

BMI Healthcare Limited

# BMI The Harbour 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 and a review of all information available to CQC including information given to us from patients, the public and other organisations.

### Ratings

Overall rating for this hospital	Good 
Medical care	Good 
Surgery	Good 
Outpatients and diagnostic imaging	Requires improvement 

# Summary of findings

## Letter from the Chief Inspector of Hospitals

The Harbour Hospital, established in 1996, is one of 62 hospitals and treatment centres provided by BMI Healthcare Ltd.

The hospital provides a range of medical, surgical and diagnostic services. The on-site facilities include an endoscopy suite, three operating theatres (two with laminar airflow), two treatment rooms, and eight consulting rooms supported by an imaging department offering X-ray and ultrasound. The hospital offers physiotherapy treatment as an inpatient and outpatient service in its own dedicated and fully equipped physiotherapy suite. Alliance Medical Ltd, a separate organisation, provides MRI and CT scanning facilities to patients in an adjacent building. These services were not included in this inspection.

Services offered include general surgery, orthopaedics, cosmetic surgery, refractive eye surgery, gynaecology, ophthalmology, oral and maxillofacial surgery, general medicine, oncology, dermatology, physiotherapy, endoscopy and diagnostic imaging. Most patients are self-pay or use private medical insurance. Orthopaedic and ophthalmology services are available to NHS patients through NHS e-Referral Service.

The announced inspection took place between 2 and 4 September, followed by a routine unannounced visit on 17 September.

This was a comprehensive planned inspection of all core services provided at the hospital: medicine, surgery, outpatient and diagnostic imaging. There is no critical care facility or emergency department at the hospital and no maternity services. There are no services for patients under 16 years, a few outpatients are aged 16 -18 years, and the majority of patients are adults

The Harbour Hospital was selected for a comprehensive inspection as part of our routine inspection programme. The inspection was conducted using the Care Quality Commission's new inspection methodology.

Our key findings were as follows:

### **Are services safe at this hospital?**

- Patients were protected from the risk of abuse and avoidable harm across medical, surgical services and diagnostic services, but safety of some outpatient services required improvement.
- Staff reported incidents, and openness about safety was encouraged. Incidents were monitored and reviewed in most services and staff gave examples of learning from incidents. There were inconsistencies across some departments with regard to receiving feedback and learning from incidents. Outpatient department (OPD) staff were not assured reported incidents or risks were taken seriously by senior management.
- There were infection control risks in outpatients due to the poor fabric of the treatment room, which limited effective cleaning to reduce risk of cross infection.
- The plumes from a piece of equipment used in outpatients posed a risk to patients when used in a room without an extractor fan.
- There were systems for monitoring infection control risks in the environment across all other services and action taken to address identified shortfalls. Clinical areas were visibly clean and tidy. Infection control practices were followed by staff and this was regularly monitored
- Although most staff understood the principles of duty of candour regulations, they were less confident in applying the practical elements of the legislation. This included senior managers.
- Equipment was maintained and tested, in line with manufacturer's guidance. There were appropriate checks and maintenance on the hospital building and plant.

# Summary of findings

- Medicines were stored securely and managed correctly
- There was regular monitoring of patient records for accuracy and completeness. They were securely stored and available when needed.
- Staff undertook appropriate mandatory training for their role and electronic records showed more than 90% compliance across the hospital. However, some staff reported difficulties in accessing practical mandatory training sessions due to workloads and cancelled training sessions.
- In medical, surgical and diagnostic services, staffing levels and skill mix were assessed and managed to meet the needs of patients. In OPD there were occasions when one nurse or two healthcare assistants were on duty in the department, which posed a potential risks to patient safety. There were no assessments completed to identify the level of risk to patients or staff when this occurred.
- There was sufficient medical cover provided by resident medical officers (RMOs) who covered the hospital 24 hours a day for all specialities. Consultants were available daily and provided on call cover and advice out of hours if necessary.
- There were suitable arrangements for handover between shifts, and all staff attended the daily 'huddle' for a brief update on patients and relevant information for the day.
- Clinical staff identified and responded to patients' risks. They received simulation training to ensure they could respond appropriately if a patient became unwell. A sufficient number of staff were trained to provide advanced resuscitation skills.
- Emergency business contingency plans were in place and regular fire drills practised.

## **Are services effective at this hospital?**

- Care and treatment followed best practice and evidence-based guidance across services.
- The medical advisory committee was actively involved in reviewing outcomes and renewal of practising privileges of individual consultants. It also reviewed policies and guidance and advised on effective care
- Patient outcome data was reported for comparative analysis for surgical services, but there were some gaps in this, particularly for cosmetic surgery. Surgical services performed well in national audits.
- The collation of outcome data across medical and outpatient services was limited. BMI had applied for JAG) accreditation of endoscopy services at the hospital but data collection on outcomes had not yet started. Oncology patient outcomes were monitored at local NHS hospital cancer multidisciplinary meetings.
- Staff were competent, skilled and knowledgeable. Surgical staff had good access to training and there were opportunities for staff to attend additional courses to extend their skills. However, some staff across services reported a lack of support in accessing training they believed would enhance the care they provided to patients in their department. Appraisal rates varied across the services.
- Staff managed pain relief effectively using a patient scoring tool and were trained to appropriately to patient needs.
- Patients received a choice of meals and drinks and the chef catered for patients requiring special diets. The hospital had a contract with the local NHS trust for a dietitian and other specialist services.
- Information about patients, care pathways and the management of the service was available to support effective care and discharge.
- The consent process for patients was well structured, with written information provided prior to consent being given. Consent was regularly audited.

# Summary of findings

- Staff were trained in the Mental Capacity Act 2005 and there was appropriate guidance and tools to assess patient mental capacity.

## **Are services caring at this hospital?**

- Staff treated patients with kindness and compassion and ensured patients had time to ask questions.
- Staff listened and responded to patients' questions positively.
- Staff treated patients courteously and respectfully, and maintained their privacy and dignity.
- Patients and relatives commented positively about the care provided and said they were involved in decision-making.
- Staff demonstrated they were passionate about caring for patients and clearly put the patient's needs first, including their emotional needs.
- Results of the latest patient survey showed a high level of patient satisfaction, with the hospital scoring 98.7%.

## **Are services responsive at this hospital?**

- The hospital had service development plans for improvements at the hospital including meeting future demand. There were plans to develop oncology services, and the endoscopy service was undergoing improvement at the time of our inspection.
- The hospital worked with Dorset Clinical Commissioning Group (CCG) in developing services for NHS patients.
- Patients were able to access services when needed and we found services responsive to meeting individual needs.
- NHS and private patients experienced the same level of care and treatment, except that NHS patients sometimes shared waiting facilities.
- The hospital had minimal numbers of patients who could not understand English. Staff made use of translation 'apps' on their personal mobile telephones and were not aware of interpreter services. In outpatients, relatives were sometimes asked to help with translation. This is not a recommended practice, as it cannot be assured the patient has given consent for their medical information to be shared with their family member.
- The hospital had a system for responding to and managing patients' verbal or written complaints; however, the guidance on how to make a formal complaint was not always readily available or consistently given to all patients. There was evidence of learning from complaints

## **Are services well-led at this hospital?**

- There was a clear vision and strategy for development at the hospital, which aligned with the corporate strategic vision for high quality and convenient patient care.
- The director of nursing and quality post had been vacant since the end of July 2015 and an action plan to implement the corporate clinical strategy had not been developed.
- There was an interim director of nursing in post at the time of inspection; they had not had any additional training to undertake the role. A BMI regional director of nursing, who covered 15 hospitals, supported them.
- There was a governance structure in place but attendance at some committees was patchy, due in part, to the large number and the work pressures of department leads. The provider identified that governance processes needed to be strengthened at the hospital and the governance structure was under review.

# Summary of findings

- The medical advisory committee (MAC) membership included consultant leads across specialities. The MAC and was involved in quality assurance of medical staff and monitoring of clinical issues. There was a lack of documentary evidence of how members reviewed actions arising from the meetings.
- There were not robust systems to monitor quality across all areas of the hospital. The senior management team tended to gain assurance of quality through knowing and working with staff, and informal discussions.
- There were different reporting forms for clinical and non-clinical incidents and unclear classification of incidents. Leaders were not skilled in investigating incidents and complaints using root cause analysis, so opportunities for learning might be missed.
- There was limited trend analysis of reported incidents. However, the information circulated to staff on quality and risk issues lacked clarity and focus on learning from incidents and complaints.
- The senior management team did not consistently understand or apply the systems and processes for identification, assessment and management of risk across all departments. The hospital risk register did not capture some risks identified at inspection; others had not been identified or addressed in a timely way.
- There were processes in place for robust recruitment of appointments to the senior management team, for example, the appointment of the substantive Director of Nursing and Quality due to start in post late September 2015.
- The leadership team was accessible to staff and there was a positive, open culture within the service that meant staff challenged poor practice.
- Staff valued their leaders; however, there was a lack of capacity for departmental managers to carry out their managerial tasks.
- In June 2015, the hospital was in third place across the BMI group for patient satisfaction scores.

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

Importantly, the provider must ensure:

- incidents and complaints are appropriately investigated, for example through root cause analysis and learning identified
- learning from investigations is appropriately shared across the hospital
- risks are identified, assessed and managed effectively across all areas of the hospital
- there are processes in place to effectively monitor the service provision and identify areas for improvement
- the outpatient environment is assessed and actions taken to reduce risks of cross infection
- risks associated with use of hyfrecator and any other equipment is assessed and appropriate action taken to reduce any identified risks
- a record of decision-making discussions held between consultants and their patient is maintained in hospital records, as well as private patient records.
- an assessment is made of the staffing levels in outpatients to ensure they are sufficient to meet the needs of patients and reduce risks to patients and staff

In addition the provider should ensure :

- accessible guidance on how to make a complaint is available to all patients

# Summary of findings

- all staff have the opportunity to contribute to annual appraisals
- staff are aware of the practical implications of the duty of candour regulation
- patient record templates are clear, consistent and easy for staff to use
- policies are up to date and reflect current guidance, legislation and best practice
- a cleaning list is maintained in endoscopy theatres that clearly demonstrates the equipment that has been cleaned, date and time when it happened, and the products used.
- the equipment stored in the endoscopy theatre is stored elsewhere to avoid clutter and minimise risks
- an assessment of the suitability of the outpatient environment is completed and adjustments made so that access to the storeroom is not through the treatment room
- translation and interpreter services are available and relatives are not used to translate in medical consultations

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

### Medical care

### Rating

Good



### Why have we given this rating?

We found medical care services provided good care and treatment to patients. Staff knew how to report incidents and told us they received feedback on lessons learnt.

There were safety systems in place to support delivery of care and treatment. The endoscopy suite environment did not comply with the standards for decontamination of equipment and so there were arrangements for decontamination at an NHS hospital. New scopes and equipment were on order. Nursing and medical competence was good, with trained professionals taking pride in their work. Consultants reviewed their patients daily and there was a 24-hour resident medical officer on site to respond to any clinical issues. Staffing levels were based on an assessment of patient needs and there was a low level of agency staff usage on the ward, in the oncology, and the endoscopy units. Mandatory training and compliance was good in some departments, and appraisal uptake varied. The provider had recently applied for Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation. The hospital had not started the collection data on patient outcomes, needed for accreditation assessment. Patient outcomes were monitored by oncology nursing staff in meetings, and by medical staff in follow-up clinics. There was an audit schedule in progress, which included record keeping and consent audits.

