnerable adults, the Mental Capacity Act and the Deprivation of Liberty safeguards. This training was provided both on line and face to face.

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- Staff told us that although issues did not occur very often they knew how to access help and support in dealing with such a situation and that they were fully supported by their line manager and the Director of Nursing.

Mandatory training

- We spoke with staff throughout the hospital and they all told us that training was readily available.
- Much of the mandatory training was electronically delivered and we were told there had been much improvement in the quality of the computer based training.
- The theatre manager told us the member of the theatre staff with responsibilities for e-learning sent weekly updates with training available and undertaken.
- Staff told us that their training was up to date and that managers reminded them when training was due.
- We spoke with agency staff who told us they had received a good induction to the hospital and the wards they worked on. They told us that they were often included in the hospitals training and gave examples of recent training they had undertaken at Mount Alvernia Hospital.
- We spoke with staff who were being supported in their further development such as theatre staff undertaking First Assistant training.
- We spoke with ancillary and administrative staff who confirmed they attended all the mandatory training in addition to role specific training such as customer care and computer skills.
- There were systems in place to enable staff to maintain and develop skills relevant to their area of work.

Assessing and responding to patient risk

- The hospital did not have the facilities to manage patients who required critical care support. We were told that should a patient's condition deteriorate they were transferred as an emergency to the nearest NHS hospital. This meant that the hospital carefully screened patients during the pre-admission consultation to exclude operating on patients assessed as a surgical risk.
- However the hospital did not have an admissions policy that set out safe and agreed criteria for the admission of patients in a robust and consistent manner. The hospital's statement of purpose did not specify that the hospital could not look after patients that required level

two critical care. This included immediate care following major elective surgery; emergency surgery in unstable or high risk patients or where there was a risk of postoperative complications or a need for enhanced interventions and monitoring.

- We were told that all patients were admitted under the care of a consultant and were assessed on an individual basis to ensure the hospital could meet their needs during the pre-assessment. In an emergency or out of hours the senior nurse on duty was responsible for undertaking the assessment.
- We saw that the hospital used an early warning system to alert them should a patient's condition start to deteriorate. However in the sample of records we reviewed staff had not taken action where the early warning system identified a patient's condition had deteriorated or their observations gave cause for concern. This meant that patients were at risk because the early warning system was not being used effectively and the hospital did not have the staff or facilities to treat seriously ill patients.
- The hospital had a Resuscitation Committee that was chaired by the Director of Nursing and attended by representatives from departments across the hospital. The minutes we saw confirmed that a consultant anaesthetist and a physician attended regularly.
- Practice resuscitation scenarios were held between each committee meeting to ensure staff maintained their skill level. The scenarios took place in different locations around the hospital. The report of one such scenario stated the Resident Medical Officer (RMO) was, "not fully up to date with the situation" suggesting they were not either fully orientated to the hospital or lacked the necessary skill to lead a resuscitation attempt effectively. This may not have been a problem during the day when there was generally a consultant anaesthetist on the premises but at night the RMO was the senior and sole doctor in charge.
- We spoke with the RMO on duty during our inspection and they told us that they carried a bleep and were always contactable. The RMO we spoke with had worked at the hospital for two years and told us they received good support from the consultants in looking after their patients. They did not have any problems with access to the consultants who were contactable by phone.

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- The Chair of the MAC told us there was an on call system where there was always consultant cover at the hospital. They told us that should a consultant not be available for any reason they would try to link up with the on-call consultant at the local NHS Trust.
- We noted that following discharge home patients were contacted to ensure they were recovering as expected. They were given emergency contact details if needed. We listened to staff talking with patients and following up on their surgery.
- We saw that theatres had a system in place to identify where an operating list had been altered. There were different coloured lists for the preliminary, actual or altered lists. This helped to reduce the risk of error due to the theatre list.
- However during our inspection a case was added to the surgical lists in a hand written format. The operating list was subsequently altered again. This was not best practice and identified as a potential risk.
- We noted that patients who had undergone procedures which involved giving injections into joints were being transferred post operatively to the Ambulatory Care Unit to recover before being sent back to the ward. Concerns were raised that the procedures undertaken in the Ambulatory Care Unit were classed as “Dirty procedures” and there was a risk of infection where patients with “Clean procedures” such as joint injections were cared for in the same bays.
- The hospital inpatient wards had a high level of vacancies which were covered by agency staff. The staff we spoke with did not voice any concerns about the numbers of staff employed although they told us they would like more permanent staff.
- We spoke with the ward managers who told us that where possible the same agency staff were used. The agency staff we spoke with confirmed that they had worked at the hospital for several months and were considered as part of the hospital team, included in training and staff meetings.
- There was a similar position in theatres. We were told that the biggest challenge was the lack of permanent registered staff. A senior staff member told us that although they were fully staffed for the operating lists they relied heavily upon agency nurses. They stated that this did not impact on the quality of care as the agency staff had worked at the hospital for several months and were fully inducted into the theatre team.
- At the beginning of each shift staff received a printout of the patients on the wards, their diagnosis, condition and any information of note. We were told that formal hand over on the wards usually occurred at the patient's bedside. This meant that patients were fully aware of the information being exchanged and had the opportunity to meet the new staff coming on duty and ask questions.
- We observed staff in theatres following the World Health Organisation (WHO) surgical safety checklist. For example before the theatre list started there was a team briefing and handover where members of the theatre team were introduced and their roles clarified. This reduced the risk of misunderstanding and errors during the operation.
- We were told that collecting patients from the ward had been identified as a risk as the ward staff did not have sufficient staff available to support the patients being brought to theatre. A member of the theatre team now collected patients from the ward. Patients did not therefore have a familiar face accompanying them to theatre and supporting them during handover to the theatre staff. We were told that when theatre staff were not available the operating lists were delayed.
- Patients we spoke with told us there was always plenty of staff around and although some were agency you wouldn't know the difference they were all good”. They told us the nurses always responded promptly to a buzzer request for help without delay day or night.

Nursing staffing

- During our inspection there were two open wards St Clare's and St Ethelbert's which accommodated 24 patients.
- The hospital used the BMI nursing dependency and skill mix tool as a guide to providing the right number of appropriately qualified staff on duty. This was reviewed daily. We looked at a sample of staffing duty rotas and noted the hospital was appropriately staffed for the acuity of the patients.
- We were told on both wards there were usually two qualified nurses and a healthcare assistant on duty although this number would be increased if the acuity of the patients changed. This was confirmed by the duty rotas on display in the office.

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Surgical staffing

- The hospital employed an agency RMO who worked one week on, 24 hours a day seven days a week for one week and then handed over to another RMO. The RMO we spoke with had worked for BMI since 2012 did not identify this as an issue. They told us they usually had ample time for rest and carried a bleep so they were contactable at all times.
- Handovers between the RMOs took place on a weekly basis when the new RMO came on duty. There was sufficient time for the incoming RMO to become acquainted with the patients and current issues before the outgoing RMO left the hospital.
- The hospital maintained a Medical Advisory Committee (MAC) whose role included ensuring that any new consultant was only granted practicing privileges if deemed competent and safe to do so.
- The role of the MAC included periodically reviewing existing practicing privileges and advising the hospital on their continuation. They gave examples where practicing privileges had been suspended or withdrawn as a result of concerns raised.
- This demonstrated that the MAC was an effective body for monitoring the competence of the consultants working at the hospital.
- We were told that the expectation was that consultants lived and worked locally. This was to make sure they could be able to attend the hospital within 30 minutes if required in an emergency. It was a requirement of the practicing privileges agreement that consultants should either be personally available or arrange alternative cover at all times when they had patients staying in the hospital.
- The surgical consultants did not always visit their patients daily although we were told that they always visited on the first and last day of the patients' stay. We spoke with surgical consultants who told us that when a patient was following an identified care pathway and there were no identified problems, there was little risk to the patient if they were not seen daily by a consultant. However the BMI Practicing privileges contract stipulated that the consultants must visit each patient on a daily basis while they were staying at BMI Mount Alvernia Hospital.
- The hospital had made arrangements for all theatre first assistants to be appropriately qualified for the role. Minutes of the Clinical Governance Committee

confirmed that all relevant staff at the hospital had undertaken the surgical first assistant training including self-employed practitioners who attended with a consultant.

Major incident awareness and training

- The hospital had in place major incident and business continuity plans that had been recently updated. We spoke with the theatre and health and safety manager who described what would happen in order to safeguard patients during any facilities failure. They gave an example of an electrical failure and the hospital's backup generators were used to ensure patients in theatre remained safe. They described how surgical patients had been moved to another area until power had been restored. They told us this had been a good test of the system.
- Staff told us how scenario training was undertaken where procedures for major incidents such as fire were tested. They gave examples of practicing evacuations in theatre and on the wards.
- The hospital had in place policies and protocols for the emergency transfer of patients to the local NHS hospital in the case of complications which required level two or more critical care.
- We noted there had been few emergency transfers in the past year.

Are surgery services effective?

We found that the hospital had a full range of policies and procedures available which were kept under continuous review by the corporate body. Audits were conducted to provide assurance that staff and clinicians worked according to the evidence-based guidance. There were systems in place to effectively manage patients' pain control and staff took prompt action where a patient was identified as requiring analgesia. Patients were supported to maintain adequate nutrition and hydration while in hospital. We found that patients were achieving positive outcomes for their conditions following intervention by the hospital. Patients told us they were very happy to return having had a positive experience previously and they couldn't praise the staff and facilities enough.

The general environment was maintained to a high standard. The facilities were modern, clean and fit for purpose and provided a safe and efficient working

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environment and a pleasant setting for patients to undergo investigations and treatment. Although in general equipment was provided to a high standard, we found that record keeping did not meet current best practice for the service provision for the medical lasers used in theatre. This meant that patients may be at risk from practitioners not having current knowledge and training of the safe use of lasers and the most current and pertinent documentation and guidance may not be available when assessing the safe use of lasers in theatres.

Throughout the hospital, staff worked collaboratively to promote the health and well-being of the patients. We observed positive interactions and collaborative working throughout the hospital and in interactions with partner agencies and health providers. Patients were given information at the appropriate time to enable them to make informed decisions and consent to treatment. Where patients were vulnerable or lacked capacity staff had the training and understanding to deal with the situation. The hospital provided opportunities for staff induction, learning development and appraisal. However, there was a lack of formal supervisory, clinical supervision or peer support arrangements in place. We saw there were robust arrangements in place to monitor the competence of consultants with practicing privileges and action was taken where concerns were identified.

Are surgery services caring?

The hospital had systems in place to allow patients to feedback their experience of care at the hospital. The results of the surveys indicated that BMI Mount Alvernia provided excellent, compassionate care by friendly and approachable staff. Patients we spoke with during the inspection confirmed that staff were kind, considerate and respectful. We observed interactions between the staff, consultants and patients and saw that staff were attentive and caring in their attitude, providing assurance and support where needed and anticipating when additional care was required.

We found the hospital provided services and information to actively involve patients and those close to them. For example patients told us that they had received ample information prior to admission and during their stay and that the staff and consultants took the time to listen to them and their concerns. We were told how staff at the

pre-assessment clinic took time to counsel patients and allay their fears. We saw that the hospital had systems and processes in place that supported staff in providing a good service. For example allocating time for post discharge telephone calls to check that all was well once the patient returned home and having adequate staff on duty which gave them time to interact with patients and their families. Patients and their families were cared for by kind and compassionate staff who went out of their way to support them.

Compassionate care

- The hospital scores for the NHS Family and Friends Test related only to those patients seen and treated on behalf of the NHS. There was insufficient information available for this to be a useful measuring tool of patient satisfaction.
- However BMI used a patient satisfaction survey administered by a third party where the results were compared against other BMI hospitals. The results were noted at the Clinical Governance Committee. We noted that the majority of patients rated the overall quality of care as either excellent or very good.
- During our inspection we observed care and spoke with eight patients who were receiving treatment. All the patients we spoke with were very happy with the care and treatment provided. They told us the staff were all friendly and they were made to feel welcome. They said “Nothing was too much trouble”.
- We noted that patients receiving treatment and support were treated with dignity and respect, particularly on the wards, where staff always knocked before entering and addressed patients in a professional manner. Patients told us that the doctors took time to discuss what was happening and their treatment plans were discussed at the ward rounds. They said “Top to bottom they are very caring”.
- In theatres staff were mindful of patients’ privacy and dignity taking care to ensure they were always covered appropriately when they were vulnerable and unable to look after themselves.
- We observed theatre staff talking gently with patients and holding their hands to reassure them in the anaesthetic room.
- Staff gave examples of “Going the extra mile” when caring for patients who made special requests. For example providing special meals or facilitating family members or carers staying with them.

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Understanding and involvement of patients and those close to them

- The hospital operated a tariff of treatment costs however we noted that many of the complaints concerned unexpected items on their invoice. The hospital website gave guide prices for the various surgical interventions but advised that this could change according to the surgeon and the procedure undertaken.
- Patients told us they had received information from the hospital on the type of surgery they were admitted for and they fully understood the care, treatment and choices available to them.
- Patients told us how everyone seemed to have time for them and listen to them. One patient said “The surgeon had taken the trouble to read through my notes; he knew all my history and was very approachable”.
- The BMI Mount Alvernia Hospital website also included information for patients on the services available at the hospital and detailed information about the individual operations, the risks and benefits.
- Staff we spoke with told us that BMI had arrangements in place to provide interpreter services if needed, although many staff members spoke multiple languages and were able to help. We spoke with one staff member who was multi-lingual and they told us their language skills had never been needed. Specialist advice was available if required. We spoke with staff who were able to access specialist advice and advocates if required. Phone numbers and contact details were available either through BMI or through local sources.