Staff worked effectively across different disciplines and had good links with staff at other BMI hospitals and colleagues in local NHS services.

Nursing and medical staff were caring, compassionate and patient centred in their approach. Patients we spoke with gave us positive feedback on the care received. We saw the same written on patient comment cards. This was especially evident in the oncology unit. The care of patients at the end of life was managed well, with a dignified plan and an end-of-life care pathway that met the full range of patient needs.

# Summary of findings

There was a planned refurbishment in the oncology unit and the hospital was investing in expanding and updating this service. The hospital had incorporated it in its future strategy.

Improvements were needed to quality monitoring and risk management. The risk register was not regularly updated and was not used effectively to identify and manage risks within the services. The hospital had recently started to implement changes to address risks.

## Surgery

Good



Surgical services provided good standards of care and treatment to patients. There were low incident and infection rates and staff took incidents and complaints seriously as opportunities for learning. The provider needed to ensure staff understood the duty of candour regulation and applied it in practice. Staff completed essential safety training and there were sufficient staff on duty, with the right skills, to keep patients safe. They carried out safety checks on equipment and the environment, but they omitted some audits from the programme and systems for learning from audits were not consistently robust. Patients received medicines safely and at the right time and there were safe procedures for managing medicines, including medical gases, in the hospital. There was a strong sense of teamwork and loyalty among the staff. Staff valued the support from their leaders and liked working in the service. The leadership within the service required improvement and there was a high vacancy rate and low appraisal rate. There was a lack of protected time for managers to complete their management roles. Service leaders had not identified key risks relating to the service and classified them on a risk register, for mitigation and escalation. This meant there was a possibility that risks would not be communicated and managed effectively. Staff followed evidence-based care and treatment, and monitored and reviewed patient outcomes. Staff within surgery services were caring and patients received kind and compassionate care and treatment. Patients understood their treatment, and consented to care. Staff carried out effective pre-assessment and planned treatment, recovery and discharge in line with patients' specific needs.

# Summary of findings

Patient feedback was positive, and patients were treated in a timely way, however they did not have consistent access to guidance on the complaints process.

## Outpatients and diagnostic imaging

### Requires improvement



Systems to keep patients safe were not fully effective. Patients, and staff, in outpatients (OPD) were not fully protected from the risk of harm. Staff had a good understanding of how to report incidents, but were not assured the hospital management team took escalated risks seriously. A piece of equipment used in a treatment room produced a plume of smoke that guidance indicated was a risk to health of patients and staff and should be used with an extractor fan. There was no extractor fan. The fabric of the treatment room meant effective cleaning to reduce risk of cross infection was not assured. Staff in OPD reported low staffing levels and increased administrative tasks reduced clinical time to provide care and treatment to patients. Staff perceived this as a risk to patient safety. They reported that although not normal practice, there were occasions when there was only a nurse or only two healthcare assistants on duty in the department, which posed a potential risks to patient safety. The hospital had not undertaken a recent assessment of outpatient staffing levels.

Individual departments did not maintain their own risk registers. In OPD where staff had identified risks, no assessments were completed to determine the level of risk posed to patients and staff. The hospital-wide risk register did not detail any risks that had been escalated from OPD.

Programmes were followed for staff to complete essential mandatory training. However, some staff reported difficulties in accessing practical mandatory training sessions due to workloads and cancelled training sessions. Some staff reported a lack of support in accessing further training they believed would enhance the care they provided to patients in their department.

Limited clinical audits were undertaken in OPD, which meant there was limited measurement of the effectiveness of the service provided.

The hospital had minimal numbers of patients who could not understand English. But staff were not

# Summary of findings

aware of interpreting services, and when needed used translation 'apps' on their personal mobile telephone or the patient's relatives to help with translation. Using relatives for translation purposes is not a recommended practice, as it cannot be assured the patient has given consent for their medical information to be shared with their family member. Information leaflets were only available in written English, and not in other formats such as other languages, pictures or braille.

Staff reported confidence in and good support from their immediate line manager, but some were not assured senior management fully considered their views and opinions. There was a view among some staff that the hospital management relied heavily on the good will of staff and that good will was running out.

There was evidence of effective multidisciplinary working that included working across the hospital and in partnership with the local NHS acute hospital and other organisations. Services were planned to meet patient needs. Patients told us there was good access to appointments and at times that suited their needs. Staff demonstrated they were passionate about caring for patients and clearly put the patient's needs first, including their emotional needs.

There was evidence of innovation and development of services across all outpatient services. Innovation and development was an integral part of the running of the physiotherapy department.

Good 

# BMI The Harbour Hospital

## Detailed findings

### Services we looked at

Medical care (including older people's care); surgery; outpatients and diagnostic imaging

# Detailed findings

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## Background to BMI The Harbour Hospital

The Harbour Hospital, established in 1996, is one of 62 hospitals and treatment centres provided by BMI Healthcare Ltd.

The on-site facilities include an endoscopy suite, three operating theatres (two with laminar airflow), two treatment rooms, and eight consulting rooms supported by an imaging department offering X-ray and ultrasound. Physiotherapy treatment is offered as an inpatient and outpatient service in its own dedicated and fully equipped physiotherapy suite. MRI and CT scanning facilities are provided to patients by a different registered provider, in an adjacent building and were not included in this inspection.

The hospital currently operates 32 beds, including six oncology day care beds, all in single rooms with end-suite facilities. The ward has 26 beds and two rooms can be equipped for enhanced monitoring post-surgery if required. There is no critical care facility or emergency department at the hospital.

The hospital provides a range of services to patients aged 16 years and over, who are self-pay or use private medical insurance. Services offered include general surgery, orthopaedics, cosmetic surgery, refractive eye surgery, gynaecology, ophthalmology, oral & maxillofacial surgery, general medicine, oncology, dermatology, physiotherapy, endoscopy and diagnostic imaging. Orthopaedic and ophthalmology services are available to NHS patients through Choose and Book.

The following services are outsourced:

- Catering and kitchen services
- Clinical engineering
- Critical care
- Decontamination of theatre instrumentation
- Maintenance provision
- Medical physics
- Pathology
- Additional pharmacy support
- Radiation protection advice
- Resident Medical Officers
- Resuscitation services

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

The registered manager, Dan Stonell, registered on 1 October 2010.

The nominated individual from BMI Healthcare Ltd Mr Richard Evans, registered on 13 November 2013.

# Detailed findings

## Our inspection team

Our inspection team was led by:

**Inspection lead:** Anne Davis, Inspection Manager, Care Quality Commission (CQC)

The team of 11 included four CQC inspectors, a pharmacist inspector and a variety of specialists: a consultant surgeon, consultant gynaecologist with specialist interest in oncology, cosmetic surgery nurse, senior governance nurse, and radiography manager.

## 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. We carried out an announced inspection visit between 2 and 4 September 2015, and a routine unannounced inspection 17 September 2015.

We held focus groups for staff in the hospital. We also spoke with staff and managers individually. We talked with patients and staff from the ward, oncology day unit, physiotherapy department, operating department, X-Ray, endoscopy unit, and outpatient services. We observed care and treatment, talked with patients, and reviewed patients' records of care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their views and experiences of the quality of care and treatment at BMI The Harbour Hospital.

## Facts and data about BMI The Harbour Hospital

### Key facts and figures

The hospital provides a range of services to patients aged 16 years and over, who are self-pay or use private medical insurance. Services offered include general surgery, orthopaedics, cosmetic surgery, refractive eye surgery, gynaecology, ophthalmology, oral & maxillofacial surgery, general medicine, oncology, dermatology, physiotherapy, endoscopy and diagnostic imaging. Orthopaedic and ophthalmology services are available to NHS patients through Choose and Book. 17% of all patients are NHS funded.

Hospital activity during the year to April 2014 to March 2015 included:

3,227 day-case inpatients;

1,029 overnight inpatients;

3,857 visits to theatre;

17,756 outpatients (first attendees).

The most common surgical procedures were :

- 633 Phacoemulsification of lens with implant procedures
  - 148 Carpal tunnel procedures
  - 125 Epidural injection procedures
  - 102 Total hip replacement procedures.
- The most common medical procedures were :
- 220 Colonoscopy
  - 136 Diagnostic gastroscopy
  - 106 Flexible sigmoidoscopy

# Detailed findings

The accountable officer for controlled drugs is Dan Stonell, registered manager.

## Our ratings for this hospital

Our ratings for this hospital are:

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

# Medical care

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

## Information about the service

The BMI Harbour Hospital provides a very small general medical service. There are four to five medical inpatients a year. Occasionally, the hospital has short-stay patients for the management of conditions such as cellulitis, high blood pressure, anaemia or unhealed leg ulcers; but not for management of long-term conditions.

Medical patients visit the endoscopy unit as day cases. Staff perform around 330 endoscopies and colonoscopies each year.

The majority of care we looked at under this core service is provided in the oncology (cancer) day unit, where patients have intravenous chemotherapy treatment from Monday to Friday between 9am and 5.30pm. The unit is staffed between 7.30am and 6pm. BMI Harbour Hospital also provides an end-of-life care service for a small number of patients.

On the oncology unit, we spoke with three nurses, a doctor, eight patients and two visitors. We spoke with two nurses in the endoscopy unit. On the ward, we spoke with a nurse and two patients. We reviewed 11 sets of patient notes across medical, oncology and endoscopy services.

## Summary of findings

We found medical care services provided good care and treatment to patients. Staff knew how to report incidents and told us they received feedback on lessons learnt.

There were safety systems in place to support delivery of care and treatment. The endoscopy suite environment did not comply with the standards for decontamination of equipment and so there were arrangements for decontamination at an NHS hospital. New scopes and equipment were on order.

Improvements were needed in quality monitoring and risk management. The risk register was not regularly updated and was not used effectively to identify and manage risks within the services. The hospital had recently started to implement changes to address risks.

Nursing and medical competence was good, with trained professionals taking pride in their work. Consultants reviewed their patients daily and there was a 24-hour resident medical officer on site to respond to any clinical issues. Staffing levels were based on an assessment of patient needs and there was a low level of agency staff usage on the ward, in the oncology, and the endoscopy units. Mandatory training and compliance was good in some departments, and appraisal uptake varied.

The provider had recently applied for Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation. The hospital had not started the

# Medical care

collection data on patient outcomes, needed for accreditation assessment. Patient outcomes were monitored by oncology nursing staff in meetings, and by medical staff in follow-up clinics. There was an audit schedule in progress, which included record keeping and consent audits.

Staff worked effectively across different disciplines and had good links with staff at other BMI hospitals and colleagues in local NHS services.

Nursing and medical staff were caring, compassionate and patient centred in their approach. Patients we spoke with gave us positive feedback on the care received. We saw the same written on patient comment cards. This was especially evident in the oncology unit. The care of patients at the end of life was managed well, with a dignified plan and an end-of-life care pathway that met the full range of patient needs.

There was a planned refurbishment in the oncology unit and the hospital was investing in expanding and updating this service. The hospital had incorporated it in its future strategy.

## Are medical care services safe?

Good



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

Staff across oncology, endoscopy and the inpatient ward knew how to report incidents, sharing of learning within the oncology service, but was variable within endoscopy. Staff were not consistently aware of the regulation relating to duty of candour, but understood the importance of being open and transparent when mistakes were made. Staff received feedback from the quality and risk lead within the hospital, and clinical team leaders shared information with staff on lessons learnt.

Nursing staffing levels were good in oncology, endoscopy and the inpatient ward, with minimal sickness. There was sufficient medical cover provided by resident medical officers (RMOs) who covered the hospital 24 hours a day for all specialities. Consultants were also available daily and provided on call cover and advice out of hours if necessary.

Clinical staff identified and responded to patients' risks, and were trained to provide advanced resuscitation. Staff knew how to identify and respond to any safeguarding concerns. Patient records were clear and well-organised. The training records of oncology nursing staff on the electronic training system showed an increase in compliance in mandatory training between the announced and unannounced visit.

Medicines were stored securely. Equipment was serviced, maintained and calibrated. The endoscopy scopes were sent to another location for decontamination, as the endoscopy unit did not comply with decontamination standards.

### **Incidents**

- There were separate incident reporting streams for clinical and non-clinical incidents, with patient falls and sharps injuries being classified as non-clinical. We were told this was due to the corporate electronic reporting system and were assured clinical incidents were escalated to the appropriate corporate lead. For

# Medical care

example, falls were reviewed by the regional director of nursing. However, the process of separate reporting did not support the identification of any clinical issues and learning from all incidents.

- There was a corporate policy for incidents, and the hospital had developed a local standard operating procedure for reporting them.
- In oncology, we found staff understood how to report incidents. They completed paper incident forms and administration staff added the information onto the provider's electronic database. Nurses confirmed they received feedback on reported incidents, but could not recall examples of recent near misses, never events or drug errors. The lead nurse told us completed forms were submitted to the health and safety officer who gave feedback. They said they shared lessons learnt at quarterly meetings of the oncology steering group, and at team staff meetings.
- Endoscopy staff said they knew how to report incidents, and gave us examples of the types of incident they would report.
- The provider had recently issued a corporate 'Being Open and Duty of Candour Policy', dated April 2015, but not all staff were familiar with this. The duty of candour regulation set out a formal process for the provider to explain and apologise to patients when something went wrong with their care. We were told workshops were held for directors of nursing and they would cascade the training to registered nurses, but this had not yet been rolled out within the hospital. The oncology nurses, including the clinical lead, knew the meaning of duty of candour, and were aware of the policy. They told us there was a policy available on the computer as well as in hard copy. However, other staff, including senior staff in theatre, were unable to explain the principles underlying the legislation and the importance of being open and transparent.
- Endoscopy theatre staff told us they did not get specific feedback from incidents, complaints or comments. A senior endoscopy theatre nurse was not aware of a recent incident relating to an endoscopic procedure, showing learning had not been shared to help minimise the risk of it happening again. When asked if there had been any incidents in endoscopy, we were told no patients had suffered complications after a procedure, and no incidents had been reported.

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

- Nurses monitored the completion of risk assessments. All patients had venous thromboembolism (VTE) assessments completed on admission. Staff also tested patients for Methicillin Resistant Staphylococcus Aureus (MRSA) infection and completed risk assessments for mobility and malnutrition.

## **Cleanliness, infection control and hygiene**

- Recent audits of 10 staff on the ward showed 100% compliance in hand hygiene and 90% compliance for 'bare below the elbow' policy. Bare below the elbow means clinical staff were not wearing long sleeves, jewellery on wrists or fingers and no false nails. The audit included nurses, doctors and healthcare assistants. There was a hand hygiene audit undertaken in theatres that perform endoscopies in July 2015, although the results were difficult to interpret.
- Staff in the oncology unit were seen washing their hands and wearing personal protective equipment when administering intravenous chemotherapy, to minimise the risk of spreading infections.
- BMI Harbour Hospital had an infection control nurse, plus link nurses in all departments. Link nurses completed environmental audits using a Quality Improvement Tool (QIT). The endoscopy QIT audit in February 2015 showed areas for improvement with an action plan, including timeframes.
- There were alcohol hand gels outside patients' bedrooms in the oncology unit but there were no sinks in the corridors for staff or visitors to wash their hands. This had been identified as a risk and hand wash sinks were on order.
- The hospital infection control lead nurse was involved in plans for the refurbishment of the oncology unit, making suggestions on the environment including hand wash facilities to minimise the risks of infection.
- We saw a cleaning schedule in the endoscopy theatre but it was a brief tick box sheet that only confirmed the room had been cleaned, but not which equipment nor areas. There was a cleaning schedule for the endoscopy equipment but not a separate cleaning list for the other items of equipment in the room, to provide assurance that items were clean.

# Medical care

- The domestic staff attended the morning meeting across the hospital and felt part of the team. When interviewed, one member of staff said they were aware of the needs of oncology patients receiving chemotherapy. They ensured they wore personal protective equipment, and cleaned the unit first before attending elsewhere, to minimise the spread of infection.
- The endoscopy suite environment was not compliant with decontamination standards and the hospital had set up an interim solution, to outsource decontamination of equipment at an NHS hospital.

## Environment and equipment

- Maintenance staff regularly checked non-medical electrical equipment (portable appliance or PAT testing). Medical equipment was PAT tested as part of annual servicing. The endoscopy equipment had been PAT tested and we saw service history documents filed in folders.
- There was a system to remind heads of department when servicing of equipment was due and to check when it was done. The materials manager kept this on a spread sheet. The service level agreement with the local acute hospital covered planned preventative maintenance for the environment and plant.
- An equipment log was held for calibration of endoscopy equipment. A night nurse was responsible for notifying theatre staff when items were due to be serviced and checking services had been completed.
- BMI Healthcare's electro-biomedical engineering (EBME) department managed the contracts for BMI healthcare that dealt with engineer contracts and the scheduling of servicing for the endoscopy equipment.
- At the time of our inspection, the oncology unit was pending refurbishment that would increase bed spaces from five to seven. This refurbishment was planned to start in October 2015, to improve the layout of the unit and create more space with computer terminals for staff to use. The plan consisted of a consulting room, a relative's room, and a separate clinical area.

- The sluice area in the oncology unit was small, with a lack of storage space and equipment however, nurses were able to use equipment from the neighbouring ward. Improvements to the sluice were part of the oncology refurbishment plan.
- The ward mechanical patient hoist was serviced regularly. If this failed, staff could access a temporary replacement from the local NHS trust. The hoist could pick a patient up from the floor if needed, alongside aiding with transferring patients from a bed to a chair. The next service of the hoist was due in February 2016. At the unannounced inspection, a ward staff nurse explained the hoist was not used very often, and they were able to borrow a particular type of hoist from the nearby acute trust if necessary. Disposable hoist slings were available in different sizes.
- There was lack of storage space for equipment. While not in use the theatre room, where endoscopies were performed was used as a storeroom, so the room was cluttered and disorganised at the time of our inspection. The equipment was moved out when procedures were performed and returned at the end of the day.

## Medicines

- All patients attending the oncology day unit received intravenous chemotherapy. The nurses told us this was supplied pre prepared, and it was a safe, efficient and effective service.
- Trained nurses administered intravenous chemotherapy using a variety of venous lines. They included central lines, peripherally inserted central catheter (PICC) lines and Hickman lines.
- Oncology nurses told us the pharmacy would not dispense chemotherapy to patients unless they had received a blood test within the previous 72 hours, which was normally completed at the pre-assessment appointment.
- Pharmacists at the hospital had not undergone competency assessments for the screening and dispensing of the cytotoxic drugs. This was on the risk register, and the Dorset Cancer Centre and chief pharmacist for BMI Healthcare were contacted for guidance on how to manage this risk safely. We found appropriate processes in place to mitigate any risks.

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- Local cancer network protocols were used in the prescribing of cancer treatments and chemotherapy.
- In the oncology unit, emergency medicines, including extravasation kits were available for use. An extravasation kit is equipment used to remove an intravenous drug or fluid that has leaked from a vein into the surrounding tissue. The unit also stocked emergency neutropenic intravenous drugs, as well as oral drugs, in case needed when the pharmacy was closed. An anaphylaxis kit, for treating anaphylactic shock, was present on the unit with its content clearly labelled.
- Medicines and prescription pads were stored securely. Cupboards that contained oral and intravenous drugs were kept locked on the oncology unit. We checked 10 intravenous drugs and all were in date and accounted for.
- All medicines requiring cold storage were held in the pharmacy fridge, which was checked each day to ensure medicines were maintained at a safe temperature.
- Intravenous sedation was used for endoscopic procedures and these sedatives were kept locked and secured in theatres.

## Records

- We saw a comprehensive chemotherapy booklet that patients brought with them at each treatment session. This kept a record of the treatment received, along with other important informative information. This benefitted both nurse and clinician.
- Patient records were locked in a filing cabinet in the oncology unit office.
- Four sets of patient notes were reviewed, and we found good documentation in clear and concise records. One set of notes had information missing on the 'Oncology Nursing Assessment' form, which meant the nurses might not have had access to important patient information that could affect their care.
- One set of medical notes were reviewed for a deceased oncology patient. The notes were clear and organised, with reference to the patient's resuscitation status. There was a satisfactory assessment and evaluation of the patient with detailed consultant entries, discussing the prognosis of the patient's terminal condition.

- Five endoscopy patient medical records were reviewed at the unannounced inspection. These patients underwent procedures such as colonoscopies and a gastroscopy earlier in the month. We found well-completed pre-assessment checks and clearly documented anaesthetic charts and the recovery notes and observations.
- Monthly audits evidenced high compliance with accuracy and completeness of record keeping across the hospital.

## Safeguarding

- A corporate BMI policy for safeguarding children and vulnerable adults was in place at the hospital. This was out of date and did not provide accurate guidance to staff on local safeguarding procedures. No flow charts on local safeguarding procedures were seen in the Oncology unit, but nurses confirmed they would escalate any concerns to the nurse in charge of oncology or the ward if necessary.
- Oncology and ward nurses completed level two safeguarding training, appropriate to their roles, and the Director of Nursing level three, to manage safeguarding investigations. However, not all nurses within these departments were compliant with their training and some records were seen out of date where annual training had not been updated.
- There had been no safeguarding incidents in the past year. Staff could explain how they would respond if they witnessed or suspected abuse.
- Hospital wide electronic training records at the unannounced inspection showed 95% of staff had completed adult safeguarding training and 97% of staff had completed children's safeguarding training.

## Mandatory training

- Staff induction training was provided every two months where mandatory training was explained and staff were expected to complete the listed subjects within a few weeks of starting in the role.
- Over 90% of hospital staff were up to date with their mandatory training. Staff members were linked to a 'role profile' on the BMiLearn, the corporate electronic training system, which automatically assigned them

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with a relevant mandatory training plan. Individual staff could access and monitor their progress with mandatory training. Management reports on training could also be extracted from the system.