Emotional support

- During the pre-assessment consultation staff told us they took extra time to allay patients’ fears. We saw that the assessment tool included assessing patient’s psychological well-being, maintaining interpersonal relationships and recording any significant life events which may have impacted on their health.
- There was not a separate assessment for anxiety and depression however the documentation included discussing any anxieties about the surgery and confirming that the patient had realistic expectations.

- During our inspection we noted the emotional support available for patients recovering from surgery. For example where surgery was life changing there were support services available such as counselling and specialist NHS nursing support.
- The hospital had a Chaplain and a multi-faith room which staff and patients could use for spiritual support. However because of the history of the hospital the room had a predominantly Christian feel although we were told that people of other faiths did access the room on occasions.
- The staff supported family and friends to visit with open visiting until 10.00pm when visiting was by arrangement with the ward staff. Visitors were able to have meals at the hospital which were charged to the patient’s account.
- There was open visiting during the day and by arrangement with the ward staff at other times. Patient’s told us their visitors were always made to feel welcome with a cup of tea. One visitor told us that they could only come to the hospital out of hours and this was easily accommodated by the ward staff.

Are surgery services responsive?

The hospital was constantly reviewing the service in order to meet the needs of the local population and the consultants who provided the services. For example the hospital was reviewing the need to provide high dependency beds and a local paediatric orthopaedic service. We found that patients had timely access to assessment, diagnosis and urgent treatment. There were no delays in accessing surgical intervention and patients told us they had been able to arrange their surgery at a convenient time for them. We saw that plans for safe discharge were considered at the pre-admission clinics where individual patients’ needs were discussed.

BMI Mount Alvernia was an older building adapted for use as a hospital. We saw throughout the hospital that reasonable adjustments had been made to enable people with disabilities equal access to the facilities. Patients were all assessed prior to admission to ensure that the hospital could meet their needs. Where possible arrangements were put in place to support patients such as extra staff, specialist nurses or family members.

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The hospital had a complaints policy and procedure in place and there was information available for patients about how to raise concerns. However complaints were not recorded if staff had managed to resolve them informally or patients did not take them further. This meant that the hospital may not be capturing all items of concerns and issues that affect patients' experience of care in the hospital. Not all stage one complaints had been recorded and staff told us they did not often receive feedback for complaints or issues of concern.

Service planning and delivery to meet the needs of local people

- The hospital was constantly looking at the services it offered in order to meet the needs of the local population and the consultants who provided the services. We saw through minutes of the MAC that different clinicians applying for practicing privileges for different procedures and that these were kept under review by the MAC and Executive Director to ensure that they were only offered practicing privileges at the hospital if there was an identified need.
- For example, following a previous inspection the hospital stopped treating children. The consultants were looking at how this service could be reinstated in order to improve the local paediatric orthopaedic service.
- We saw that discharge planning started as part of the pre-admission assessment process. This was considered as part of the patients overall suitability for elective surgery and was monitored and organised throughout the patients stay.

Access and flow

- We found that patients had timely access to assessment, diagnosis and urgent treatment. Staff told us that there were no delays in accessing surgical intervention once the patient was identified and had accessed the hospital's booking systems.
- Patients all told us they had been able to arrange their surgery at a convenient time for them. One patient told us that their surgery had been arranged at short notice but they were happy with this.
- As the surgery was elective and planned in advance there were few instances of unplanned surgical

interventions. During the past year there had been two cases of patients returned unexpectedly to theatre and this was managed without inconveniencing other patients.

- We spoke with staff who told us that they liaised with social services and the patient's GP to ensure there was a safe discharge plan in place. This was then documented in the integrated surgical care pathway.
- We were told by the Director of Nursing that planned elective surgical admissions were scheduled to take into account the need for the appropriate investigations to be carried out. Where surgical procedures required a faster access, such as fractures, there were processes in place to enable a faster access such as undertaking the preadmission process on the day of the surgery.

Meeting people's individual needs

- BMI Mount Alvernia was an older building adapted for use as a hospital. We saw throughout the hospital that reasonable adjustments had been made to enable people with disabilities equal access to the facilities. For example there were ramps in place, assisted bathing, disabled toilet facilities and extra wide doors and corridors, although the assisted bath was out of order during our visit. .
- We were told that patients' individual needs and requirements were assessed and documented during the pre-assessment clinic appointment.
- Staff told us that if any specialist requirements were identified the patient would be referred to the consultant, anaesthetists and senior nursing staff to ensure that their needs could be met while they were an inpatient at the hospital.
- They gave an example where a patient with communication difficulties had their carer stay with them to ensure they were fully understood and their needs were met by a familiar face.
- The integrated surgical care pathway included documenting that suitable arrangements were in place for a safe discharge. This included ensuring that family and carers needs and responsibilities were taken into consideration. For example community services were considered and discussions documented if the person's carer would be able to meet the patient's discharge needs.

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- Although staff were aware that patients with complex needs such as dementia and learning difficulties had specialist needs they had not received training. This was because the nature of the service offered meant that few patients with reduced capacity accessed the service.
- BMI Mount Alvernia Hospital was noted to be compliant with the Government's requirement to eliminate mixed-sex accommodation. Patients admitted to the hospital only shared facilities when clinically necessary such as in the Ambulatory Care Unit or in theatre recovery room. There were sufficient curtains and screening in these areas to maintain patient privacy and dignity.
- Staff on the wards and in theatre were not aware of any learning from complaints although it was acknowledged that the hospital received few formal complaints.
- We noted that thank you letters and compliments to staff were displayed on the ward. This gave immediate and positive feedback to staff on the service they offered.
- We found that patients concerns were listened to and action taken as a result, however it was less clear if any learning from the complaints both formal and informal had been disseminated to staff.

Learning from complaints and concerns

- The hospital had a complaints policy and procedure available for staff to access if needed. We noted that in June 2014 not all Level one complaints had been entered onto the hospital's electronic data system. Data recording remained an issue but we were told that once the new quality and risk manager was in post these issues would be resolved.
- We saw that information about how to make a complaint was included in the patient guide. A copy of the patient guide was provided in each bedroom in the hospital. We noted that the hospital's website did not give information about how to make a complaint or raise concerns.
- Staff told us they encouraged patients to raise their concerns with them or their managers in the first instance, where the issue would be addressed without accessing the formal three staged formal complaints process.
- The wards and theatres did not keep a record of the informal complaints and concerns raised. This was a missed opportunity for learning from minor issues and concerns raised by patients.
- Complaints were discussed at the Clinical Governance and where relevant at the MAC meetings. The discussions included the actions taken but the minutes reviewed had not identified any learning from complaints.
- The managers we spoke with told us that unless they were directly involved in a complaints investigation they did not receive information related to learning from complaints.

Are surgery services well-led?

BMI Mount Alvernia had a robust and realistic strategy in place for delivering safe care and the senior management teams were aware of the challenges the hospital faced and had plans in place to address them. Staff throughout the hospital were aware of the changes taking place and consistently told us how hospital was now committed to delivering safe and effective clinical care. We found that the hospital had a governance framework in place which included policies, procedures and oversight by the senior management team, the clinical governance committee, quality and risk committees and the MAC. The hospital was supported by the BMI regional clinical quality committee and the corporate clinical governance board. All the staff we spoke with were clear about their roles and responsibilities.

Staff throughout the hospital spoke of the visibility of the Executive Director and senior management team. They told us they felt able to approach the senior managers with any concerns if needed. Staff told us that there was now good leadership within the surgical services and the hospital as a whole. They told us the managers were very approachable and they would have no hesitation in raising issues confident that they would be listened to and action taken. The senior management team told us the previous year had been challenging and meant a lot of change for the hospital and staff. Their priorities included ensuring staff felt valued and ensuring they maintained a safe and effective service. Staff at ward level and in theatres were proud of the service they offered. They were keen to tell us of successes they had achieved, and the changes that had been made to improve the patient experience.

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Vision and strategy for this service

- BMI Mount Alvernia as part of a large independent healthcare provider had the corporate vision and values of BMI Healthcare. These included quality, patient care and choice as the priority areas.
- We were shown the company's vision and mission statement which included current business objectives. We noted that patient safety and clinical quality were business fundamentals, although involving patients was not included.
- At corporate and senior management level the hospital had a clear vision and statement of values. Staff in theatres and on the wards also told us that the hospital was committed to delivering safe and effective clinical care. They told us how the team brief in theatres
- We saw that the hospital had a robust and realistic strategy in place for delivering safe care and the senior management teams were aware of the challenges the hospital faced and had plans in place to address them. For example staff recruitment and investing in the hospital's infrastructure.
- At ward level and in theatres senior managers were aware of the business objectives for core surgical services and were involved at a senior management level in developing the service.
- Staff told us that meetings had been held where the future direction and vision of the hospital had been discussed together with the challenges faced and how they were going to be addressed.

Governance, risk management and quality measurement

- The hospital had a governance framework in place which included policies, procedures and oversight by the senior management team, the clinical governance committee, quality and risk committees and the MAC.
- The hospital was supported by the BMI regional clinical quality committee and the corporate clinical governance board.
- The Clinical Governance Committee and MAC were responsible for ensuring that the surgical interventions undertaken at the hospital were safe and effective. Both committees monitored the incident reports, complaints and issues that impacted on the surgical activity.
- There was an effective governance framework in place.

- The staff we spoke with were clear about their roles and responsibilities; however we noted that some senior managers did not have information available to enable them to effectively monitor issues in their departments such as clinical incidents and complaints.
- We saw that provider visits took place periodically where members of the regional quality and risk management team together with a regional director and a senior manager from another hospital within the BMI Healthcare group undertook quality monitoring visits. Following the visit a report was compiled with actions for the hospital to take.
- We saw the report from a provider visit undertaken in June 2014 and noted that areas identified as requiring action had been addressed. For example issues relating to accurate swab counts in theatre had been addressed.

Review of governance arrangements

- We found that the hospital's governance arrangements were now kept under review. Following the last inspection where serious issues had been identified at inspection and not through the hospital's own monitoring arrangements BMI had put systems in place to continually assess the quality of care offered.
- At a local level in the theatre and on the wards team meetings were held regularly to discuss key issues relating to the department. The minutes from a theatre meeting were seen and demonstrated that governance issues routine equipment checks, outcomes of provider visits and maintaining accurate theatre registers were discussed with the staff.

Leadership of service

- Staff throughout the hospital spoke of the visibility of the Executive Director and senior management team. They told us they felt able to approach the senior managers with any concerns if needed.
- We spoke with all grades of staff across the hospital who told us they now felt supported and encouraged to carry out their day to day duties.
- The ward and theatre managers spoke with enthusiasm about their role and the service they offered. They told us they worked closely with the executive team. One manager told us "It's different now, we are free to say what we want and if we have issues they are listened to".

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- Staff told us that there was now good leadership within the surgical services and the hospital as a whole. They told us the managers were very approachable and they would have no hesitation in raising issues confident that they would be listened to and action taken.
- Managers told us how they were supported through regular meetings with other managers within the BMI Healthcare group. For example the theatre manager told us that monthly theatre manager meetings were held within the Southern Region which was a forum to provide support and share best practice.

Culture within the service

- The senior management team at the hospital told us here had been much learning and reflection on the previous culture at the hospital and much work had been undertaken to understand why it had happened and where the hospital needed to make changes.
- We were told that significant changes had taken place since the last inspection and staff were now looking forward to the future.
- We spoke with consultant surgeons and anaesthetists. They told us there had been a big difference in the atmosphere within the hospital and credited the change in management for the positive improvement.
- We were told by staff and managers that the reporting culture had improved and they were now encouraged to raise concerns. Although one or two staff told us their manager would try to deal with issues 'in-house' and not escalated concerns this was not the general opinion.
- We spoke with members of the ancillary and administration teams who told us if they had concerns about a member of staff or a consultant's behaviour they would raise it with their line manager and were confident that it would be addressed. They told us that this wasn't always the case and the leadership and culture within the hospital had improved dramatically and they now felt empowered to question behaviours.
- All the staff we spoke with told us they felt valued and respected. One member of staff told us that "All the problems from 2013 were due to management problems, they wouldn't listen to us – now it's the complete reverse". Another member of staff told us previously they had raised a concern and was told "If you don't like it go" but now they felt listened to and managers were actively asking their opinions.

- We spoke with an agency nurse who told us they lived a fair distance from the hospital but would travel twice that to work at BMI Mount Alvernia Hospital as it was, "By far the best place to work".

Public and staff engagement

- The hospital had a patient feedback system that operated across the BMI healthcare group. This was an inpatient questionnaire managed by an outside provider.
- There was also a short survey where patients were asked four questions relating to the quality of care and if they would recommend the hospital to family and friends.
- The results for BMI Mount Alvernia indicated that the 689 patients who had completed the questionnaire between January to December 2013 and the 326 patients who had completed the Friends and Family questionnaire between April to December 2013 were generally very happy with the care and quality of service they received.
- There were no other forums identified where the hospital engaged with the general public.
- We noted that the BMI healthcare website provided much information about the surgical interventions which included information on marketing cosmetic surgery. The information was noted to be honest and gave responsible advice.
- The senior management team told us they had undertaken a number of team building exercises to improve staff morale. This included charity and volunteer work.
- All the staff we spoke with were positive about how the hospital had improved and told us they enjoyed working there. The theatre focus group told us "It's just like one big happy family – we all rotate and look out for each other". Another member of staff on the wards said "I am so glad I made the decision to work here, the staff are fantastic and my manager so supportive". One consultant told us "The culture has completely changed for the good; it's come from the top and is reflected in the staff morale".