- Staff needed to complete an online competency assessment after any practical training, for this to be registered as completed. The training manager told us there were challenges for some clinical staff to complete the online training but reported gradual increase in compliance with training since October 2014.
- Staff that had attended and completed training successfully were labelled as 'certified' on the BMI e-learning system. For the oncology department, that was 97.3% and theatres (which included endoscopy staff) was 95.2%.
- Training listed as corporate or mandatory included an appropriate range of subjects and the compliancy rate hospital wide at the time of our inspection was between 85-100%. The BMI target was 90%.
- The hospital had started the 100 club to encourage 100% compliance with mandatory training. A list of successful staff was displayed on the training notice board. Staff were now required to be 100% compliant with mandatory training to be considered for a pay review.
- In addition to e-learning, face-to-face mandatory training was provided in house for example, infection control, moving and handling, safeguarding and fire safety. Resuscitation training was provided at the local acute hospital.
- Consultants and clinicians with practising privileges were not required to complete training via the hospital system but assurance of mandatory training was checked by the medical advisory committee. The registered manager told us if doctors were not up to date with mandatory training, and did not provide current and valid practice certificates, they were suspended from practice until the training was renewed and evidenced.
- The resident medical officers (RMOs) received mandatory training via their RMO agency and had access to the hospital's on-line training systems.
- The resident medical officers (RMOs) received advanced life support (ALS) and paediatric advanced life support

(PALS) training via the RMO agency. Unannounced emergency ALS scenarios, led by NHS acute hospital resuscitation officers, were practised six times a year. Reports on the performance of the RMO and staff were provided to the hospital. Quarterly resuscitation committee meeting minutes recorded that additional training for RMOs was being arranged in the resuscitation simulation room at the local acute trust

- BMI Healthcare provided an Acute Illness Management (AIM) training workshop and online assessment as a mandatory course for registered nurses and health care assistants.
- At the announced inspection, the mandatory training compliancy rate of oncology nursing staff found in training files did not reflect the data we saw on the unannounced inspection a couple of weeks later. We viewed three oncology nurses' mandatory training records and found all were non-compliant with out of date training. This included the clinical lead nurse. Records were either incomplete or certificates missing. At the unannounced inspection, we had access to the BMI learn system and the oncology department was recorded as 97% compliant with training.

## Assessing and responding to patient risk

- Before oncology patients attended the day unit for chemotherapy, they attend a pre-assessment appointment where staff assessed risks relating to patient treatment. This clinical assessment was undertaken the week before treatment started and took around two hours to complete. Patients had their weight and height taken as well as blood tests.
- If any medical problems or complications were identified at the pre-assessment clinic, the nurse referred to the resident medical officer (RMO) or an anaesthetist. Oncology patients could be admitted as inpatients, under the care of their consultant, if they were experiencing complications with the chemotherapy, so they could be monitored more closely.

## Nursing staffing

- On the day of the inspection, the oncology nursing staff consisted of two permanent staff, one part time and one full time. There were also two bank nurses, one of which

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was waiting the return of references for a substantive post. Nursing levels were planned to a ratio of one nurse to four patients. There were two nurses on duty per day, and patients were allocated a nurse in advance.

- There were five oncology nurses employed which included a clinical lead nurse. There were no healthcare assistants. This was because only registered nurses who had completed the intravenous chemotherapy course, and could administer the drugs to patients, could work on the unit.
- The use of agency nurses for oncology was minimal, and in August 2015 totalled 10 hours. On the ward, agency nurses were used infrequently, making up less than 5% of nursing staff between April 2014 and March 2015.
- There was a consistent team of ward nursing staff. There was a relatively low sickness rate of 2% from April 2014 to March 2015. Clinical staff turnover for the ward was 5% from January to December 2014; and the vacancy factor was 6% as of 31 March 2015.
- As there was only one ward, nursing staff who looked after the few medical patients also looked after surgical patients. Newly qualified nurses were taken onto the ward as well as student nurses who were mentored through preceptorship.
- The ward sister used a labour standard acuity tool to calculate a staff to patient ratio on the ward, determined by the needs of the service. The staffing ratio was five to six patients for one registered nurse, but if a seventh patient was admitted, the nurses were assigned a healthcare assistant for support.
- At times, theatre staff were used to work on the ward if nursing staff levels were low.
- The ward had a ward sister and a ward manager. The clinical aspects of the ward were managed by the sister and the administrative side by the manager. The ward manager also provided clinical support to the ward team.
- At the time of our inspection, there was one senior staff nurse vacancy and a part-time (10 hours) registered nurse vacancy. There was no staff sickness.

## Medical staffing

- The doctors at the BMI Harbour were NHS consultants performing private work, they were based at local NHS trusts. There were eight oncology consultants and a number of consultants with practising privileges for endoscopy services.
- Oncology consultants attended the day unit on a daily basis to review the patients. This was on a rota system, and the consultant on duty would also review other doctors' patients and communicate any progress or deterioration in patient health, and their decisions.
- RMOs provided 24-hour medical cover to the ward for all specialities, on a two-week rotation system. The RMOs worked at the hospital regularly and knew the hospital and its routine well. RMOs were advised of cover arrangements for any consultant on leave. Consultants were required to live within reasonable travelling distance of the hospital to provide on call cover.

## Major incident awareness and training

- Business continuity plans were in place, and gave details of the actions needed and who to call in emergencies. These were kept in folders on reception, the ward and plant room.
- A generator was available for use in case of power failure, and tested monthly.
- Fire evacuation drills were held three times a year, during the day, night and at the weekend. The fire officer made notes on the simulation exercise and this was then discussed at the fire team meeting to review actions needed. Every bed was fitted with a fire evacuation sheet and checked monthly.

## Are medical care services effective?

Good



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

Medical services followed evidence based guidance and best practice. The endoscopy service was not auditing their performance or collecting data on patient outcomes. Collation of outcomes data for Joint Advisory Group on

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Gastrointestinal Endoscopy (JAG) accreditation was due to commence. Oncology patient outcomes were monitored at cancer multi-disciplinary meetings and doctors monitored them in their follow up clinics.

We found staff were competent, skilled and knowledgeable. Appraisal rates varied across the services, endoscopy staff told us they were overdue.

Staff communicated effectively with the multidisciplinary team across the hospital and with the wider NHS community, including GPs and the local acute trust, to support their patients.

Pain relief was well-managed, staff were competent in using a patient scoring tool to keep patients comfortable. Patients' nutritional needs were met, and staff could access specialist advice from the local NHS hospital at short notice when required. Nutrition was well catered for, but generally patients had been unhappy with the quality of meals being provided, since outsourced.

Consent was obtained for care and treatment and, although seldom needed, staff had awareness of the Mental Capacity Act (2005). Appropriate procedures and guidance were followed for 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions.

## Evidence-based care and treatment

- Endoscopy staff followed National Institute for Health and Care Excellence (NICE) guidance but did not have a Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation. This had been applied for corporately but had not started the data collection required to obtain this. JAG accreditation provides evidence that best practice guidelines are being followed for endoscopy. JAG measures quality and safety indicators, including outcomes. The structure, process and staffing levels and competencies are reviewed, and outcomes audited.
- The oncology unit followed best practice guidance in the care of their patients using NICE sources, and up to date clinical aspects were discussed at oncology steering groups. This was attended by the oncology lead nurse and ensured collaborative working within oncology teams in the wider NHS. The information was then disseminated across the team.

## Pain relief

- On the ward, staff used a pain score for medical and surgical patients, on a scale of 0-3. All staff spoke positively about the pain score and felt it was a useful tool for describing patients' pain.
- Medicines, including controlled drugs were available to relieve pain if patients required them. Oncology patients usually brought their own medicines when attending treatment, but the pharmacy was able to provide drugs if prescribed.
- If a patient needed a controlled drug, a nurse from oncology could access drugs kept on the ward. The team lead in oncology was a nurse prescriber and could issue patients with pain relieving medicines when required.
- The oncology staff also sought advice from the Palliative Care Nurse Specialist at the local acute trust, or the local hospices. The RMO and consultant could also be contacted to discuss the need for prescribed medication.

## Nutrition and hydration

- The food quality provided for patients at the hospital had declined since the contract was outsourced. We were told patients complained about the food quality, and the hospital management were addressing this issue where some improvements had been made.
- The hospital provided effective nutrition for patients.. The chefs were adaptable and accommodating, happy to prepare any specific foods patients wanted, even at short notice. They were aware of side effects from surgery and treatments and recognised the importance for patients to eat something they chose and to their liking. The kitchen staff catered for all diets and had patient diet cards in folders that indicated their preferences. This included diets due to health reasons such as lactose intolerant, and coeliac disease; as well as religious diets.
- Malnutrition assessment tools were undertaken and there was a service level agreement with the local NHS trust to provide dieticians and speech and language therapists (SALT) when required. The ward staff reported they provided a prompt, same day service visit for advice and support. However, oncology patients, receiving day-case treatment seldom needed this service.

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## Patient outcomes

- We found the audit of patient outcomes was limited. Oncology nursing staff and medical staff monitored individual patient outcomes in follow-up clinics after treatment. The hospital participated in cancer networks with NHS acute trusts and cancer care was discussed and benchmarked in meetings.
- The Medical Advisory Committee (MAC) monitored outcomes of individual consultants and fed back any concerns that were not within normal ranges.
- Staff had audited the 'central venous catheter care bundle', in May 2015, but the method, results and learning were unclear. The document showed two PICC lines had been inserted by doctors and they were 100% compliant, but the document did not demonstrate what they were being measured against.
- There was an audit schedule in progress across the services we inspected which included record keeping and consent audits.

## Competent staff

- The nurses working in the oncology unit were all appropriately trained and had completed competencies in the administration of intravenous chemotherapy.
- Medical consultants carried out endoscopy procedures assisted by theatre nurses. All theatre staff rotated to support endoscopy, and assisted in the endoscopic procedures.
- Some theatre staff had attended training specific to endoscopy, such as a technician's training course in gastrointestinal endoscopy, which was accredited by the Royal College of Nursing. This was an annual conference and a two-day workshop that staff took turns to attend.
- Oncology nurses told us access to professional development was limited. Staff could apply to attend an external course if it was relevant to their role in BMI and staff sometimes accessed training from the local NHS trust.
- The regional director of nursing told us that additional training applicable to staff roles was encouraged but usually required some negotiation in relation to study time and funding.

- One full time permanent nurse held a degree in oncology nursing, but overall there was limited access to this level of training.
- The lead oncology nurse was an independent non-medical prescriber, which meant patients attending the day unit would be able to get medicines prescribed promptly without having to wait for the resident medical officer to attend.
- The deputy theatre manager told us they could access courses for professional development from equipment suppliers.
- Appraisal rates for theatre nurses (including endoscopy) at Harbour Hospital from January to December 2014 were 38%. At the time of our inspection, the lead oncology nurse and the ward sister reported that the appraisal rate for nursing staff was good. However, the deputy theatre manager told us all appraisals were overdue for staff that undertook endoscopy as they had been too busy to do them and some staff had been off sick.
- Clinical supervision was completed annually for oncology nurses, which included assessment of clinical competencies.
- Compliance rates for corporate training included pain assessment and management were 100% hospital wide; Blood transfusions 83% and Acute Illness Management (AIMS) 92% for registered nurses and 67% for healthcare assistants.
- The oncology clinical lead nurse attended regular oncology conferences and internal corporate meetings within BMI healthcare and disseminated the information to her team.
- Theatre staff told us they had started 'lunch and learn' teaching sessions. This was ad hoc training which could be from consultant surgeons, nurses or operating department technicians about a range of clinical subjects that included endoscopy teaching.
- The medical advisory committee (MAC) was responsible for granting and reviewing practising privileges for medical staff. New consultants were required to provide evidence of qualifications, training, and registration. The chair of the MAC gave examples of when they had refused admitting rights to consultants, or had set limits on their practice, based on their skills and

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competencies. Clinicians with practising privileges had to reapply and undergo reviews biannually, which included reviews of clinical outcomes, complications, and training and appraisal records. The hospital maintained a list of consultants showing their indemnity insurance and review dates, and all had submitted appraisals as required.