Innovation, improvement and sustainability

- The senior management team told us of their priorities for the future to ensure BMI Mount Alvernia Hospital remained competitive and financially viable whilst

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continuing to offer a safe and effective service. They told us that the surgical areas for growth included enhancing the general surgery provision and providing for higher dependency patients in an identified unit.

- They told us the previous year had been challenging and meant a lot of change for the hospital and staff. The priorities included ensuring staff felt valued and ensuring they maintained a safe and effective service.
- Staff told us of areas they had looked at to find solutions such as staff car parking which was a problem. To provide some relief support services had rented 30 parking spaces from neighbours around the hospital which was proving successful.
- Staff at ward level and in theatres were proud of the service they offered. They were keen to tell us of successes they had achieved, and the changes that had been made to improve the patient experience.

End of life care

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

BMI Mount Alvernia Hospital provides end of life care for patients who have been diagnosed with incurable illnesses and are approaching the last phase of their life. BMI Mount Alvernia offers a Consultant led palliative care service made up of Consultants in Palliative Medicine working closely with a Palliative Care nurse.

On average 20/30 patients die each year at the hospital, the majority of patients having had a cancer diagnosis and were known to the Oncology team.

Three Palliative Care Consultants work as a team providing specialist palliative and end of life care including advice on pain and symptom control, providing practical advice to healthcare professionals and supporting families.

The Palliative Care consultants visit BMI Mount Alvernia to review patients daily and out of hour's advice was available via the consultants on – call rota. The palliative care nurse is available Monday to Friday 8am to 4pm and is the point of contact for healthcare staff and families who may have concerns regarding an end of life patient.

The palliative care team work closely with the Community Palliative Care teams and with local voluntary sector hospices including Princess Alice Hospice in Esher and the Phyllis Tuckwell Hospice in Farnham. In addition, the pastoral care staff provided multi-faith support.

During the inspection we visited St Clare and St Ethelbert Wards and spoke with a variety of staff including a palliative care consultant, ward nursing staff, the Palliative care nurse, pastoral care worker and the oncology nurse manager.

We reviewed the medical records of three patients who had received care at the end of their life at BMI Mount Alvernia. During the inspections no patients were receiving end of life care at the hospital.

End of life care

Summary of findings

Palliative and end of life care specialist input was via the palliative care medical consultants and the palliative care nurse. The end of life care delivered was a consultant led service with the palliative care consultants reviewing patients daily as well as being contactable by telephone if staff required support. Out of hours and over the weekend the Palliative Care consultants provided on-call cover and undertook any reviews necessary. This meant that patients had access to specialist advice at all times.

The care people receive at end of life was a whole team approach with the ward nursing and medical staff and the palliative care team all working together to deliver holistic care. Medicines were provided in line with the Adult Palliative Care Guidance 2nd edition 2006. The choice of medications at the end of life had been aligned to local community guidelines to support safe and consistent practice between care providers. A fast track process was in place to support patient's wishes and preferences to achieve their Preferred Place of Care.(PPC)

The nursing staff we spoke to on the wards had not received end of life training and no end of life care link nurses were present on the wards. At the time of the inspection BMI Mount Alvernia did not have an end of life pathway to support staff to identify and care for people at the end of life. End of life patients were placed on the generic medical pathway with specialist input from the palliative care consultants and nurse.

Leadership of the specialist palliative care team was good and quality and patient experience was seen as a priority.

Are end of life care services safe?

BMI Mount Alvernia cared for approximately 20 to 30 patients per year who were approaching the end of their lives. No end of life care staff training was provided to maintain staff skills and knowledge and keep up with the latest practice. We were told of two nursing incidents that had happened in the last year which involved an end of life patient. We reviewed the incidents and saw that investigations were undertaken resulting in extra training being delivered to staff. However, on reviewing the most recent incident forms on the ward we found two similar incidents has occurred recently which demonstrated a lack of organisational learning.

Guidance about caring for patients after death was available to staff in the Management of Deceased Patients Policy.

McKinley T34 syringe drivers were available and were being used across both St Clare's and St Ethelbert's wards to support patient who required continuous infusions of medication to control their symptoms. The ward manager on St Clare's ward told us that all permanent staff had attended IV study days in May 2014 to ensure the safe use of the syringe drivers. The choice of medications at the end of life had been aligned to local community guidelines to support safe and consistent practice between care providers. On discharge, sufficient medication was prescribed (and dispensed) before leaving the Hospital to ensure patients did not run out of their medication whilst the community teams took over their care.

Incidents

- Nursing staff on St Clare's ward told us that if incidents occurred a paper proforma was completed and sent to the Quality and Risk Group, where the information would be entered onto an electronic system within five days of the incident occurring. However, with staffing shortages within the Quality and Risk Group there were delays in inputting incidents into the system which resulted in delayed responses. St Clare's ward had a ward action plan which had incident reporting as a key improvement objective for 2014/15. We saw the current issues had been identified, possible solutions with a timeline for improvements to be made. We saw the

End of life care

action plan had not been updated but nursing staff told us that the incidents forms were being photocopied and were being kept on the ward to help staff monitor trends and improve practice.

- On St Clare's ward we were told of two nursing incidents that had happened in the last year which involved an end of life patient. We reviewed the incidents and saw that investigations were undertaken resulting in extra training being delivered to staff. However on reviewing the most recent incident forms on the ward we found two similar incidents has occurred recently. On questioning the nursing staff we were told no further training had taken place to date.
- In St Martha's Oncology Centre, incidents related to end of life care were investigated by the oncology manager and actions taken to prevent similar incidents taking place in the future. However we found that no systems were in place to disseminate learnings across the hospital wards and departments to embed the learnings to improve the quality of care delivered to end of life patients.
- There were 0 Never events relating to end of life care.

Cleanliness, infection control and hygiene

- We saw that the wards we visited were clean and well maintained. In all the patient areas the surfaces and floors were covered in easy to clean materials which allowed high levels of hygiene to be maintained throughout the working day.
- We saw that ward and departmental staff wore clean uniforms with arms bare below the elbow. Personal protective equipment (PPE) was available for use by staff in all clinical areas.
- Clear guidance was available for staff to follow to reduce the risk of infection when providing care for people after death. Guidance was available to staff in the 'Management of Deceased Patients Policy'. We saw, for example, that it advised staff that PPE must be worn when performing care after death and body bags were available to support deceased patients during the transfer to the funeral directors. Ward staff showed good knowledge of when body bags should be used. Good after death care ensured that no person involved in caring for the deceased patient were placed at risk. All rooms were steam cleaned after patients vacated the room.

Environment and equipment

- All patients had a tissue viability risk assessment on admission to ensure the skin integrity needs of the patients were being met. End of life patients requiring an air mattress received this promptly to prevent the development of pressure sores. We were told that there were no issues around securing the necessary equipment for end of life patients. The Registered Nurse on St Ethelbert's ward told us that a local company delivered the air mattresses and were very responsive if any issues developed with the mattress.
- Syringe drivers were available across the hospital to support end of life patients with complex symptoms to deliver continuous infusions of medication. We were told by the nursing staff that the McKinley T34 syringes were available and were being used across both St Clare's and St Ethelbert's wards. The ward manager on St Clare's ward told us that all permanent staff had attended IV study days in May 2014 to ensure the safe use of the syringe drivers. We were told that agency nurses do not receive syringe drivers training therefore when agency staff are on duty any procedures related to syringe drivers were performed by the bleep holder and a trained member of the substantive nursing workforce to ensure patients safety.

Medicines

- Medication Guidance had been agreed and implemented as per the 'Adult Palliative Care Guidance 2nd edition 2006'. This set out the medication necessary to support the management of dying patients. The guidance was comprehensive and guided staff on the prescribing of medication covering the five recommended areas including pain, agitation and restlessness, nausea and vomiting. The document guided staff where complex medical conditions existed. Palliative care consultants prescribed the medication which ensured patient safety was paramount and that specialised skills supported the prescribing process.
- We were told by staff on both the wards we visited that medication for end of life care was available on the wards and was easily accessible. If a specified drug was not available the on-call pharmacist would be called in to dispense the required medication. This meant that 24/7 access to end of life medication prevented end of life patients waiting for the necessary medication.

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- The choice of medications at the end of life had been aligned to local community guidelines to support safe and consistent practice between care providers. On discharge, sufficient medication was prescribed (and dispensed) before leaving the Hospital to ensure patients did not run out of their medication whilst the community teams took over their care. The palliative care consultants worked across the local acute, community and hospice providers which supported improved safety and continuity of care for patients who moved between care providers.

Records

- On St Clare's Ward we found paper medical records were in use which documented the patient's personalised care and treatment. We reviewed an end of life patients' medical notes and found the palliative care team entered review updates after each daily consultation; this allowed the ward based nursing and medical staff to deliver the appropriate optimal care.
- The palliative care team undertook holistic assessment which identified the patient's individual needs. The holistic assessment was clearly documented, signed and dated. This showed that accurate personalised records were kept and maintained on all the occasions the palliative care team reviewed the patient. We observed that information such as clinical information and conversations undertaken with the family were recorded.

Assessing and responding to patient risk

- On admission, risk assessments were carried out to ensure the needs of the patient could be identified to ensure the optimum care was delivered. Risk assessments included a moving and handling, pressure area and nutritional risk assessments. For example depending on the score of the pressure area risk assessment and clinical judgements a selection of preventative aids, would be allocated to the patient such as air mattresses to prevent pressure ulcers developing.
- The hospital used the National Early Warning Score (NEWS) system to identify patients who were at risk of sudden deterioration in their condition. The tool supported staff to monitor patient functions such as the patient's heart rate, blood pressure, temperature and oxygen levels. On St Clare's ward the sister told us that

patients were observed 4 to 6 hourly but if there was an increase in the score (5 and above) the Resident Medical Officer (RMO) and palliative care consultant were informed and the patient reviewed.

- We reviewed an end of life patient's notes and observed the patient had a high NEW score. We saw evidence that the palliative care consultant had been called by the nursing staff and was present to support in the management of the patients complex symptoms. The RMO was available on the ward 24/7; therefore any changes in the end of life patient's condition were reviewed by a doctor in a timely manner. However in four medical patients' notes we found that no action was taken when patients had raised NEW scores.
- For end of life patients, where the progression of their illness was more clear the amount of intervention was reduced to a minimum. Care was based on ensuring the person remained as comfortable as possible, at all times.
- One of the palliative care consultants told us that Mount Alvernia was 'very responsive' to national patient safety alerts. We were told that following the National Patient Safety Agency rapid response report (NPSA/2010/RRR019) relating to syringe drivers and the reporting of fatal errors, BMI Mount Alvernia removed the syringe drivers used and replaced them with the recommended McKinley T34 syringe drivers.

Nursing staffing

- BMI Mount Alvernia's 'Management of the Deceased Patient Policy' outlined the expected standards of care for deceased patients. End of life care was the responsibility of all staff, and was not limited to the palliative care team.
- The palliative care consultants were supported by a palliative care nurse who worked with the ward staff in supporting patients who were approaching the end of their life. They were available 8am- 4pm, five days per week. During times of absence, we were told this role was covered by the oncology manager.
- The ward sister on St Clare's ward told us that they used a nurse based dependency tool at the start of each day. If extra staff were needed to support end of life patients, extra staff would be brought in. We saw evidence in an end of life patient's notes that an extra nurse was offered to a family to allow the family member's time to relax.
- We were told by the Director of Nursing that named nurses were not identified for each patient. The wards

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were split into two groups of six beds and the nursing teams are divided to manage a particular group of patients depending on the workload and skill mix that was available. However, we were told that patients receiving end of life care had the same nurse allocated to them during the night shifts.

Medical staffing

- End of life care was supported by three palliative care consultants who delivered consultant led care. The consultants provided medical consultant advice and support five days a week with out of hours support via the palliative care consultant's on-call rota. This meant that specialist knowledge was available 24/7 for patients receiving end of life care.
- The three palliative care consultants worked within the local NHS acute and community palliative care services allowing streamlined care between service providers for patients needed to move between providers when receiving end of life care.
- Support on the wards was available from the Resident Medical Officer (RMO) who was available at all times to support the management of end of life patients and undertake medical duties whilst the palliative care consultants were off site. The RMO are available from 8am to midnight and from midnight the RMO is on call until 8am in the hospital. A seven day shift was worked, which meant consistent care was delivered over this period of time.

Are end of life care services effective?

The palliative care consultants based their care on the NICE End of Life Care Quality Standard 13 providing evidence based advice to other professionals as required. The oncology manager told us that BMI Mount Alvernia had not been registered to use the Liverpool Care Pathway (LCP) however parts of the framework were used to support end of life care.

We did not find personalised end of life care plans. End of life care patients were placed on the Generic Medical pathway. We saw evidence that care was delivered and recorded but we did not see any information on how personalised care would be delivered around patient's needs and preferences.