- All staff, including nurses, allied health professionals and staff working under practising privileges held valid professional registration for their roles.

## Multidisciplinary working

- There was effective multidisciplinary working amongst the oncology team. The oncology nurses worked in liaison with the community healthcare practitioners and provided support and guidance to NHS teams where appropriate.
- At 9 am each day, staff assembled for a clinical staff meeting called the 'huddle.' This enabled staff to handover any patient-specific details to therapists, the pharmacist or other healthcare professionals. Housekeeping staff also attended. /In the oncology unit, staff had meetings every three months with a wider audience such as pharmacy, the breast care nurse, a ward nurse, the director of nursing and physiotherapists.
- The resident medical officer (RMO) attended the ward staff handover each evening, and there was a handover every two weeks where any changes in policies and practice were also discussed.
- At the unannounced inspection, the nurse in charge of oncology explained they had close working relationships with pharmacy, who visited the oncology unit several times a day.
- The oncology unit lead nurse told us they used to work in isolation but this had improved since becoming part of the BMI National Cancer Clinical Steering Group. This resulted in better communication and networking amongst oncology staff in BMI healthcare.
- Minutes of oncology team meetings and the oncology steering group showed there was effective partnership working that involved hospital staff in patient care, including the director of nursing, pharmacy and medical team staff.

## Seven-day services

- The oncology unit was open Monday to Friday 7am to 6pm. The endoscopy procedures were also planned interventions and were carried out in office working hours.
- Good links were forged with the local palliative care hospices and the oncology unit received support from the oncology doctors for patients receiving end of life care. The nearby acute trust had a specialist palliative care nurse that worked in close liaison with the oncology unit, and they visited patients at The Harbour Hospital to provide support if necessary. Nurses also had access to an oncology consultant out of hours if required.

## Access to information

- Oncology patients were given a folder that contained a chemotherapy record booklet at their pre-assessment appointment. This logged records regarding their entire treatment plan, including clinical advice on potential side effects and out of hours contact details. Patients were asked to keep this booklet in a safe place and bring it with them at each chemotherapy appointment or session.
- Some doctors had their own set of notes for their patients, which they brought with them when they visited, but the information was also transcribed into the unit notes.
- Oncology nurses communicated with other healthcare professionals involved in patients' care. They sent letters to GPs confirming pre-assessment information for the patients about to start chemotherapy courses. This helped to forewarn them that their patient was about to undergo the treatment and might require their support.
- The oncology nurses liaised with district nurses once patients were discharged. If a patient felt sick and needed medication, the unit would discharge the patient with the injections and the prescription ready so the district nurse could visit and administer it promptly.

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

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- Completed consent forms were seen in the oncology unit's patient records. These were clear and concise and showed consent had been obtained from the patient for planned treatment.
- Staff training for consent, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was an e-learning module. DoLS provides for the lawful deprivation of liberty of patients who lack the capacity to consent to their care or treatment in either hospitals or care homes, but who need to be deprived of liberty in their own best interests, to protect them from harm. Staff had mixed levels of understanding of the MCA legislation and how it worked in practice, but refresher training was booked for September 2015.
- Ward and oncology staff stated they had not needed to apply for a DoLS and said they would seek advice on how to follow the process should the need arise.
- The ward staff told us two nurses were experienced in assessing a patient's mental capacity, and they were usually called upon if staff considered a patient might lack understanding.
- Oncology nurses provided end of life care (EOLC), although this was limited and did not occur often. They held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) forms, which were in line with NHS forms; and we saw one that had been completed satisfactorily in a patient's notes. These are forms that demonstrate nurses and doctors have discussed end-of-life care with patients and recorded decisions made if the patient is not to be resuscitated at the time of their death. On our inspection, we saw leaflets for patients and relatives explaining DNACPR decisions that were given to patients as and when necessary.
- Monthly audits evidenced high compliance with accuracy and completeness of records of consent across the hospital.

## Are medical care services caring?

Good



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

Nursing and medical staff were observed as caring, compassionate and patient centred in delivering their care and treatment. A good rapport was observed between patients and staff. Patients were actively informed and involved in decisions about their treatment. They were provided with emotional support as needed.

Patients we spoke with gave us positive feedback on the care received. We saw the same written on patient comment cards. This was especially evident in the oncology unit.

### Compassionate care

- Six patient comment cards were seen and all gave positive feedback about the clinical staff in the oncology unit. Patients gave praise for the 'excellent' and 'brilliant' care they received. Patients referred to the oncology nurses as a 'wonderful team of caring professionals.' Patients described exceptional care and treatment, with friendly and caring staff that were hard working and efficient. They said nurses made them feel relaxed and safe, and showed a sense of humour, which was appreciated. They provided reassurance to patients when they felt low and made them feel better. Patients said the staff went beyond their duties to make them feel special and important, treating them with dignity and respect. Patients described staff as always doing their best to meet patient's requests. Many patients mentioned they were grateful, and entirely happy.
- Non-clinical staff were also praised by patients in the oncology unit, with one patient saying they received the best possible care and attention from clinical and non-clinical staff. Lastly, patients regarded the rooms as lovely, clean, safe and comfortable.
- We spoke with an oncology patient whom had been diagnosed with cancer three weeks earlier and was receiving their second dose of chemotherapy. Both the patient and their wife were satisfied with the nursing care and felt nursing staff were sympathetic. They gave a rating of 10/10. Another patient receiving chemotherapy was very positive about the hospital in general and the organisation of the chemotherapy suite. Nursing staff were described as being professional, compassionate and empathetic.
- We observed staff supporting oncology patients in a caring and compassionate manner whilst administering chemotherapy. There was evidence of a good rapport

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between patients and their nurses and staff demonstrated professionalism and knowledge that provided reassurance and support to their patients during their treatment.

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

- Patients in the oncology unit stated staff kept them informed about their care, involved them in any decision-making, and always listened.
- Patients on the oncology unit had access to many disease-related information leaflets provided by the nurses. Booklets were available on the unit from Macmillan Cancer Research that included clinical information about types of cancers, managing signs and symptoms, and other relevant subjects. These were also available to order in other languages if necessary. The oncology unit had access to interpreters from the acute trust, but said they rarely treated patients where an interpreter was required.
- Oncology nurses provided patients with information on discharge, should they have any concerns when not attending for treatment. They gave them information about the signs and symptoms to look out for following chemotherapy, and what they could do to relieve them. They also gave them in and out of hours contact details in case of a worry or concern, if not attending the day unit the following day.

## Emotional support

- The provider offered a counselling service to oncology patients. This was provided by a registered nurse that worked in the hospital and was qualified as a counsellor. There was a fee for this service however; patients could also be referred to the local NHS trust for counselling support.
- The oncology unit had a 'survivorship programme', which was a three-day course that patients attended as a retreat. Its aim was to help patients get back to work and normal living after treatment was completed. Breast Cancer UK sponsored this.

## Are medical care services responsive?

Good



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

There were development plans for Oncology services to meet future demand. The endoscopy service was undergoing review at the time of our inspection.

Oncology patients were able to access services when needed and services were responsive to individual patient needs. Oncology nurses provided phone triage for concerned patients at home receiving treatment as a day case.

Staff were piloting a new end of life care pathway. The hospital's lead oncology nurse had contributed to the development of BMI's new policy for the dying patient.

There had been few complaints in the service, some staff were aware of learning from complaints across the hospital.

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

- There was a planned refurbishment in the Oncology unit that would see it expand to provide treatment for a further two patients. Recruitment was planned to support an increase in the services provided.
- The endoscopy service was undergoing change due to non-compliance and this had been identified some time ago and placed on the risk register. Funding had been secured to order new scopes and storage units, and these were planned for delivery in October 2015.
- The future service planned for decontaminating the scopes was a six-day service, with two collections a day, which would be an improvement and provide a quicker turn-around time. Additional new scopes had been ordered to update and replenish stock. The provider had agreed to an improved turn-around time for scope decontamination, to increase their capacity for endoscopy procedures.

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- The most common procedures performed using the scopes were colonoscopies, gastroscopies and sigmoidoscopies. Other procedures performed included joint injections and biopsies.

## Access and flow

- Patients reported they did not have to wait long for chemotherapy treatment and they could choose a time and date that suited them best.
- Oncology and endoscopy patients were able to access treatment through their insurance companies or privately.
- Oncology patients and their families chose their end of life care arrangements. They could be transferred to local NHS hospices for palliative care if necessary, or choose to die at the Harbour Hospital or at home. Although initially a private or fee paying patient, once they were transferred to a hospice for care, they became an NHS patient.
- The RMO told us oncology patients were occasionally admitted out of hours and a consultant would attend the hospital. One example was given of a cancer patient that was admitted to the unit and was receiving 'healthcare at home'. This patient's needs were not being met, so they agreed to admit the patient so they could be monitored and medication given effectively.
- One oncology patient mentioned they were grateful about the flexibility of their chemotherapy treatment, being able to have it when it suited them.
- The endoscopy scopes were sent to an acute NHS hospital for decontamination and the service was waiting for additional scopes. The deputy theatre and registered manager said there were no delays to patient procedures during this time as the service reviewed bookings daily. Theatre staff always made sure sufficient numbers of scopes were available for the planned procedures, which resulted in no cancellations or deferments. If they were unable to provide an appointment for a private patient when necessary, the consultant would perform the endoscopy procedure at another location.
- BMI Harbour Hospital had a contract with Dorset Clinical Commissioning Group to undertake endoscopic cases within the 18-week timeframe. Data from the last three months (June – August 2015) showed 100 % compliancy

with patients being treated within the 18-week NHS referral time for endoscopic procedures. The private and self-pay patients were also seen and treated within the set referral time.

- There were clear terms and conditions for fee paying medical insurance companies, which required regular liaison with nursing staff due to the expense of chemotherapy treatment. This was to confirm in advance of treatment that costs were covered before treatment commenced.

## Meeting people's individual needs

- The oncology unit had a 'personalised end of life care plan', which was currently being trialled in other units across BMI. The clinical lead for BMI The Harbour was involved in creating this clinical patient pathway. They were waiting for confirmation that it was effective in meeting the dying patient's needs before implementing it across the wider BMI hospitals.
- The staff followed guidance in managing deceased patients. A draft policy on the management of the deceased patient for BMI was written by the Cancer Clinical Steering Group, but no date was visible on the document. It discussed the procedure for last offices and guidance for nurses in looking after the body. The document also contained information on different faiths and religions and look after the deceased respectfully, in line with people's chosen faith or religion.
- The hospital seldom nursed end of life care (EOLC) oncology patients on the ward, telling us the last patient had been admitted over a year ago. However, the ward sister outlined the care they had given a patient who had recently chosen to die on the ward, although not an oncology patient. The ward staff and oncology team supported the patient jointly and the patient died in their place of choosing in a dignified way.
- The hospital responded promptly to patients' queries and concerns relating to their health. At the unannounced inspection, we observed a patient telephoning the oncology unit complaining of a high temperature. The nurses arranged for the patient to be seen the same day by the resident medical officer (RMO), so they could review their condition and rule out a complication of chemotherapy. When the patient arrived, the RMO examined the patient and took blood samples. The RMO reviewed the blood results, and

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along with his examination, thought it was may be a viral infection. The patient was not happy to stay after this, as preferred to be at home and after the RMO liaised with the oncology nurse and consultant, they agreed to let them go home. This demonstrated a team work approach but also responsiveness to meeting a patient's needs.

- We saw a triage log sheet that oncology nurses used to document advice given when taking phone calls from patients. . On this document, they also recorded the patient's signs and symptoms and what action or follow up was taken.

## Learning from complaints and concerns

- Staff were encouraged to report verbal complaints and these were recorded. However there was a lack of consistency in learning from complaints. Some staff told us they received feedback and others said they did not.
- The registered manager held a weekly complaints meeting with the interim director of nursing and the quality and risk manager, to discuss specific issues, investigations and learning.
- The hospital complaints leaflet did not mention the Health Ombudsman; we were told that NHS patients were provided with those details in second stage complaint response letters.
- Staff from the oncology unit and endoscopy service said they could not recall specific examples of complaints they had received from patients. All complaints were dealt with by the management team, and information cascaded down as appropriate and necessary.

## Are medical care services well-led?

Requires improvement 

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

Cancer services were in the corporate strategy, with investment planned to expand the service by increasing bed capacity. Endoscopy was being led through change that would result in an improved service.

There was a positive culture, with competent local leadership and a happy workforce. This was especially evident in the oncology unit.

The leadership team did not manage governance arrangements and risks consistently to identify and implement improvements. The risk register was not actively managed or updated and did not reflect progress or actions taken, with timeframes not reviewed. Some managers did not have the capacity to attend meetings and some meetings were held less frequently to compensate for this. Meeting minutes and action plans did not clearly identify issues for staff to address and report on at subsequent meetings. There were also gaps in the audit programme.

Although staff reported incidents, leaders were not skilled in investigating them using root cause analysis to fully understand causal factors. The incident categorisation system lacked clarity and there was a risk from staff classifying patient falls as non-clinical incidents.

## Vision, strategy innovation and sustainability for this core service

- The hospital's registered manager outlined the BMI corporate vision, to deliver the highest quality outcomes, the best patient care and the most convenient choice for patients.
- The BMI strategy and vision was cascaded to staff through heads of department and senior nurse meetings. Strategic objectives included investment in departments such as cancer services and acute general medicine.
- The oncology unit was about to be expanded by adding a further two beds. At the time of our inspection, there were five beds and the plan was to reconfigure the unit with three beds and four 'pods.' Pods are reclining treatment chairs rather than hospital beds for patients undergoing short treatments. Work was due to start two weeks after our inspection for an 8-12 week period.
- BMI had focused on the principles of the '6 C's', initiated within the NHS, to put their vision into practice. These were to demonstrate commitment, courage,

# Medical care

communication, care, compassion and competence. The 6 'C's' were evident across the hospital at the time of our inspection. Staff were familiar with the 6 C's and were passionate about delivering a high quality service.

## **Governance, risk management and quality measurement for this core service**

- The hospital held a risk register, but this was limited to a small number of high-risk items. Some had been on the register since 2011 and although some action was now being taken, the risks were not managed in a timely way. We were told that, in some cases, delays were due to corporate decisions and funding, but there was little detail about actions taken to mitigate risks in the interim. For example, the endoscopy department and decontamination problems had not been identified as a risk before 2014 and outsourcing of decontamination of scopes had not started before autumn 2015.
- The risk register showed the equipment and environment in endoscopy was non-compliant with Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation. This was because there was no segregation between clean and dirty areas, no hand washbasin, and storage facilities were inadequate. The scopes they had in stock were on average, 18 years old. This concern was placed on the risk register on 19 May 2014 with a review date of 19 June 2014, but action was only starting to take place at the time of our visit. The risk showed a score was 10, which classed it as a high risk on their register due to 'possible infection.' At the time of our inspection, the scopes were sent away for decontamination, and new scopes had been ordered.
- Staff expressed frustration about the delay in responding to risks associated with the endoscopy suite. Staff attributed the delay to the provider not responding to the risk adequately. Locally there was awareness that change was needed but we were told it took time to convince the national organisation. There were some delays due to the corporate approach to a solution, and a risk the service would be stopped.
- On 27 July 2015, an entry was made on the risk register regarding the lack of competency for pharmacists dealing with oncology. This had a high risk score rating, and a review date of 27 January 2016. It was not clear whether the score accurately reflected the risk, as competencies were being developed at the time of our inspection.
- Some audits, for example in endoscopy, services had not been completed in full and there was no action plan resulting from the audit.
- Arrangements for implementing and embedding learning from incidents across the hospital were not robust. Incidents were discussed but action plans were not developed, implemented and reviewed.
- The governance structure included many subcommittees and clinical managers did not have adequate protected time for their management responsibilities, including attending governance meetings. This meant that meetings such as the clinical governance meetings were not attended consistently and other meetings, such as the pharmacy meetings, were held only quarterly. Infection control issues were not adequately covered. This had been identified and there had been recent decision to remove the infection control committee. The infection control lead would report directly to the clinical governance committee instead. The lead continued to hold infection prevention and control meetings with link nurses from different departments,
- The medical advisory committee (MAC) included representation from medical services. The MAC had bimonthly meetings, scheduled a week after the clinical governance meeting. This arrangement enabled issues identified at clinical governance to be carried forward for discussion with the consultants. The MAC meeting minutes indicated that members raised and discussed key issues, such as incidents and complaints. There was a lack of evidence that members reviewed actions arising from the meetings. The chair of the MAC confirmed there was effective learning from complaints and incidents and they shared learning with relevant members; however, we did not see how this was achieved.
- The MAC had a role in reviewing consultant practicing privileges maintaining safe standards amongst consultants and clinicians. Each consultant was required to complete biannual reviews with the MAC chair, where data on their clinical performance was discussed. The hospital also ensured that consultants had appropriate professional insurance in place and received regular appraisals.

## **Leadership/culture of service**

- The head of oncology for BMI, the service clinical lead, was not based at this hospital, but a senior nurse

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managed the oncology unit. The theatre manager also oversaw endoscopy services as this was not a standalone unit, but a theatre that performed the procedures within the department. The ward manager and sister managed medical and surgical patients on the ward.

- The oncology nurses spoke highly of the unit they worked in and were happy in their jobs. The clinical lead told us they felt supported by the registered manager, and an example of this was given by a member of staff that needed time off work due to family bereavement. The ward sister said they felt fulfilled at work and were well supported in their role by the senior management team.
- Some staff felt that BMI did not invest in its staff by offering or supporting training courses for their personal development.
- There was no staff survey completed in 2015, but we reviewed the results on the 2014 staff survey. There was a 49% uptake on completing the survey, which the hospital management team felt was a good result. It showed 98% of staff would recommend the hospital for care and treatment, and 75% would recommend it as a place to work. An action plan was drawn up and certain

items had been implemented at the time of our inspection. A staff pay rise, daily departmental staff meetings and pin badges awarded for length of service were items identified and instigated.

- A consultant oncologist spoke very positively about the hospital in general and the good working relationships between clinical and non-clinical staff. They said the treatment for patients was good with prompt access to medicines and effective nursing care.
- A staff drop in session was attended by a medical secretary, a fixed price co-ordinator, a staff nurse in oncology, an NHS process lead, a chef and a healthcare assistant. All the staff spoke highly of working at BMI Harbour Hospital and felt satisfied in their roles. Many staff had been there many years and wore pin badges with pride.

## Public and staff engagement

- Results of the latest patient survey showed a high level of patient satisfaction, with the hospital scoring 98.7%. Areas of concern, such as catering were being addressed.
- Staff were involved in decision making in the hospital and had opportunities to put ideas across to improve the service or patient care, for example oncology services.

# Surgery

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

## Information about the service

BMI The Harbour Hospital has three surgical operating theatres, a lay-up room, a scrub room and a six-bedded recovery area. There is a decontamination reception and dispatch area, storage areas for sterile supplies and prostheses, and a dirty utility. Two theatres have laminar flow ventilation systems for clean air when carrying out operations that are more complex.

Between April 2014 and March 2015, there were 3,857 visits to theatre. Surgical operations included ophthalmology, cosmetic and plastic surgery, orthopaedic and cancer surgery. All operations were planned. The hospital can provide enhanced monitoring post-surgery but does not have provision for treating high dependency patients, and in an emergency, these patients are transferred to the nearby NHS hospital.

The hospital has one main ward with 26 inpatient beds and an oncology unit with six day-case beds, some of which were occasionally used for surgical patients. During the year to March 2015, there were 3,227 day-cases treatments and 1,029 inpatient treatments. The NHS funded approximately 30% of day cases and 10% overnight inpatients; over 90% of inpatient treatments were privately funded.

The surgical operations most commonly performed were cataracts, carpal tunnel release, total hip replacement, hernia repairs, laparoscopic cholecystectomy (gall bladder removal) and arthroscopic knee procedures. Surgeons carried out the majority of operations on weekdays, with one theatre open on Saturdays.

The hospital carries out surgical treatments on young people over the age of 16 years only, generally for ear, nose and throat, orthopaedic procedures and general surgery, following a risk assessment carried out at pre-assessment. In the period from April 2014 to March 2015, there were six inpatient and three day-case treatments for young people aged 16 and 17 years.

The inspection included a review of all areas where surgical patients would receive care and treatment. We also spoke with seven patients and reviewed 16 patient records. During the inspection, we spoke with 20 members of staff, including senior managers, consultant surgeons, nurses as well as allied health professionals, housekeeping staff and clerical staff. We spoke with seven patients. We reviewed performance data and reports relating to the management of the service, including incident reports, complaints, staff training records and equipment service reports.

# Surgery

## Summary of findings

Surgical services provided good standards of care and treatment to patients. There were low incident and infection rates and staff took incidents and complaints seriously as opportunities for learning. The provider needed to ensure staff understood the duty of candour regulation and applied it in practice. Staff completed essential safety training and there were sufficient staff on duty, with the right skills, to keep patients safe. They carried out safety checks on equipment and the environment, but they omitted some audits from the programme and systems for learning from audits were not consistently robust. Patients received medicines safely and at the right time and there were safe procedures for managing medicines, including medical gases, in the hospital.

There was a strong sense of teamwork and loyalty among the staff. Staff valued the support from their leaders and liked working in the service. The leadership within the service required improvement and there was a high vacancy rate and low appraisal rate. There was a lack of protected time for managers to complete their management roles. Service leaders had not identified key risks relating to the service and classified them on a risk register, for mitigation and escalation. This meant there was a possibility that risks would not be communicated and managed effectively.

Staff followed evidence-based care and treatment, and monitored and reviewed patient outcomes. Staff within surgery services were caring and patients received kind and compassionate care and treatment. Patients understood their treatment, and consented to care. Staff carried out effective pre-assessment and planned treatment, recovery and discharge in line with patients' specific needs. Patient feedback was positive, and patients were treated in a timely way, however they did not have consistent access to guidance on the complaints process.

## Are surgery services safe?

Good



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

Staff reported incidents and openness about safety was encouraged. Incidents were monitored and reviewed and staff gave examples of learning from incidents. Although most staff understood the principles of Duty of Candour regulations, they were less confident in applying the practical elements of the legislation. There were systems for monitoring safety, including checks of the environment, equipment, cleanliness and hygienic practices. There were safe arrangements for managing medicines and for responding to suspected or actual incidents of abuse. Staff were up to date with their mandatory training.

Patient records were accurate and provided detailed records of care and treatment. The pre-printed care pathways for patients were inconsistent in layout, and hospital staff were prompted to use two different tools for monitoring a deteriorating patient. The handover records had insufficient space for adding comments.