We were able to review one 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) order that we found in a deceased patient's medical notes. We found that the form was completed correctly and was placed at the front of the medical notes for easy access in an emergency. However, we noted that a mental capacity assessment had not been undertaken as it stated in the order that the patient lacked capacity. Ward staff told us that if there was any question around whether a patient was able to make decisions around their treatment/care or DNACPR, a 'mental capacity assessment' would be completed by the admitting doctor and a best interest's decision would be made. We saw no evidence of this process during the inspection.

At the time of the inspection there were no in-patients with DNACPR order in place so we were unable to review the completion of the orders.

BMI Mount Alvernia had no spiritual/religious policy and we were told by the pastoral care worker that spiritual/religious input did not inform the hospital end of life policy.

No local Bereavement Survey was carried out. This meant that the opinions of bereaved relatives are not being collected and no service improvement programme was initiated to improve the quality of care.

Evidence-based care and treatment

- Mount Alvernia had a Specialist Palliative Care team (SPC), consisting of palliative care consultants and a palliative care nurse, that demonstrated a high level of specialist knowledge and provided the wards across the hospital with up-to-date holistic symptom control advice for patients in their last year of life.
- We were told by the oncology manager that the hospital had not been registered to use the Liverpool Care Pathway (LCP) for patients entering the last phase of their life but that parts of the tool were used as an aid memorandum to support the care delivered at the end of life.
- We reviewed one set of medical notes of a patient that had recently received end of life care. We found no personalised end of life care plan, we saw that care was delivered and recorded but we did not see any information on how they delivered individualised care. Patients receiving end of life care were placed on the 'generic medical pathway' however we saw that a 'Personalised care plan for the Last Days of Life' had

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been developed and was due to be piloted across the hospital starting in late November 2014. The personalised care plan incorporated the Nice Quality Standard for End of Life Care for Adults (QS13) and the 'Priorities of care of the dying person' set out within the recommendations from the Leadership Alliance for the care of the dying released in June 2014. We were told by the Oncology manager that staff training will be given to introduce the new personalised care plan.

- While reviewing a second set of medical notes, we saw evidence that demonstrated that the palliative care team had supported and provided evidence-based advice for example, on complex symptom control. (QS statements 10 & 11) This specialist input by the team ensured that a high level of expertise was used to ensure the best possible care was delivered to end of life care patients.
- An 'End of life Booklet' from Macmillan and Marie Curie Cancer Support was available to give to patients and relatives (QS statement 2). We were told by the nursing staff that this will be given out by the palliative care nurse. This supported patients and relatives with written information around many aspects of end of life care and included titles such as 'the last few weeks and days of life'. We were unable to confirm that patient /families were given the booklet as no patients were receiving end of life care at the time of the inspection.
- Referrals to the palliative care team were made via a telephone referral. Any members of the multi professional team could make a referral; family members could request a referral. We were told that many patients referred to the team were known to the multi-disciplinary teams as patients had often received treatment in St Martha's Oncology Centre and were known by the palliative care nurse. Direct access to the Palliative Care consultants and out of hour's advice meant that patients received reviews on the day of referral. No audits were performed to confirm the timeliness between referral and the patient being reviewed by the team.
- It was unclear whether dying patients who did not have cancer were recognised as being at the end of their life and received the same level of input from the palliative care team.
- In BMI Mount Alvernia's 'Management of the Deceased Patient Policy staff were signposted to take into consideration the multi-cultural needs of their patients

and the importance of the specific requirements related to the care of the patient after death. A section of the policy guided staff to ensure end of life patients were managed in line with their culture and faith.

- We saw a folder containing Royal Surrey County Hospital Clinical Guidelines with a section on palliative care. We were unsure whether these guidelines had been validated by BMI Healthcare Limited to be used by staff across the hospital. There were no other local guidelines available.
- BMI Mount Alvernia had no spiritual or religious needs policy and we were told by the pastoral care worker that spiritual and religious input did not inform end of life policy.

Pain relief

- Effective Pain control was an integral part of the delivery of effective end of life care and this was supported by the palliative care consultants. On reviewing an end of life care patient's medical records, we saw that the palliative care consultant was actively involved in daily reviews of the patient's pain management.
- We were told by staff on the wards that all patients who needed a continuous subcutaneous infusion of opioid analgesia or sedation received one promptly. McKinley T34 syringe drivers were available on St Clare's ward; we observed the use of a McKinley T34 syringe driver monitoring chart which the nursing staff used to monitor the driver 4 hourly. We reviewed the monitoring charts of end of life patients and saw that the medication had been prescribed and delivered in line with hospital policy and that the patients had reviewed at the appropriate intervals.
- A 'Pain Scoring and Management Analgesic Ladder' was used to assess the pain management of all patients including end of life patients. Pain was usually reviewed 4 times per day. We reviewed a pain chart on a palliative care patient and saw that it had been completed appropriately and pain was regularly assessed throughout the patients stay. Information for patients and relatives on end of life medication including a description about syringe drivers; side effects of painkillers was available in the 'End of Life: a guide' booklet.

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- We were told that staff had attended a 'lunch and learn' in April 2014 from an anaesthetist on pain management. This meant that staff were being supported to keep their skills up to date and relevant to improve the quality of care delivered.

Nutrition and hydration

- We were told that discussions around the nutritional support that end of life patients needed included discussions with the patient and family. Their views and preferences around nutrition and hydration at the end of life were explored and addressed along with the risks and benefits. We were told that separate menus were available which included soft and pureed food and food to meet cultural requirements.
- On admission a risk assessment was completed by a registered nurse. We were told that a Malnutrition Universal Screening Tool (MUST) assessment was carried out; this identified patients at risk of poor nutrition, dehydration and swallowing difficulties. Patients identified as high risk were referred to the dietician and speech and language therapist (SALT). Out of hours the dietician and SALT were contactable, should support be required. We reviewed the medical notes of a patient approaching end of life care and saw that a nutritional assessment had been undertaken and the patient was encouraged to take 'nutritional drinks' by the nursing staff and family as the patient was unable to tolerate food.
- We were told by a ward manager that mouth care management was carried out on all end of life patients. Mouth care packs were available on the ward and an in-house mouth care chart was available to record when mouth care was performed, which included the removal of dentures and offering a mouth wash.
- End of life care patients were supported to eat by nursing staff, if required. Relatives were also encouraged to support family members at meal times. We reviewed a set of medical notes which showed that a food chart was being completed daily. At the bedside handover any problems associated with food and hydration were identified and shared between staff.
- A 'Nutritional Steering Group' had recently been set up with a nominated staff member from the wards attending the group. The aim was to inform the group on nutritional support methods available and provide

information, disseminated via the nominated individual, on nutritional support for all ward staff. We were told the first meeting included training on Percutaneous Endoscopic Gastrostomy (PEG) feeding lines.

- Within the 'Generic Medical Pathway' a prompt was in place to assess the patient's nutritional status and signpost staff to complete a dysphagia screen if the patient had swallowing difficulties, weight loss or recurrent chest infections. We were shown that the new Personalised End of Life Care Plan 'due to be piloted' included a section on assessing the nutritional and hydration status of the patient.

Patient outcomes

- We were told by the oncology manager that end of life data on referral patterns, patient demographics and patient activity was not collected and not sent to the National Council for Palliative Care Minimum Data Set (NCSPC MDS). We saw no evidence that end of life care data was collected and used to develop the service.
- BMI Mount Alvernia did not undertake a bereavement survey, however the palliative care nurse told us that feedback on care delivered was through contact with the relatives. During the inspection we did not see any examples of formal feedback from relatives nor any examples of service changes based on relative's feedback.
- We found that there were no systems in place such as the End of Life Care Quality Assessment Tool (EOLCQuA) to gather robust data to enable regular assessments of the organisational and clinical performance of the hospital against the NICE End of Life Care Quality Standard 13. No service improvement programme was therefore produced around the outcomes to ensure a continuous cycle of improvements were being made to end of life care. However we did see that the nursing teams and the palliative care team were implementing the NICE QS 13 statements in the care they were delivering to end of life patients but how well they were performing on each of the 'statements' specified was not known.

Competent staff

- End of life training was not mandatory across the BMI Mount Alvernia. Nursing staff we spoke with on the wards had not received end of life training and there was no evidence that any study days were available for

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staff to attend. This meant that staff did not receive support in end of life care to develop their skills and knowledge to deliver the best care for those at the end of their life.

- The palliative care consultant's provided specialist advice to all grades of staff across the hospital to ensure that ward staff felt confident to deliver end of life care by reviewing patient's daily and communicating recommendations to nursing teams and the RMO.
- The palliative care nurse had experience in oncology and was developing skills in palliative care. We were told that recent training included an advanced communications course, European Certificate in Palliative Care, pain management and advanced care planning. This meant that the hospital was supporting key staff to develop their skills and provide specialist input when managing end of life care patients.

Multidisciplinary working

- We saw evidence across the wards of multidisciplinary team (MDT) meetings taking place throughout the week to review patient's management plans. Bedside handovers took place daily and 'catch up's' took place with the physiotherapists and occupational therapists. This allowed a multi-professional approach to care and specialist input to take place to improve patient outcomes.
- The palliative care nurse told us that individual MDT meetings were patient driven. If an MDT meeting was asked for by the family it would be arranged on the same or next day when all the team were available. The Palliative care nurse liaised with the family. We were shown evidence in an end of life patient's medical notes of the MDT meeting that took place with the family.
- Nursing staff on the wards were aware of how to contact the palliative care nurse and could cite examples of their involvement with specific patients. However we found that the palliative care consultants did not perform a palliative care MDT meeting to discuss treatment plans for new and current patients. This was due to the small amount of patients that received end of life care at any one time.
- The palliative care nurse told us they worked alongside other palliative care nurses in the acute, community and hospice teams to ensure that end of life patients received streamline care across care providers. We saw

evidence in an end of life patients' medical notes of engagement with the hospice team and the transfer of the patient to the hospice which was the patients preferred place of care.

Seven-day services

- Five day face to face specialist care was not available from the palliative care consultants. However, an on call system managed by the palliative care consultants ensured that access to advice at all times was available for patients who were approaching the end of their life. One palliative care consultant was told us that patients were reviewed over the weekend, if complex management issues developed.
- The chapel was open 24 hours a day for those of any faith who wished to pray or spend time in quiet reflection. The pastoral care worker was available three days per week. We were told by the Director of Nursing that any patients that required support outside the three days would receive the necessary support as systems were in place to receive support from the local parish chaplain.

Access to information

- All Staff had access to the 'Management of Deceased Patients Policy'. This gave guidance to all staff on all aspects of caring for patients who had died. However, we saw no overriding policy on end of life care that covered how BMI Mount Alvernia hospital set out the care patients could expect to receive as they entered the late stages of their life and how relatives of patients could expect to be supported.
- At the time of the inspection BMI Mount Alvernia did not have an end of life pathway to support staff to identify and care for people at the end of life. End of life patients were placed on the generic medical pathway with specialist input from the palliative care consultants. We were told that as patients enter the last phase of their life, discussions took place with the family to ensure they were supported. GP's were not informed when the patient was entering the last stage of their life but the medical consultant would inform the GP by letter after the patient had died.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We were told by ward staff that if there was any question around whether a patient was able to make decisions

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around their treatment or care, a 'mental capacity assessment' would be completed by the admitting doctor and a best interest's decision would be made. We saw no evidence of this process during the inspection because there were no patients that lacked capacity receiving end of life care.

- We were unable to review any DNA CPR orders as there were no inpatients who had orders in place. During the unannounced inspection we reviewed the medical notes of a patient who had recently received end of life care. We found a DNA CPR order had been completed and signed by the consultant and was found at the front of the medical notes for easy access. However, we saw no evidence of a mental capacity assessment in place, as there should have been as the patient lacked capacity.

Are end of life care services caring?

During the inspection no patients were receiving end of life care at BMI Mount Alvernia Hospital. We were therefore unable to talk to patients and relatives about the care they received. However, the staff spoke to us in a way that demonstrated that they were caring and compassionate about how they cared for patients that were receiving end of life care.

Advanced Care Plans (ACP) were available to be completed with support from the palliative care nurse. However, we were unable to see any completed ACPs during the inspection.

We were told that families were encouraged to participate in care such as mouth and personal care.

Processes were in place that ensured deceased patients were treated with dignity and respect at all times.

Compassionate care

- During the inspection no patients were receiving end of life care at BMI Mount Alvernia Hospital. We were therefore unable to talk to patients and relatives about the care received.
- Hospital staff we spoke with demonstrated a strong commitment to empathy and enhancing the environment for dying patients. The oncology manager told us and showed us the 'end of life care package' that was available to patients receiving end of life care which

included blankets, candles, diffusers and fluffy socks. The oncology manager told us these were available, if required, on the wards to improve the environment and comfort of the end of life patients.

- We were told that bed side handovers took place daily. The nursing staff conducted the handover by the bedside so the patients and family were an integral part of their care. However if the information was thought to be too upsetting for the patient the hand over would take place in the nurse's office.
- One sister explained to us how the deceased patients were cared for after death. We were told that family could stay as long as possible after death has occurred; refreshments were offered to the family. Relatives are given the choice of whether they helped in the after death care or whether they left this to the nursing staff. The RMO verified death in front of the relatives and the Medical Certificate of Cause of Death (MCCD) was available to the family before leaving the hospital. Deceased patients left the hospital with the Funeral directors. A nurse was present during the transfer of the patient from the hospital bed to the concealment trolley to support the funeral directors and ensure patient safety and dignity was maintained at all times.