There were safe systems for risk assessing patients and staffing levels were managed to meet the needs of the patients and to provide emergency responses. Staff had practiced emergency responses including fire evacuations.

There was sufficient staffing and skill mix on the wards and in theatres. Resident medical officers were well supported by consultant surgeons and anaesthetists, both during working hours and through out of hours on call cover.

### **Incidents**

- The hospital reported 163 clinical incidents between April 2014 and March 2015 of which one was classified as a serious incident (SI). The number of clinical incidents per 100 inpatient discharges showed a downward trend during this period, from five to less than four in March 2015. There had been two hospital acquired infections during this period, and no 'never events.'
- The serious incident had been investigated within the hospital and reported to the Care Quality Commission (CQC).

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- The infection control nurse monitored incidents of surgical site infections (SSIs). The minutes of the last infection control meeting showed that SSIs were investigated and changes to practice to improve patient safety were made. For example, as a result of learning, pre-admission nurses had revised advice for preparing patients for surgical procedures. The infection control nurse had identified an issue with cosmetic patients reporting infections after a 30-day cut off point for reporting. Further investigation of these incidents was planned, to improve SSI identification post discharge. Overall, the number of reported surgical site infections was low, with six identified in the quarter May to July 2015, which indicated the systems for identifying surgical site infections post discharge might not be robust.
- Staff said there was an open culture to reporting incidents and they knew how to report them using the hospital's paper-based incident forms.
- Some incidents were discussed in detail at the quality and risk bimonthly meetings. Actions for learning and follow up were included in the text but there was no clear action plan and actions were not reviewed at subsequent meetings. However, staff were able to describe examples of learning and changes in practice resulting from incidents but there was a risk that opportunities for learning could be missed.
- Staff reported they discussed incidents at their team meetings. For example, the theatre team meeting had recently included a 'lessons learnt' item in their agenda and a recovery nurse was able to outline learning and changes resulting from a recent incident.
- The quality and risk monthly summary report for July 2015 showed a list of clinical incidents with any learning and trends. The report we reviewed indicated there were no trends from incidents in that period. The quality and risk manager confirmed that they looked for any trends using the incident database.
- Staff had a variable understanding of the Duty of Candour regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation sets out a formal process for informing patients or their relatives when an incident during treatment has caused harm. Staff were able to describe the principles of the regulations and some staff were aware of a new policy on the topic that they were required to read. The senior managers recognised a gap in knowledge of this regulation. The previous director of

nursing had attended BMI training workshops, but this did not extend to others at the hospital. A corporate policy outlining responsibilities had recently been issued

- The medical advisory committee (MAC), a leadership group of 10 consultants, reviewed selected incidents at their bimonthly meetings in order to identify and share lessons learnt. Medical staff and surgeons told us that there was a strong culture of sharing learning.
- Safety alerts, for example relating to medical devices, medicines or infections, were received by the hospital and communicated to heads of department. The provider's clinical governance and quality and risk team included safety alerts on their bulletin publication. Safety alerts were monitored centrally and the hospital reported any action taken where necessary.
- The hospital reported incidents to the CQC in line with regulations.

## Safety thermometer or equivalent

- The hospital displayed safety data on the ward, showing any hospital acquired infections, staffing levels, trends in staffing levels and patient feedback. This was updated to provide a visual summary for staff, patients and visitors.
- Data from the hospital showed staff risk assessed patients for venous thromboembolism (VTE). VTE screening rate of 95% met for three of four quarters. There was one case of hospital acquired VTE (Apr 14 to Mar 15). Trend analysis showed patients had not been receiving consistent preventative interventions for VTE, but this had improved since July 2015.
- The rate of pressure ulcers had remained consistent between September 2014 and August 2015, at about 4%, and the rate of falls was between 0.7% and 0.6%. The proportion of patients with a urinary catheter was above the national level of 20% in July and August 2015, but there were no catheter related urinary infections.
- The hospital reported on patient harm, using the 'NHS safety thermometer' to survey patients on one day each month. The hospital did not display results from this tool or refer to the tool in clinical governance reports.

## Cleanliness, infection control and hygiene

- Healthcare-acquired infection rates were low. The hospital reported one incident of *Clostridium difficile*,

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one incident of methicillin-sensitive *Staphylococcus aureus* (MSSA) and zero incidents of methicillin-resistant *Staphylococcus aureus* (MRSA) in the year to March 2015.

- Patients were routinely screened for MRSA prior to surgery. If positive, they received treatment for MRSA and surgery was not performed until they were clear of the infection.
- The theatre suite was visibly clean, and there was a safe 'flow' from clean to dirty areas to minimise the risk of cross contamination of equipment. The cleaning records showed there was a programme of daily and weekly cleaning, and the hospital used single use equipment where possible. We observed cleaning of non-single use equipment between patients. There were gaps in the sign sheets for two days in August and we were told the theatre was not operational on those days, however, this was not recorded in the records.
- Staff were 'bare below the elbow', and used personal protective equipment, such as aprons and gloves, to minimise the spread of infections.
- The ward areas were visibly clean and there were hand sanitisers available for patients, visitors and staff. The ward-cleaning records were completed with no gaps in August 2015, and the ward sister checked these regularly.
- Policies and procedures for the isolation of patients to minimise the spread of infections, were implemented when required. There was no spread of the one case of *C. difficile* on the ward.
- There were housekeeping staff on site between 6am and 10pm or 11pm and they used a system of colour-coded, disposable cleaning materials to minimise the risk of spreading infections. There were clear responsibilities and procedures for cleaning blood spillages.
- The hospital had appointed an infection control nurse, who worked across two hospitals and maintained links with the local NHS infection control team for advice. The lead monitored audits, provided guidance at senior nurse meetings and managed the infection prevention programme. This included training and supporting link nurses in each department of the hospital.
- The hospital operated safe infection control procedures, as shown by audits and checks. The infection control lead nurse had completed environmental audits using the Infection Prevention Society's quality improvement

tool (QIT). Audits were carried out on aseptic procedures, taking blood cultures and hand hygiene, and staff were advised on how to improve their practices.

## Environment and equipment

- Equipment was managed safely and checked to ensure compliance with safety standards. The service level agreement with the local acute hospital covered planned preventative maintenance for the environment. The maintenance manager oversaw portable appliance testing (PAT) of non-medical equipment. Medical equipment was PAT tested as part of annual servicing.
- Appointed staff champions oversaw maintenance and servicing of equipment in each department.
- There were safe systems for controlling access to the ward and the operating theatre suite, including at night.
- Appointed staff champions oversaw maintenance and servicing of equipment in each department. There was evidence of regular hoist and sling checks on the ward.
- Staff said they had good access to equipment, which was well managed.
- Water supplies were maintained at safe temperatures and there was regular testing and operation of systems to minimise the risk of *Legionella* bacteria colonisation.
- Anaesthetic and resuscitation equipment was checked on days when the theatre was operating. Records showed the trolleys used for resuscitation and associated equipment, for example suction and oxygen, were checked daily in line with professional guidance. Equipment for pacing heart rhythms was available, accessible and checked.
- Resuscitation equipment on the ward was regularly checked. Resuscitation committee minutes noted that the local NHS trust resuscitation team had audited resuscitation equipment across the hospital.
- There was an up to date sign-sheet showing staff had been assessed for their competency in using equipment in the theatre suite.
- The risk register included some items of equipment that needed replacing, such as beds and areas requiring refurbishment. The windows were being replaced at the time of our inspection, and there was planned removal of ward carpets in 2016.
- There were risk assessments in place for the window replacement work. Work was planned to avoid patient activity on the ward and out patients.

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## Medicines

- The hospital had an on-site pharmacy. This was staffed by a pharmacist and a pharmacy technician who worked across two hospitals. The pharmacy had recently moved into a new room on the ward and was accessible.
- On the ward and in theatres, medicine-related stationary and medicines including Controlled Drugs were stored securely. Access to the pharmacy was controlled by a keypad with a secure code system.
- Medicines were stored at safe temperatures. Refrigerator and room temperatures were monitored and appropriate actions were taken when temperatures were outside the recommended ranges or when staff had made recording errors.
- Emergency medicines, including oxygen, were available for use and expiry dates checked on a weekly basis to ensure they were safe to use.
- The ward emergency trolley and an occasional use emergency trolley within theatres were stocked with the correct medicines.
- Medicines used to reverse the effect of anaesthetics were available as pre-filled syringes to be used when required, rather than drawn up on the day then destroyed when not required.
- There was a safe system for generating medical air in theatres. It was produced by on-site compressors and the air quality was monitored.
- The labelling of some medicines was non-compliant with Medicines (Labelling) Regulations 1976, by failing to display the address of the supplying hospital pharmacy. One supplier's medicines did not include the hospital address label on 'to take out' medicine packs. To overcome this, staff added the hospital address manually until pre-printed labels were available.

## Records

- Patient records were stored securely and could be withdrawn from the medical records department when required by authorised staff. Records were held on site, including those created by visiting medical staff. Staff were careful to ensure records were not left where unauthorised people could see them.
- Records were in paper format and for the most part legible, with entries dated and signed. We saw one set of

notes where it was difficult to read the consultant's writing. Records were scanned and archived onto a secure electronic system, one year after patient discharge.

- The provider used printed booklets for recording patient care for different care pathways. These standard care pathways included prompts to record key information about patients, including their past medical history and medication, as well as details of their pre-operative risk assessments. These pathways were completed accurately. There was one set of notes where the national early warning score (NEWS) used to monitor deterioration in a patient, was not calculated, however there was no adverse impact from this omission. We raised this with the sister who agreed this was an error.
- Records were not ordered in a consistent way across different procedures. The booklets for surgery included the World Health Organisation (WHO) five steps to safer surgery checklist. There were pages to complete with details of the patient's care during anaesthesia, surgery and recovery as well as their discharge arrangements. The WHO surgical checklists were not standardised across the different booklets. Theatre staff said they used a separate, loose sheet and inserted this into the records booklet later, following BMI corporate policy. Although this was labelled with the patient's identity, there was a risk the loose sheets could be omitted from the records.
- The NEWS system for monitoring if a patient's health was deteriorating was incorporated into the inpatient pathways, but not in those for day-cases. Day-case pathways used a different scoring process, which did not display results graphically and used a reversed scale for pain. Staff commented that having two different systems was not helpful. There was not a standardised approach to recording nursing care and there was a risk that deterioration in a day-case patient might not be escalated safely.
- The handover forms were not useful working documents for staff to annotate with additional information. They listed patient details, their procedure, consultant, and dates of admission and discharge but were not laid out with sufficient space for staff to add their own notes clearly. In addition, although the printed forms highlighted if there was an alert associated with a patient, they did not show any detail as to the nature of the risk. This meant there was a risk that important information could be omitted at handover.

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- Patient records included multi-professional clinical notes, including those from physiotherapists and occupational therapists, to support safe care and treatment.
- Ward staff regularly audited records and shared learning with their manager and colleagues. The ward sister included the findings in ward meetings and these were minuted.
- The operating theatres maintained a comprehensive log of implants in their prosthetics register. Reference stickers were retained from each implant in the register as well as in patient notes, and these were signed for when used.