Understanding and involvement of patients and those close to them

- We saw evidence in the medical notes of a patient who had recently left the ward that the palliative care nurse was actively involved in ensuring the wishes and preferences of the patient were met and that they were supported to transfer to their preferred place of care. We were told by the palliative care nurse that regular contact took place with the family to ensure that the necessary support was in place by liaising with support agencies in the community.
- Advanced Care plans (ACP) were available on the wards to be completed. The palliative care nurse told us that support was given to patients who wished to complete an advanced care plan. No formal training had been given to staff to support the development of the ACP plans therefore this task was left to the palliative care nurse to complete with the patient. The staff we spoke to had not seen completed ACPs on the ward.
- The staff were able to give examples of where they encouraged families to get involved if they wished to care for the patient who was approaching the end of

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their life. This included personal care such as placing creams on arms and getting involved in mouth care. Families were asked to support relatives at meal times, if appropriate.

Emotional support

- The palliative care consultant we spoke to was able to provide level 2 psychological support to patients and carers. If patients or families required additional emotional support a referral was made to the community palliative care team or to the local hospice team. The palliative care nurse was able to give an example where a referral had been made to support a family.
- We were told that no bereavement services were available in the hospital but the palliative care nurse was able to signpost relatives to the bereavement councillors at the Beacon Centre in Guildford where support was offered for up to 2 years. We were told that a service to support children whose parent was dying was available from the Phyllis Tuckwell hospice. If there were concerns about the family, a call to the General Practitioner (GP) was made to flag up any concerns and keep the GP informed.
- The pastoral care worker was able to provide practical, emotional and spiritual support. Patients were offered chaplaincy support on request or put in touch with a minister of their faith. The local Catholic parish priest at St Joseph's Church provided support when required. We were told that end of life patients that did not have family were offered pastoral care support along with nursing staff support.
- Staff debriefing sessions were encouraged. The ward manager told us that staff who were involved in a difficult case were encouraged to talk about their experiences and support each other. The palliative care nurse told us support was available through the oncology manager, pastoral care officer and the palliative care consultants. Macmillan Cancer Care ran an emotional wellbeing day which taught strategies; the palliative care nurse had attended one such day and found it extremely useful.

Are end of life care services responsive?

All patients requiring end of life care could access the palliative care consultants and the palliative care nurse. The palliative care nurse was able to support complex and a fast track discharge process in order that patients achieved their preferred place of care (PPC)

All patients receiving end of life care were cared for in a single room. An extra bed could be placed in the room to allow family members to stay overnight.

Medical Certificates of Cause of Death (MCCD) were completed immediately by the RMO and given to the family before they left the hospital.

BMI Mount Alvernia had no access to an Electronic Palliative Care Co-ordinating System (EPaaCS) as this has not been commissioned by the local NHS Clinical Commissioning Group.

Service planning and delivery to meet the needs of local people

- All patients requiring end of life care received holistic care which included; being nursed in a single rooms with en-suite shower facilities that had space for relatives staying overnight. (A spare bed was brought into the room). Visiting times were unlimited. Complimentary therapies were available and there was access to a patio area where patients and relatives could reflect and enjoy time together. Access to physiotherapists, occupational therapists, dieticians and speech and language therapist ensured that patients' wider needs were met.
- BMI Mount Alvernia did not have the systems in place to support patients at the end of their life with advanced dementia. However, the Director of Nursing told us that if such a patient required end of life care, engagement with the carers would take place to ensure the care available met the needs of the patient. The ward had not supported a patient with learning disabilities who was approaching the end of life. Visual pain charts were the only system in place to support these patients.
- BMI Mount Alvernia Hospital did not have a social worker available on site to support end of life patients

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and their relatives. We were told by the oncology manager that systems were in place to refer patients to the local community social worker at the Beacon Centre and at the Phyllis Tuckwell hospice.

- We asked the oncology manager what systems were in place to ensure the wishes and preferences of patients who wish to donate organs or tissue were considered. We were told that if patients had a donor card completed the nursing staff contacted the donor line, after discussions with the next of kin. If surgery was required this took place in the hospital prior to the patient going to the funeral directors.
- We saw in 'The Management of Deceased Patients Policy' that strict guidelines were in place around the patients that required a post mortem. The oncology manager was able to describe the processes set up in order that the patient was transferred to the Royal Surrey County hospital where the post mortem was undertaken.

Meeting people's individual needs

- All patients at BMI Mount Alvernia, who required end of life care, had access to the palliative care consultants and the palliative care nurse. Referrals were made by the nursing and medical staff. As this was a consultant led service, urgent advice was available at all times.
- Information leaflets for families whose relatives were receiving end of life care were available and given out by the palliative care nurse, usually in clinic prior to admission to the ward. The information leaflets included 'End of life care; a guide'. The consultants gave the patient and family information during the consultation and the information leaflet supported the verbal information given. However, we found that the ward staff we spoke to were unclear which leaflets were given to the patients and relatives as this was undertaken by the palliative care nurse.
- After a patient died the ward staff provided practical advice such as signposting relatives to registering the death. Bereavement boxes were available on the wards which contained all the necessary documents to be completed after a patient has died.
- Books of remembrance were on display in the chapel and were completed each year with the names of the people that have died during the year. We saw a prayer book was available outside the chapel for anyone who wished to place a message or a prayer in the book.

- The ward manager told us that relatives received support from nursing staff during the time they spent with their relative. This included practical support such as comfort packs containing shampoo, toothbrush, tooth paste and towels along with food and refreshments.
- The pastoral care worker told us that no religious services took place weekly in the hospital chapel. A memorial service took place yearly to celebrate the lives of patients that had died during the year.
- Guidance was available on wards in the Bereavement box to support staff in providing care in accordance with people's religious and cultural preferences. (Management of the Deceased Patients Policy) Staff had access to specialist advice from the pastoral care worker where clarification was needed.

Access and flow

- Mount Alvernia accepted patients for end of life care both inside and outside normal working hours. The palliative care consultants were available, on call, to receive referrals at all times. The oncology manager told us that referrals were received with and without a cancer diagnosis. Data on the percentage of patients that were referred with a cancer and non-cancer diagnosis were not collected so we were unable to establish the mix of patients requiring end of life care.
- The palliative care consultants had their own caseload and reviewed patients daily. During the consultant reviews a member of the ward nursing team was present so that they would be able to feed back to family, if required. However, two nurses we spoke to did not attend the patient reviews. Weekend reviews took place if patients required specialist advice. The palliative care consultants worked together to ensure that patients would be reviewed daily even in times of absence via the consultants on call rota. Data was not available on how promptly patients were reviewed after being referred to the palliative care team.
- We were told that systems were in place to facilitate the rapid discharge of patients to their preferred place of care. (PPC) As there was often only a small window of opportunity to discharge the patient, the community teams were contacted along with the Surrey equipment store and district nurse ordering service to secure the required equipment at home. The palliative care nurse,

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with support from the palliative care consultants in complex cases, would ensure discharge care plans and 'just in case' medication was available to support the patient on their discharge.

- No data was available to confirm the percentage of patients that received their PPC and how rapid the discharge pathway was. We were told that the number of patients achieving their PPC was high and patients were discharged to their PPC within 48 hours if equipment was required.
- No Electronic Palliative Care Co-ordinating System (EPaaCS) was available across the NHS Clinical Commissioning Groups BMI Mount Alvernia sits within. One of the palliative care consultants told us that a group had been set up and they were a member of that group. This system would support better care by recording patients PPC and prevent inappropriate admissions to hospital.
- There was no End of Life care alert system in place to alert staff to a new admission but as very few patients were admitted to BMI Mount Alvernia for end of life care, the patients that were admitted were usually known to the oncology team and the admission was often expected. No systems were in place to support those patients that did not have a cancer diagnosis but as very few patients were admitted for end of life care new admissions were flagged up daily and referrals made to the palliative care nurse.

Learning from complaints and concerns

- We were shown one complaint relating to end of life care that had been received in the last year. We saw both the complainant's and the BMI Mount Alvernia's response. We saw that proper procedures were being followed and statements had been received from all healthcare staff concerned in delivering the care. BMI Mount Alvernia has a 3 stage system to manage complaints and we saw that this complaint had reached the second stage. Nursing staff on the ward were not aware of how far the complaint had progressed and no feedback had been given to staff.

Are end of life care services well-led?

Due to the small amount of patients that received end of life care at BMI Mount Alvernia no end of life Steering Committee was in place to develop, implement

improvements and discuss any risks associated with end of life care across the hospital. The Cancer Clinical Committee reviewed end of life policy; we saw that no palliative care consultants attended these meetings.

We saw no evidence of an action plan which set out the key areas the palliative care team would like to develop around end of life care in 2014/15.

There was good leadership of the team led by the palliative care consultants. We observed that the team worked well together which supported improved patients outcomes.

All the staff we spoke to talked positively about the service they provided for patients. Quality and patient experience was seen as a priority and everyone's responsibility; this was evident in the palliative care team's patient centred approach to care. Staff had a 'can do attitude', which meant that the staff were very patient centred and wanted to deliver good care through good training and support.

Vision and strategy for this service

- We found no evidence of an end of life strategy for BMI Mount Alvernia Hospital or a corporate BMI Healthcare Limited strategy. The hospital's vision around end of life care was unclear. We were told by one of the palliative care consultants and the oncology manager that they hoped to increase the number of patients who wished to be cared for at BMI Mount Alvernia as they approached the end of their life and the development of a new ward would allow patients to die within a specialist environment.
- We found no action plan had been developed which set out the key areas the palliative care team would like to develop around end of life care in 2014/15.
- BMI Mount Alvernia had developed a new personalised care plan which was due to be piloted across the hospital in November 2014 which contained brief guidance on the care of the dying to support staff.
- A more comprehensive policy around the care of the dying in areas such as the duties of the differing staff groups, withdrawal of active treatments, informing relatives and next of kin and organ donation would provide assurance that all patients were receiving the best possible care.

End of life care

Governance, risk management and quality measurement

- End of life care was discussed at the Cancer Clinical Steering Committee where policies such as the 'Management of Deceased patients' policy and the new personalised end of life care plan were approved. Policies were ratified by the Local Clinical Governance Group. The Cancer Clinical Steering Group membership did not include representation from the palliative care team.
- The palliative medicine consultants did not meet regularly to discuss any future developments in the end of life care service provision or any issues that develop related to end of life care. We were told by the palliative care consultant that any issues around end of life care were taken to the Medical Advisory Committee where they were discussed.

Leadership of service

- There was good leadership of the palliative team led by the palliative medicine consultants. The palliative care nurse told us that the palliative care consultants were very supportive and could be contacted by telephone or email if any concerns developed whilst they were not in the hospital. Ward nursing staff were also able to name members of the team and gave examples of their involvement in optimising patient care.
- All the staff we spoke with felt their line managers and senior managers were approachable and supportive. We were told by nursing staff on the wards that the chief operating officer and chief nurse were visible on the wards.

Culture within the service

- All staff we spoke with demonstrated a positive and proactive attitude towards caring for dying people. They described how important end of life care was and how their work impacted on the overall service.
- Across the wards we visited we were told by ward staff that the palliative care team worked well together with nursing and medical staff and there was obvious respect between not only the specialities but across disciplines.

Public and staff engagement

- BMI Mount Alvernia Hospital did not receive structured feedback on end of life care. No bereavement surveys were undertaken. The palliative care nurse told us that relatives would give feedback on the care when contact was made with the family after the bereavement; we saw no evidence of any feedback and how it was being used to develop the service.
- A recent Macmillan coffee morning was arranged by the palliative care nurse and took place with the hospital collecting money for charity. A promotional video was made during the coffee morning.

Innovation, improvement and sustainability

- We were told by the oncology manager that the plan was to develop an oncology/end of life care ward where the environment and atmosphere would lend itself towards patients and families experiencing a very holistic care setting with quiet rooms and family rooms.
- The oncology manager told us that a system was being developed to introduce a 'peer review' process into oncology and end of life care to measure the service against national standards. This would support the teams to benchmark their service against other services.

Outpatients and diagnostic imaging

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The Outpatients & Diagnostic Imaging departments at BMI Mount Alvernia Hospital saw a total of 41,633 patients in the financial year 2013/2014.

The Outpatients Department offers both Private and NHS Choose and Book appointments in Orthopaedics which include Hip & Knee Shoulder & Elbow, and Hand & Wrist Clinics. Pain Clinic, Gynaecological clinic, and Ear, Nose and Throat (E.N.T) clinics. With further private appointments for Cardiology, Audiology, Care of the Elderly, Colorectal surgery, Oncology, Physiotherapy, Women's Health, and Cosmetic Surgery.

The hospital also offers diagnostics and imaging services offering Computerised Tomography (CT), Magnetic Resonance Imaging (MRI), X-Ray, Positron emission tomography (PET CT), Digital Mammography, Ultrasound, and Bone Densitometry and nuclear medicine.

The hospital has 11 consulting rooms. The Imaging department offers imaging technology with a 128 slice CT scanner, a 1.5 Tesla MRI Scanner and general X-ray rooms. The hospital have ultrasound and osteoporosis screening services

The hospital has a Cardiology department whose list of diagnostic tests include: resting and stress electrocardiograms, echocardiograms, carotid artery ultrasound scanning and pharmacological stress testing for those patients who cannot exercise on a treadmill.

The Physiotherapy department offers an outpatient service. The department has an exercise area and five private treatment rooms. In addition to general physiotherapy

treatments they offer a sports injury service with computerised muscle testing, acupuncture, back and neck care, Women's Health including bladder dysfunction, domiciliary physiotherapy and occupational therapy.

Outpatients and diagnostic imaging

Summary of findings

The Outpatients Department (OPD) was a calm and comfortable environment for patients. Patients we spoke with on the days of our inspection were very pleased with the care that they had received in the department. They told us that their care had been unhurried, caring, and that they felt well informed about their choices and treatment.

In the medical imaging department we saw evidence of systematic audit both clinical and safety which was used to inform practice. However, although nurses in the Outpatients Department were recording incidents they were not receiving feedback following the investigation into these incidents and were therefore unable to evidence that they were learning or making service improvements as a result of incident reporting.

Staff were mostly up to date with mandatory training. However, training over and above mandatory requirements was not being taken up by nursing staff and the appraisals that we looked at did not outline requirements for learning and development.

Patients had been satisfied with the waiting time for their appointments following their initial referral. We were told that patients waited around two weeks for an appointment and this was confirmed by patients we spoke with. The department did not audit the referral to treatment waiting times for private patients although they were able to evidence that NHS patients who had been booked through 'Choose and Book' had all been seen within the Referral to Treatment (RTT) waiting time 18 week target.

Although waiting times in clinics were recorded by patients completing patient surveys the department did not audit patient waiting times. We were told that staff were expected to keep patients updated of any delays and offer them a beverage. We could see from patient questionnaire results that the department was improving in keeping patients informed about waiting times.

The OPD did not have any systems in place to assist patients with a diagnosis of dementia through the department. The department did not have literature or

communication tools available to assist patients with learning or other disabilities. Although the OPD could access translation services none of the staff were aware of this.

Staff were complimentary about their managers. Staff felt that the culture of the department had improved and they felt empowered to make positive changes to patient care. They also felt able to raise issues when they saw behaviours in other members of staff that did not support the department's values and vision.

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Incidents were being recorded by staff. However, staff were not made aware of the conclusion of any investigation into incidents that had occurred. Learning from incidents was not being discussed with staff.

The OPD met with required cleaning standards. However, a lack of cleaning schedules meant that the department was unable to evidence robust systems to ensure that these standards were maintained.

Although staff had received training in safeguarding, some staff were unable to describe their role in safeguarding.

Patient records were stored securely and were available to clinicians during clinic appointments.

Equipment was available and had been tested for safety in line with hospital policy.

There were enough nurses available to work in the department, and chaperones were always available when needed. Most nurses had completed their mandatory training in line with the hospital's policy.

Staff were aware of their role should a medical emergency occur within the department.

Incidents

- At the time of our inspection visit there had been no recent serious incidents (STEIS) or near events relating to the OPD.
- The OPD recorded incidents in two incident books, one which was for clinical incidents and the other for non-clinical incidents. This information was then sent to a manager who recorded the incidents on an electronic incident reporting tool.
- The staff that we spoke with told us that when incidents occurred in the department they would discuss them with the nurse in charge who would be responsible for completing the incident report paperwork.
- We looked at the types of incidents recorded. In some cases incidents recorded as non-clinical appeared to be clinical incidents. For example, one of the incidents recorded as non-clinical was an occasion where a nurse with the correct skills to dress a wound was unavailable to dress a leg ulcer that had been reviewed in clinic.

- We asked staff for examples of where learning from incidents had been used to influence practice. Staff were unable to give us examples of this.
- The department's sister was able to describe an example of where practice in the department had changed following an incident. As a result of a patient falling on some stairs new signage had been displayed to encourage patients and visitors to use the lift.
- In one case an incident report had been raised as a result of a patient becoming seriously unwell in the department which resulted in them being transferred to the local NHS hospital. We asked the staff involved in this incident if they had received any feedback and were told that they had not received any feedback following the reporting of this incident.
- The OPD sister told us that learning from incidents would be fed back to staff during departmental staff meetings. We looked at three meeting minutes and found that incidents had not been discussed at these meetings.

Cleanliness, infection control and hygiene

- Housekeeping staff were responsible for the general cleaning of the department. Staff were unaware of any auditing of the cleaning standards. We looked at an Infection control report from June 2014 which did not report on cleaning audits. However, we reviewed the cleanliness of the clinic rooms, public areas, visitor toilets, waiting areas and medical imaging department and found the standards of cleanliness met with required standards.
- There were hand hygiene and 'Bare below the Elbow' audits undertaken which demonstrated staff were compliant with best practice guidance. These were documented in infection control reports.
- Staff working in the OPD had a good understanding of responsibilities in relation to cleaning and infection prevention and control.
- Nursing staff were responsible for cleaning clinical equipment. We saw that there was a cleaning book in place where staff had recorded what equipment they had cleaned. However, this did not contain a schedule for cleaning clinical equipment.
- We were told that the nurses were responsible for cleaning clinical equipment and treatment rooms in the areas of OPD that they were working in. Clinic rooms did not have check lists. Staff told us that they felt assured that cleaning was done because they knew each other

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well and trusted that their colleagues had done their cleaning. Although the department was unable to provide documented assurance that clinical equipment was cleaned, all of the equipment we looked at was cleaned to the required standard.

- The green labels the hospital staff used to indicate that equipment had been cleaned were not always used and this risked leaving staff uncertain as to which equipment was cleaned and ready for use.
- All of staff we observed in the OPD were complying with the hospital policies and guidance on the use of personal protective equipment (PPE) and were bare below the elbows.
- We observed staff in the main OPD washing their hands in accordance with the guidance published in the Five Moments for Hand Hygiene published by the World Health Organisation (WHO 2014).
- We observed good practice in regard to proactive decontamination of transvaginal ultrasound probes. There was a system in place which demonstrated equipment cleaning schedules.
- The Nuclear Medicine department had recently undergone an environmental agency inspection of their waste management for radioactive waste. The report from the environmental agency was positive.
- The department had an Administration of Radioactive Substances Advisory Committee (ARSAC) licence holder (a registered medical practitioner responsible for the administration of radioactive substances to patients in a clinically appropriate system of work). This was documented within the radiation protection documentation which was held by the imaging manager.

Environment and equipment

- All mobile electrical equipment that we looked at had current Portable Appliance Testing (PAT) certification. Some equipment was missing a label to evidence that it had been PAT tested. We raised this during the inspection and were shown documented evidence that equipment had been tested. All equipment had required stickers in place before the end of our inspection.
- All equipment in the OPD had a process for updating and maintaining contracts with external providers for specialist equipment. A register was kept of the contract arrangements.

- We saw that the resuscitation trolley was checked and maintained ready for use in an emergency. However, records on one trolley showed that the anaphylaxis kit on the trolley was out of date. Through further investigation we found that the kit was in fact in date but that staff had not updated the records. This meant that staff checking the equipment had not been vigilant to this error in paperwork when they made their check of the resuscitation equipment.
- From observation in the OPD we saw that there was adequate equipment. Staff told us that there was not a problem with the quantity or quality of equipment and that replacements were provided, when necessary.
- The imaging department had a robust quality assurance programme in place for equipment. Checks were undertaken by the hospitals quality assurance radiographer on a rolling two week programme. We reviewed the quality assurance records for the past year and found that they were in line with The Institute of Physics and Engineering in Medicine (IPEM) recommendations.
- The quality assurance radiographer undertook regular reject analysis. The system reject local variation was sensitive and sufficient to reject new radiographic standard variation. The outcomes of this analysis were shared with the radiographic team in order to improve practice.
- The imaging department kept records of all equipment faults and recorded the actions taken to mend faulty items. Some specialist equipment required paperwork to evidence that the quality assurance checks had been completed following equipment repairs before use. We saw that the relevant documentation had been completed in line with legislation.
- Staff within the MRI department had a clear understanding of equipment labelling systems and their responsibilities with regard to these.
- The environment was well maintained and there were no obvious hazards such as worn flooring

Medicines

- Medicines were stored in locked cabinets within the department. All medicines were ordered by nursing staff through the hospitals pharmacy.
- All of medicines were administered by clinicians. Private prescription pads were stored in a locked cabinet. When

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clinicians wrote patient prescriptions the OPD kept a log which identified the patient, the doctor prescribing and the serial number of the prescription sheet used. This ensured the safe use of prescription pads.

- Contrast agents for CT and MRI scanning were stored appropriately. We inspected contrast agents within the drug cupboard and these were in date.

Records

- The hospital held its own patient records in a records library on site. NHS patient records were obtained from the local NHS hospital when required and returned following their use. The hospital ran a van daily to the local NHS hospital in order to obtain and return medical records.
- During our inspection we saw that health records and patients personal information was stored securely in all areas of OPD.
- We were told by all of the staff that we spoke with that the OPD never ran clinics without records and that obtaining records for clinics never caused an issue in the department.

Safeguarding

- OPD staff were encouraged to contact the safeguarding lead if they had any concerns about patients. Staff assured us they knew who the hospital safeguarding lead was and how to contact them.
- Most staff working in the OPD had completed the mandatory safeguarding training. Some staff were able to talk to us about the insight and knowledge they had gained from this training. Some staff however demonstrated a poor understanding of their role and responsibilities with regard to safeguarding. Staff were also able to locate the hospital safeguarding policies when asked.
- Staff in the OPD were unable to give us examples of when staff in the department had followed the hospital safeguarding policy and made an appropriate referral. We were told that this was because staff had never had to make a referral.
- The hospital had a chaperone policy that was followed by the OPD staff. Staff also maintained a chaperone register which demonstrated where and when chaperones had been required.
- Radiologists were required to submit valid Disclosure and Barring Service (DBS) certificates as part of their practising privileges arrangements.

Mandatory training

- The hospital held a training matrix electronically which stored staffs attendance at mandatory training and prompted staff when they needed to update their mandatory training.
- Most staff were up to date with their mandatory training.
- Staff that we spoke with all felt that their training was good and provided them with the information that they required to perform their roles safely.
- Radiologists attended mandatory training at the local NHS hospital where they also worked. We were told that there was a managerial arrangement in place that this training is shared with BMI Mount Alvernia. Mandatory training that had been undertaken was detailed in people's appraisals.

Assessing and responding to patient risk

- Staff attended Basic Life Support training annually as a part of their mandatory training. Echo Technicians and nurses working in the cardiac clinic rooms had also taken attended training in Advanced Life Support.
- Staff we spoke with were aware of their role in a medical emergency.
- We were shown an example of a patient who had become acutely unwell during a clinic appointment. The cardio-respiratory resuscitation team had been called to assist the patient who had been transferred to a local NHS hospital.
- We saw that the National Early Warning Scores (NEWS) scores used in the rest of the hospital were not used in this instance. The nurse was able to show us how they had documented the patient's well-being on the Electrocardiogram (ECG) along with a clear record of how the emergency was managed in the patient records. We were told that the OPD department did not use NEWS scores to assess the deterioration of a patient.
- We observed the system in place for prevention of contrast induced nephropathy. The computerised tomography (CT) and Magnetic resonance imaging (MRI) scanning units had a machine and system of work that enabled radiographic staff to test blood samples from patients before contrast injection to ensure that patients at risk of AKI did not inappropriately receive contrast agent. This system significantly reduced patient risk.

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Nursing staffing

- The OPD ran with two nurses for each geographical area of the department.
- All of the staff that we spoke with told us that this was adequate numbers of staff and that they were always able to provide a chaperone when needed.
- Nursing staff appeared calm and unrushed in their work.
- The department never used agency staff and covered all of the required shifts with their own staff. Records we viewed confirmed this.
- The cardiology clinics were covered by a cardiology nurse specialist with the required skills to work in that area.
- The radiographic and clerical staffing levels we observed were appropriate for the volume of work being undertaken at that time. We spoke with staff who were comfortable with the staffing levels within the department. The MRI department had two senior specialist radiographers in post and one who was training.

Medical staffing

- All of the staff we spoke with told us that they had very good relationships with clinicians.
- The OPD managers told us that they did not have any issues with clinicians not arriving for clinic. They said that on the very rare occasion that a clinic had to be cancelled at the last minute the OPD would ring every patient and stop them from attending and rebook them into a new appointment.
- Consultant Radiologists are not employed within the department but had a contract with the hospital to provide services on a sessional basis.
- We spoke with one consultant during our inspection who told us that they were happy with the way that clinics were arranged and the level of support they received from nursing staff. They confirmed that patient health records were always available at appointments.
- The recent patient survey results showed that 100% of respondents felt that their consultant had given them all the time and attention that they needed, and had explained their treatment in a way that they understood.

Major incident awareness and training

- The hospital had a Business Continuity Management Plan which had been approved by The Quality and Risk Steering Group. The plan established a strategic and operational framework to ensure the hospitals resilience to a disruption, interruption or loss of its services.
- The plan covered major incidents such as loss of electricity, loss of frontline system for patient information, loss of information technology systems and internet access, loss of staffing, and loss of water supply.

Are outpatients and diagnostic imaging services effective?

We saw evidence that the WHO surgical safety checklist for radiological intervention was being used for interventional procedures. However, this was not being used in the ultrasound department. We were told that they did not use it in this department because of resistance from the consultants in that department. The WHO checklist should be used for all interventional procedures in radiology.

National Diagnostic Reference Levels (DRL's) were available together with the local rules master documentation. However these were not displayed for staff reference in x-ray, fluoroscopic rooms and CT.

The radiology service manager monitored the radiology turnaround times for reports. This data was shared with radiologists.

Nursing staff were expected to achieve competencies within the area they worked in. However, we found that these had not been completed by all staff.

We found that nursing staff were not always encouraged to develop and learn through the yearly staff appraisal system.

We found that the environment was pleasant with plenty of comfortable seating for patients, and clear signage. Parking however was a problem as the car park did not have sufficient spaces for patients and visitors to park their cars.

Although staff had received training in Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards nursing staff were unable to demonstrate a consistent and sound understanding of the principles and legislation.

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Evidence-based care and treatment

- Radiation protection policies, including Local Rules, were available within the central records and also within clinical areas. This included radiation risk assessments. The radiation safety supervisor is the Imaging Service Manager. We reviewed her training record and notes from recent Radiation Protection Committee meetings which were in date and order.
- In medical imaging a gap analysis of regulatory requirements against current practice was undertaken by a quality lead for BMI Healthcare Ltd. This was then reviewed with the radiology manager. We saw the documentation for this summarising the current position across the regulatory requirements.
- We saw evidence that the WHO surgical safety checklist for radiological intervention was being used for interventional procedures. Although this was not being used in the ultrasound department. We were told that they did not use it in this department because of resistance from the consultants in that department. The WHO checklist should be used for all interventional procedures in radiology.
- A master copy of the Local Rules for radiation protection was available within the Imaging Department. Abridged versions were available within the clinical rooms and on mobile x-ray equipment. The document was in order and in date.
- We saw evidence that staff had read the Local Rules by viewing a signature sheet.
- National Diagnostic Reference Levels (DRL's) were available together with the Local Rules master documentation. Additionally local DRL's had been developed and were listed within the same documentation. DRLs should be established for common examinations across all modalities including CT scanning.
- Department managers might want to consider the potential benefits of improving the awareness of their staff of patient dose, while at the same time reinforcing their understanding of which patient doses are considered to be excessive, and potentially may need reporting to IR(ME)R authorities.
- DRLs should be displayed within the x-ray and fluoroscopic rooms and CT together with a locally determined action levels (derived from the DRLs and with input from the medical physics expert). Advice from senior staff or a Medical Physics Expert (MPE) could be

sought in the event of the action levels being exceeded. This would enable operators to be familiar with the DRL's and better understand what to do in the event of a high dose reading for an individual patient which might be a potential incident.

- We saw that staff followed the patient identification checks policy when checking patients into the department at reception.

Pain relief

- We were told that nurses did not administer analgesia to patients in the department.
- The sister told us that the nurses in the department did not have anything to do with patient's pain as, "We don't know what's wrong with the patients coming to clinic, and the consultants hold their records, so we wouldn't know anything about their pain".

Patient outcomes

- The radiology service manager monitored the radiology turnaround times for reports. This data was shared with radiologists. The majority of reports were turned around within one day. The exception to this was where a clinician would request a particular radiologist to undertake the reporting as this could take longer.
- Discrepancy meetings are held at the local NHS hospital where most of the radiologists working at Mount Alvernia attend from. This was a requirement of the consultant contract with BMI Healthcare Ltd. A Discrepancy Meeting is an educational meeting whereby consultant radiologists discuss cases where the reports were subsequently found to either not match exactly with the patient's condition discovered at later surgery. Discrepancy Meetings are good clinical practice and education for radiologists in a lessons learned continuous cycle of improvement to benefit future patient outcomes and to enhance reporting skills. It's a form of continuous professional development and service improvement.

Competent staff

- Nurses within OPD were expected to complete competency assessments. We were shown an example of the Health Care Assistants (HCA) competencies. There were 12 competencies for consulting room HCAs which included policies and procedures, infection control, wound care, chaperoning, suture removal, and joint aspirations.

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- We were told that staff learning needs would be assessed during their annual performance review and development plan.
- The department's sister told us that the nurses in the department were 'not interested' in doing any extended learning on top of their mandatory training. They said that this was because staff had been working in the department for a number of years and were mostly part time workers.
- We looked at three nursing staff members recent annual performance review and development plan. None of the plans had any training needs identified over and above mandatory training.
- One HCA plan for a member of staff who had worked in the department for a long time said that they did not wish to participate in HCA competency assessments as they were not working long enough hours in the department to complete them. There was no consideration in the plan of how the HCA may be able to achieve some or all of the competencies within the limitations of their working schedule.
- The service manager told us that in order to increase the skills and knowledge of staff within the department they planned to rotate staff into other departments. By doing this they hoped to increase staffs skills and knowledge by them working alongside staff with a more varied skills and knowledge base.
- We were told that the radiology department did not have a departmental induction programme for consultant radiologists that included orientation on the department's equipment. One member of staff told us that a colleague would go through the controls with them when a piece of equipment was new to them; however, they said that this was not recorded formally. We reviewed more recent consultant radiologist induction and training records and these were found to be in order.
- Consultant radiology staff received appraisals and induction at the local NHS hospital where most of the radiologists working at Mount Alvernia attend from. This was a requirement of the consultant contract with BMI Healthcare Ltd.
- In the MRI department we found that staff had completed training and had a good understanding of the dangers of MRI scanning. Staff were able to

articulate the requirements for safety and hazard warning. Staffs were involved in the training programme for domestic staff to ensure safe entry within the MRI environment.

Multidisciplinary working

- The imaging department held a data base which outlined the non-medical staff who were able to make referrals for radiology for example, physiotherapists and podiatrists. Non-medical referrers must have undertaken Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) training. We were able to see documented evidence of this training for the non-medical referrers on the list.
- We saw examples of multidisciplinary working within the OPD. For example, physiotherapists worked alongside clinicians in the musculoskeletal clinics.

Seven-day services

- Clinics ran between 8am and 9pm Monday to Friday. Staff cover was provided between these times.
- Blood samples were taken from patients in the pathology laboratory which was open 8am -5pm. Outside of these hours nursing staff who had completed the required venepuncture competencies performed this task.

Access to information

- The radiology service used a picture archiving and communication system (PACS) image which could be viewed via the intranet on computer terminals in any BMI hospitals and via a remote access facility. Report results were available from the radiology management computer system where the report was typed.
- Health records were stored on site or in the case of NHS patients were collected and returned to the local NHS hospital.
- Consultants were able to access results such as blood tests through the electronic system. All clinic rooms had computer terminals and all staff needing to access these systems had required passwords and training to do so.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff in the radiology department were able to demonstrate their understanding of the mental capacity

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act by demonstrating how they had raised concerns through safeguarding when they felt that a patient may not have had capacity to consent to a procedure that they were due to undergo.

- Nursing staff had received training in Mental Capacity Act 2005 and Deprivation of Liberty Safeguards however on discussion they were inconsistent on their knowledge and how they would apply it.
- None of the nursing staff or the sister that we spoke with were able to give examples of when they had raised concerns around a patient's capacity.

Are outpatients and diagnostic imaging services caring?

One of the strengths of the service in the OPD was the quality of interaction between staff and patients.

We saw very caring and compassionate care delivered by all grades and disciplines of staff working at the hospital. Staff offered assistance without waiting to be asked.

Patients were treated with dignity and respect by staff at the hospital.

Compassionate care

- One of the strengths of the service in the OPD was the quality of interaction between staff and patients.
- We watched staff assisting people around the different OPD areas. Staff approached people rather than waiting for requests for assistance, asking people if they needed assistance and pointing people in the right direction.
- We noticed that staff squatted or sat so that they were at the same level as the person they were speaking to in the waiting areas and maintained eye contact when conversing.
- We observed staff interactions with patients as being friendly and welcoming. We saw staff stopped in clinics to greet patients that they knew and ask after their well-being. We observed that patients that attended clinic regularly had built relationships with the staff that worked there.
- Staff were expected to keep patients informed of waiting times and the reasons for delays. We observed that during our inspection the majority of clinics were running on time.
- All of the patients we spoke with were complimentary about the way the staff had treated them. A patient

waiting for an ENT appointment said, "The staff are lovely, I had a very friendly welcoming reception". Another patient said, "The atmosphere here is lovely, you don't get that anywhere else, I would give them a 10/10".

- Patients also told us that they had been treated with dignity in the department. One patient told us, "I come here for a review every three to four months; I can't fault the hospital at all. They are very good helpful and caring and always treat me with respect". Another patient said, "This is a different league, they have the time to give you care and attention".
- Reception staff told us that when patients arrived for appointments their name, date of birth, address, and telephone number were checked with them at this desk. The receptionist told us that as they checked patients personal information they ensured that other people stood back so that they could not be overheard. This showed that staff had considered ways to ensure that patient's personal information was protected.
- We saw that staff always knocked and waited for permission before entering clinic rooms.
- We saw that chaperones were always available. Notices informing patients that chaperones were available were on display in waiting areas. One patient who required a chaperone said, "I always get my chaperone, I got called straight in today".
- We were shown a complimentary letter from a patient's husband in regard to prompt, kind and caring service from the Imaging Clinical Manager in regard to an emotionally distressed patient.

Understanding and involvement of patients and those close to them

- We spent time in the department observing interactions between staff and patients.
- All of the patients we spoke with told us that their care was discussed with them in detail, and in a manner that they were able to understand. Patients told us that they felt included in decisions that were made about their care and that their preferences were taken into account.
- There were no patient leaflets in waiting areas. Patients told us that they had not been given any information leaflets about the hospital prior to their appointments. There were no information displays explaining to people how they could complain. Although there were

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complaints leaflets available they were not displayed. When we asked for a complaints leaflet staff only had a vague recollection that the department had one and it took them some time to locate it for us.

- Patients would receive a copy of the letter that was sent to their General Practitioner (GP) this outlined what had been discussed at their appointment and any treatment options. Patients that we spoke with confirmed that they had received a copy of this letter.
- We observed consultants behaving in a friendly and respectful manner towards the patients in their care. Most of the consultants came out to the waiting area to greet and show patients to their treatment rooms.

Emotional support

- The OPD was a calm and well-ordered environment. We saw nurses constantly checking that patients were comfortable and happy. One patient said, “The care here is brilliant. I never have to wait long for my appointment. The doctor explains everything, I always feel fully informed and aware but you never feel like you can’t ask. When you do ask you always get a good response.”
- We saw an example of staff supporting a frail elderly patient with compassion and dignity. The patient was very tired from their journey to the department and staff ensured that they were supported during their stay in the department.

Are outpatients and diagnostic imaging services responsive?

The department did not offer services to assist patients with a diagnosis of dementia. They also did not have communication tools available or leaflets in easy read formats to assist people with learning disabilities or communication problems.

The complaints procedure was not displayed in the OPD. Staff were unable to provide evidence that they had received feedback about complaints about the department or had changed practice as a result of a complaint.

Patients were able to access appointments in a timely manner. Patients told us that they were very satisfied with the time it took for their appointment to be arranged following referral to the service.

GP letters were being sent in a timely manner. However, the hospital did not have a policy which formalised the length of time this was expected to take.

The environment was comfortable and well signposted. However parking was an issue due to a lack of parking spaces available on site.

Service planning and delivery to meet the needs of local people

- Both patients and staff told us that car parking was a problem on the hospital site. We were told that although there was a bus stop close by buses were infrequent.
- There was a free hospital car park but it did not have enough spaces in it to manage the amount of cars requiring a parking space. Patients and visitors were able to park in the roads around the hospital but most of this was metered parking. The hospital was also in a hilly area which could cause problems for people with mobility problems who were forced to park any distance from the hospital site.
- The main reception desk was behind glass and separated by glass panels. The staff behind these desks were friendly and welcoming and the glass allowed for relatively private conversations to take place.
- We did not see any queues at these desks and staff and patients told us that staff in the reception area of the hospital were always available to give directions when required.
- The waiting areas were comfortable and uncrowded. There was a coffee shop in the main lobby where patients and their family could buy themselves food and drink if they wished.
- We were told that if appointments were delayed staff would give patients free beverages of their choice.
- Signage around the OPD department was clear. We saw staff stopping to ask patients and visitors if they required assistance or directions if they saw them appearing to be lost.

Access and flow

- Access to appointments was fast and patients told us that they were very satisfied with the amount of time it had taken for them to be seen following referral from their GP.
- We were told that on average private patients waited around two weeks to be seen in the OPD from their

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referral date. The department did not audit the waiting times of their private patients so we were unable to verify this. However, all of the patients we spoke with had been seen within two weeks of referral.

- The hospital saw NHS patients using the Choose and Book referral system. Data collected for these patients showed that they had met with 18 week referral targets every month since April 2014 with 100% of patients being seen on both admitted and non-admitted patient pathways between April 2014 and September 2014.
- People entering the OPD service accessed this in different ways. Some appointments were made by medical secretaries, some through central bookings, and some NHS appointments through the 'Choose and Book' system. This created some issues for the service in terms of consistency, as letters going out to patients did not always fit a standard template so some patients received more details than others about their appointments and the costs involved where applicable.
- In order to address this issue the service manager held Medical Secretary Forum meetings every other month to discuss a consistent approach to patient care and processes.
- We were told that the service did not have many issues with patients not attending their appointments. We were told that this was because there are financial penalties for patients who miss their appointment. We saw that the service had a target of 5% of patients not attending appointment. With the exception of one month (June 13.3%) the service had fallen below this target every month since April 2014
- In order to manage people not attending appointments an opt in mobile phone text reminder service was used in the hospital
- The department did not audit patient waiting times. Once people arrived in the department we were told that they mostly got seen promptly. Patients that we spoke with confirmed this. Staff told us that when clinics were delayed they would keep patients updated on waiting times and offer them a complimentary beverage.
- The results of the latest patient survey showed that 75% of patients surveyed over the past year had been kept informed of waiting times when clinics were delayed. These figures had improved dramatically in August 89.5% and September 92.3%.
- The recent patient survey results which asked patients how long they had waited for their appointment showed

that 70.3% of people were seen on time, 16.2% had a 10 minute wait, 5.4% waited 15 minutes, 5.4% waited 20 minutes and 2.7% waited 30 minutes. No patients waited longer than 30 minutes for their appointment.

- GP Letters following appointments were typed by medical secretaries. The medical secretaries that we spoke with told us that this was done within a day or two of the appointment. Medical secretaries told us that there was no policy which directed them on the amount of time GP letters were sent in. The letters being sent at the time of our inspection were all within three days of the patient's appointment.

Meeting people's individual needs

- Although the hospital did have access to translation services, with the exception of the service manager, none of the nursing staff or managers that we spoke with were aware that the hospital had access to translation services. The sister told us, "If it was a problem I would probably call the matron and see if there was a member of staff working who spoke the language we needed".
- The OPD did not have any systems in place to assist people with a diagnosis of dementia through the service. They did not use any systems to identify patients with dementia and offered them no assistance such as moving them to the front of queues or offering them private spaces to wait.
- The sister told us that staff would have no idea which patients coming into the hospital had dementia as the nurses did not know why patients were being seen.
- However, because of the high levels of support offered to patients all staff pointed out to us that if someone did need extra help there were always staff on hand to offer assistance.
- The nurses and sister were unable to describe to us ways in which they would support a person with learning disabilities. We were told that the OPD had no literature available in easy read formats.
- Staff were unable to communicate with people with communication difficulties with communication tools as these were not available in the department for staff to use. Again the sister told us that they would be unaware if a patient was coming to the department with a disability as nurses did not know why patients had been brought to see the consultant.
- The sister told us that if a patient required particular care due to cultural or religious preferences then it

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would be the patient's role to raise this when they booked their appointment. Once the department was aware of this we were told they would accommodate the request. The sister was unable to give us examples of where this had happened.

Learning from complaints and concerns

- Staff that we spoke with were unable to give us examples of complaints received by the department or of where practice in the department had changed following a complaint.
- The sister told us that if there was any learning from complaints this would be fed back to staff during staff meetings.
- We looked at staff meeting minutes and saw that complaints had not been discussed during these meetings.
- We looked at a summary of complaints made to the service and found that the majority of these complaints were around financial costs and charges.
- We were given the Hospital responses to three complaints. We saw that the complaint had been investigated and responded to within the required timeframe.
- Complaint responses in one case (made by the consultant) appeared to be centred around apportioning blame rather than apologising for the mistakes that had been made that had inconvenienced the patient.
- Patients that we spoke with were unaware of the complaints process. The complaints procedure was not displayed in the OPD.

Are outpatients and diagnostic imaging services well-led?

Staff were complimentary about their managers and felt that they were well led and supported in their work.

Staff were aware of the department's vision and were consistent across all staff groups in the key messages of the vision.

Staff felt empowered to make changes to the service, and to challenge people that they felt were not demonstrating the department's values and vision.

There was good communication amount the department managers. However, this was not always fed down to the staff who did not get feedback following incidents or complaints about the service.

Vision and strategy for this service

- Hospital staff knew about the 'BMI vision', some staff needed to find it on their computer screens in order to tell us what it was but they were able to do this without any issues.
- All of the staff we spoke with were able to tell us how they work in a way that promotes the BMI vision. For example, most of the staff we spoke with told us that they strived to improve patient experiences through the service in order to improve patient survey results. The service manager told us that their main aim was to improve patient survey results across the service.
- We found that the messages in the management team were reflected in what the staff working throughout the hospital were telling us throughout the inspection.
- Staff were very enthusiastic about improving patients experience. However we found nursing staff less engaged with improving clinical quality through learning and development.
- The service manager was monitoring the delivery of the strategy through constant scrutiny of patient survey results and Friends and Family testing which had just been introduced to the department.

Governance, risk management and quality measurement

- The department held operational meetings for department leads where they discussed quality, financial performance, and business development along with feedback from other hospital committees. During this meeting they discussed complaints, patient satisfaction scores, serious incidents (STEIS) and never events relating to the OPD.
- However, the robustness of the management arrangements in OPD for patient risks was ineffective because staff were not receiving feedback from the incidents that they were recording. This meant that the department was not improving services as a result of learning from incidents.
- In the medical imaging department we saw evidence of systematic audit both clinical and safety which was used to inform practice.

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- Radiation protection advice for x-ray and nuclear medicine was provided by the Head of Regional Radiation Protection service. We were shown bi-annual reports and local rules for radiation protection which all met with required legislation.
- In the medical imaging department an audit of contrast agent reactions in MRI had led to a triangulation of adverse events with other BMI hospitals and resulted in a BMI group approach. This meant that by reporting and auditing adverse events the service was able to make improvements in patient safety.

Leadership of service

- The service managers office was located in the main reception area of the hospital and had glass wall and doors which meant that they were very visible to passing patients, visitors and staff members. They told us that because they were able to hear and see visitors to the hospital and staff they were able to hear and see when patients or staff were in need of assistance and were able to approach them. We saw this happening during our inspection.
- Each morning the service manager gathered their senior staff for an informal meeting. During this meeting they discussed the day ahead and any challenges. This meeting included discussing staffing issues.
- Staff were complimentary about the changes that had been made in the leadership of the service. Staff felt that their managers were approachable. Staff told us that the care that was given to patients had improved as it had become a top priority to their managers.
- The medical Imaging manager was visible and described as 'the go to person' for all staff in the department. They demonstrated a clear grasp of the service needs and priorities and demonstrated good and clear leadership for staff. Staff in the medical imaging department told us that they felt supported by their manager.
- The Hospital Imaging Manager sat on the BMI Imaging Clinical Steering Group and influenced clinical best practice across BMI Healthcare as a result of this involvement.
- Staff that we spoke with were complimentary about the Executive Director. They all felt that he was approachable and supportive of them. The service manager told us about the level of support that had been offered to them by the Executive director with their own personal development.

Culture within the service

- Staff and managers all told us that they felt that the culture of the service had changed significantly since a previous Care Quality Commission inspection made following concerns being raised with the commission. Staff told us that they had gone through a difficult time following the inspection but that the changes that had come about following the inspection had been positive.
- We were given many examples of where staff had felt empowered to make changes to the service which directly improved patient experience and care. The service manager told us that staff challenged consultants when they saw practice that they felt may be wrong. They said this was something that "would have never happened in the past".
- The sister gave an example of how they had dealt with a situation where a consultant had been rude to a staff member. Their challenge demonstrated that staff felt supported to make a stand when they felt a colleague was not behaving in a way that reflected the values of the organisation.

Public and staff engagement

- The OPD collected the views of people using the service through a continuous rolling patient survey. The results of this survey were collated and reported on quarterly.
- The survey showed that in the imaging x-ray department they had received 53 responses from patients who rated their care at 100% with 100% of people saying they would recommend the hospital to other people.
- The OPD department had collected 37 responses with 36 of these respondents saying that they were 100% satisfied with the service that they had received and would recommend the service others.
- The department was just starting to do Friends and Family Testing but had not yet been able to gather the results of this due to it being in its early stages.
- All of the staff we spoke with were aware of the patient satisfaction surveys and were able to discuss how the department was doing in these survey results.

Innovation, improvement and sustainability

- The service manager described how they encouraged staff innovation. They said that where a problem was identified that they would push this back to staff and encourage them to find ways to make improvements to

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the service. They gave us an example of this where staff had devised the chaperone register in order to monitor the demand and availability of chaperones for patients who required them.

- We saw some good examples of staff innovation in the imaging department where staff had worked hard to establish a robust system around the cleaning and visible assurance of cleanliness of the vaginal probes.

- Staff we spoke with told us that if they had an idea that would improve services they would raise this with their manager. They all said that they would feel confident that their ideas would be listened too.

Outstanding practice and areas for improvement

Outstanding practice

The physiotherapy service provided was excellent within the constraints of a private healthcare setting. The department had contracts to work in the community treating NHS patients in GP practices and providing easy access to physiotherapy services within the hospital through self-referral, GP referral and consultant referral. They worked closely with the wider multidisciplinary team to reduce the risk of falls and to optimise rehabilitation for post-operative patients. The constraints were around consultants preferring to do some work that within the NHS is undertaken by physiotherapists because of the payment arrangements. This limited the opportunity to fully develop physiotherapy staff by allowing them to undertake extended roles.

We saw that the hospital had systems and processes in place that supported staff in providing a good service. For example allocating time for post discharge telephone calls to check that all was well once the patient returned home and having adequate staff on duty which gave them time to interact with patients and their families. Patients and their families were cared for by kind and compassionate staff who went out of their way to support them.

Areas for improvement

Action the hospital **MUST** take to improve

- The provider must ensure that CQC is notified without delay if a patient receives an injury; Which has caused impairment, changes to the structure of a patient's body, caused prolonged pain, psychological harm or has shortened the patient's life expectancy; Or which requires treatment in order to prevent death or serious injury, any allegation of abuse or incident investigated by the police.
- The provider must consider feedback mechanisms following the reporting of incidents, and should review the arrangements for monitoring the implementation and efficacy of mitigating actions.
- The provider must amend the Statement of Purpose to ensure it reflects the service provided and the range of patients' needs the service can meet.
- The provider must review the process for monitoring compliance with practicing privileges.
- The provider must consider the formal arrangements required to support patients living with dementia or learning difficulties. This must include appropriate training and monitoring processes for the assessment of people who lack capacity to consent to a Do Not Attempt Cardio-Pulmonary Resuscitation order.

Action the hospital **SHOULD** take to improve

- The provider might wish to develop clear antibiotic prescribing protocols as we were told, "Consultants like to do their own thing". This increased the risk of resistant bacteria developing which could affect the wider community as well as the patients at BMI Mount Alvernia.
- The provider should review the use of the NEWS to ensure that hospital protocols are followed and that emerging concerns are appropriately escalated.
- The provider should consider how it combines development plans and projects for oncology services into a coherent, strategic whole.
- A policy on Duty of candour is implemented with respect to the recently introduced legislation.
- There are better systems to audit and monitor compliance with guidelines and patient outcomes.
- The provider should ensure that staff follow the BMI incident reporting policy and that there is learning and feedback given from each incident to staff to reduce the risk of them happening again.
- The provider should ensure that where risk assessments identify a patient at risk from harm appropriate action is taken and recorded in the medical and care records.

Outstanding practice and areas for improvement

- The provider should ensure that the records relating to the safe use of lasers in theatre are updated and provide assurance that the consultants are trained in their use and the equipment is appropriately monitored following best practice guidelines.
- The provider should ensure that they have clear admission guidelines in place adhered to in practice to ensure the hospital only admits patients they are able to provide a safe level of care to.
- The provider should consider the practice in the Ambulatory Care Unit for caring for patients undertaking “clean” and “dirty” procedures in the same space.
- The provider should consider reviewing how complaints are managed to ensure that all complaints are captured and recorded, and then following investigation any action taken is feedback to staff to enable learning and prevent future reoccurrences’.
- A more comprehensive policy around the care of the dying in areas such as the duties of the differing staff groups, withdrawal of active treatments, informing relatives and next of kin and organ donation would provide assurance that all patients were receiving the best possible care.
- The provider should review the handover arrangements when consultants are absent to ensure they are compliant with its practicing privileges agreement.
- Ward staff should be provided with training in the care of dying patients.
- The provider should maximise the opportunities to be more proactive in encouraging the development of all staff through regular appraisals and completion of competencies.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider has not always notified CQC of serious incidents that have occurred. The provider must ensure that CQC is notified without delay if a patient receives an injury; Which has caused impairment, changes to the structure of a patient's body, caused prolonged pain, psychological harm or has shortened the patient's life expectancy; Or which requires treatment in order to prevent death or serious injury, any allegation of abuse or incident investigated by the police. Regulation 18 (2) HSCA 2008 (Regulated Activities) Regulations 2010.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose The service does not provide level two critical care. The provider must amend the Statement of Purpose to ensure that it sets out the kinds of services provided for the purposes of the carrying on of the regulated activities and the range of service users' needs which those services are intended to meet it reflects the service provided and the range of patients' needs the service can meet. (Regulation 12) Care Quality Commission (Registration) Regulations 2009HSCA 2008 (Regulated Activities) Regulations 2010.

Regulated activity	Regulation
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This section is primarily information for the provider

Compliance actions

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation 18 CQC (Registration) Regulations 2009

Notification of other incidents

Mental capacity assessments were not always completed and recorded, when necessary such as when considering DNACPR orders.

The provider must consider the formal arrangements required to support patients living with dementia or learning difficulties. This must include appropriate training and monitoring processes for the assessment of people who lack capacity to consent.

Regulation 18 Health and Social care Act 2008(Regulated Activities) Regulations 2010

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers

The investigation and reporting of incidents and systems for organisational and local learning was insufficiently robust. The provider must consider feedback mechanisms following the reporting of incidents, and should review the arrangements for monitoring the implementation and efficacy of mitigating actions.

Regulation 10 Health and Social care Act 2008(Regulated Activities) Regulations 2010