## Safeguarding

- The acting director of nursing was the safeguarding lead for the hospital and she had been level three trained, to be able to investigate safeguarding issues in a management capacity.
- Other staff were trained to level 2 in safeguarding. All staff we spoke with knew what the term safeguarding meant and how to recognise signs of abuse. They knew how to seek support if they had queries and said they would raise alerts if they had concerns.
- There had been no safeguarding alerts or concerns reported by the hospital in the 12 months prior to the inspection. A senior staff member said they had raised an alert with the local authority when they had concerns relating to a patient admitted from a care home. They followed up their concern to check that action had been taken.
- Staff could access the BMI safeguarding children and vulnerable adults' policy for reference. There were local procedures for contacting the safeguarding authorities including Bournemouth, Poole, Dorset and Hampshire in the ward office.
- Staff had access to information about the Mental Capacity Act 2005 (MCA). There were printed policies for the MCA, including the Deprivation of Liberty Safeguards (DoLS) and the Pan Dorset, Bournemouth and Poole DoLS guidelines. DoLS are to protect the rights of people, by ensuring that any restrictions to their freedom and liberty have been authorised by the local authority.

- The hospital had not made a DoLS application for any patient. The director of nursing said consultants advised patients who might be assessed as lacking capacity to make decisions about their care to be treated in NHS hospitals, where there were wider support mechanisms.

## Mandatory training

- Staff were up to date with mandatory training. The training report provided in September 2015 showed that the staff group as a whole achieved 92% compliance with mandatory training, above the BMI target of 90%. Within theatre staff, the compliance rate was 95% and nursing staff had achieved 91%. There had been a focus on completing mandatory training and the hospital recognised individuals achieving 100%.
- Each staff member was linked to a role-profile in the BMiLearn system so they were automatically assigned to a relevant mandatory training plan. Some training was e-learning, but this was supplemented by face-to-face and practical training where appropriate.
- The resident medical officers (RMOs) were employed from an agency and had completed advanced adult and paediatric life support training. Ward staff were trained in intermediate life support and staff reported that the training received in this topic was provided on site, by specialist trainers from the local trust. Additional training was also provided at the local NHS trust.
- Staff reported good access to training and they were reminded by their manager to maintain their skills by attending update courses. Theatre staff had reported a difficulty in attending practical training sessions and the theatre manager had arranged to book them onto days with no planned surgery.
- Fire safety training was mandatory and the hospital had undertaken a fire drill with an evacuation exercise within the past six months.

## Assessing and responding to patient risk

- Risks to patients were assessed and monitored at pre-assessment, and then checked again prior to treatment. These included risks relating to mobility, cognitive understanding, medical history, skin damage and venous thromboembolism (VTE). Patients had to meet certain criteria before they were accepted for surgery, to minimise the risks to their health and wellbeing.
- Patients completed medical questionnaires. These were reviewed at pre-assessment appointments, to assess

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the suitability of patients for surgery and to carry out health assessments such as blood tests, and discussions about the procedure. The pre-assessment nurse may have carried out a short, telephone pre-assessment for lower-risk surgery, depending on the information provided in the patient's questionnaire. The pre-assessment nurse confirmed that if these discussions indicated a potential safety concern, they escalated the issue to the surgeon or anaesthetist.

- The theatre manager commented that pre-assessments were carried out safely, so that any specific equipment was prepared and ready; and patient specific-information, such as allergies had been considered. The theatre team signed off the booking forms before patients were booked onto a surgical list.
- The theatre team used the 'Five steps to safer surgery' WHO checklist to minimise errors in surgery, by carrying out a number of safety checks before, during and after surgery. The use of the WHO surgical checklist was monitored and the hospital had recently taken steps to improve compliance with this procedure.
- Procedures were in place to monitor patients after surgery for any deterioration in their health. The National Early Warning System (NEWS) was used after inpatient surgery. NEWS scoring was initiated in recovery and continued on the ward. For day cases, a simplified scoring system was used, where the scores were less clearly linked to specific actions.
- The cosmetic surgeon or the pre-assessment nurse carried out psychological screening for cosmetic surgery patients. The surgeon and nurses identified if the patient needed additional psychological assessment in advance of consenting for surgery. The interim director of nursing confirmed that the surgeon and nurse had refused treatment to patients who they assessed as psychologically unsuitable for this type of surgery. It was not clear however that they asked GPs for patients' psychological history when patients referred themselves directly for treatment.
- The resident medical officers took part in unannounced resuscitation scenarios six times a year, led by the NHS acute hospital, to ensure they could provide safe care in an emergency.
- There were no facilities to support patients who needed critical care. In these cases, the hospital followed procedures to transfer the patient to the local NHS hospital that was in close proximity. In an emergency,

the procedure was to call emergency services for a rapid transfer. The resident medical officers outlined how they had managed such events, commenting that the procedures had been managed safely.

## Nursing staffing

- Staffing levels were sufficient to support safe care. The ward staffing levels were based on a BMI nursing dependency and skill mix tool. This was used to plan the skill mix requirements for each shift one week in advance. There was scope for the ward manager to adjust the tool's predicted staffing requirement based on experience and professional judgment. Fewest clinical hours were required at weekends, when there was reduced activity, and staffing hours were highest midweek.
- The hospital monitored staffing levels on the ward, and the 'clinical hours report' showed the required versus actual staffing levels, in hours, for each day. This report indicated a close correlation between the required and actual staffing hours. The ward sister described reasons why some days there more staffing hours than the model suggested, and examples when there were fewer hours used than predicted.
- Staff worked flexibly, and said there were enough staff to provide safe care. The night shift was always staffed with at least two registered nurses, including when patient occupancy levels were low, in order to be able to respond to an emergency. On weekdays, a healthcare assistant worked a twilight shift, to support patients with meals, discharge arrangements and general care.
- The resident medical officers had a high level of confidence in the skills and experience of the nursing staff.
- In theatres, the hospital operated with a ratio of a nurse manager to two nurse team leaders and one team leader to 2.4 nurses and 2.8 operating department practitioners (ODPs). In March 2015, the hospital reported 20% significant vacancies for ODPs in theatres, and high levels of sickness amongst ODPs and care assistants. The hospital employed regular agency staff and the theatre manager also worked in theatre to cover the vacancies. We reviewed rotas and found appropriate numbers and skill mix of staff, in line with Royal College of Surgeons guidelines. Two new staff had been recruited to start in September 2015.

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- Student nurses worked on the ward in supernumerary role, as the hospital was part of a student nurse training rotation.

## Surgical staffing

- Over 140 doctors, surgeons, anaesthetists and dentists worked at the hospital under practising privileges contracts. Of these, about 50 worked at the hospital regularly, and over 80 had not carried out any treatments in the year to March 2015. All had their practising privileges status reviewed every two years by the hospital Medical Advisory Committee to check they continued to be suitable to work at the hospital.
- Consultants provided personal cover for their patients 24 hours a day, seven days a week. They arranged alternative cover from another consultant with practising privileges at the hospital when they were not available. The resident medical officers (RMOs) reported that consultants returned their calls promptly if they had any queries about patient care.
- All staff we spoke with reported good communication links with consultants and the RMOs. The RMOs worked for two-week periods and stayed on site to be available for call outs. They reported there were very few patients on the ward and infrequent call outs at night. There was consistency in the RMO cover, and there had been fewer than five different RMOs at the hospital over the past year.
- Handovers between RMOs were effective and the RMOs also attended the handover to night shift. They had a good understanding of the patients' needs on the ward.

## Major incident awareness and training

- The hospital had local and corporate business continuity plans with supporting action cards to use in events such as internet or electricity failure. The business continuity plans were available in folders in reception, the ward, in theatres and the plant room.
- A generator was available for use in case of power failure and it was tested monthly.
- All staff understood their responsibilities if there was a fire within the building. Fire evacuation drills were held three times a year, during the day, night and at the weekend. The fire officer made notes on the simulation exercises and this was discussed at fire team meetings to review actions needed. Every bed was fitted with a fire evacuation sheet and checked monthly.

## Are surgery services effective?

Good



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

The hospital had policies and procedures to ensure staff provided care and treatment in line with evidence-based guidance and standards. Patient outcome data was reported for comparative analysis however, there were some gaps in this, in particular for cosmetic surgery.

Patients reported their pain was managed effectively, and staff worked well together, communicating important information about patients, their needs and any changes required for their care. Information about patients, care pathways and the management of the service was available to support effective care and discharge.

Patients received a choice of meals and drinks and the chef catered for patients requiring special diets. The hospital had a contract with the local NHS trust for dietitian and other specialist services.

Staff had good access to training and there were opportunities for staff to attend additional courses to extend their skills. They ensured patients understood and consented to their treatments. Staff had completed training in the Mental Capacity Act 2005 and there were appropriate guidance and tools to use to assess a patient's mental capacity. A low proportion of staff working in surgery had completed an annual appraisal, although staff told us they felt well supported.

## Evidence-based care and treatment

- The hospital followed surgical protocols based on best practice, researched guidance. There were limited audits to demonstrate best practice was followed consistently, but those that had been completed recently showed a high level of compliance.
- Patients were assessed for venous thromboembolism (VTE) and staff took steps to minimise the risk where

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appropriate, in line with the National Institute of Care Excellence (NICE) guidelines. Audits had shown there were gaps in the screening and this had improved following actions taken by staff.

- Over 98% of patients had been assessed for VTE in three out of four reporting quarters to March 2015. In the period October to December 2014, this rate had dropped to 91%; below the targeted rate of 95% required for NHS contracts. Reasons for this had been identified and addressed and rates had improved thereafter. There had been one case of hospital acquired VTE, and this was in the reporting period July-September 2014.
- The hospital followed NICE guidance for preventing and treating surgical site infections. Orthopaedic patients were asked to complete a surgical wound healing questionnaire post discharge to assess infection rates.
- The use of the surgical site infection care bundle was audited in July 2015 to ensure it was used effectively, and results showed good compliance with suggestions for any improvements.
- In theatres, a recovery nurse had used NICE guidance to research replacement temperature probes, showing a good understanding of applying best practice techniques.
- The hospital had set up off-site endoscopy decontamination, as their endoscopy suite had not been compliant with requirements and guidance on decontamination, issued by the Joint Advisory Group on gastrointestinal endoscopy (JAG) of the Royal College of Physicians.
- Audits had been carried out in May, June and July 2015 on
  - Urinary catheters insertion
  - Insertion of peripheral intravenous cannula
  - Insertion of central venous catheters.

Results showed that practices showed a high level of compliance with NICE quality standards.

- Consultants confirmed that BMI surgical procedures were in line with best practice and were followed consistently. The clinical governance and quality and risk bulletins highlighted latest NICE guidance however it was not clear how this information was used in practice.

- The team brief, carried out in advance of surgery by the operating team, included confirmation of equipment checks. Staff laid out the intubation trolley in compliance with the Difficult Airways Society guidelines.

## Pain relief

- Patients were given an information booklet about pain control as part of their information pack. This included advice on how to describe pain to staff, and guidance about asking for assistance. The anaesthetist also explained pain control and pain management procedures to patients.
- Anaesthetists, recovery staff and nurses monitored patients' pain, during and after surgery. Healthcare assistants and nurses had attended pain study days to help them undertake effective pain observations and support patients with pain management.
- All pain relieving medicine was recorded in patient records.
- Patients said they had been given clear information about pain control and pain relief had been given promptly. One patient commented that the anaesthetist had been very helpful and reassuring in the way they had explained pain management. Another said they had minimal pain, and had a warming blanket to help them feel comfortable.

## Nutrition and hydration

- Pre-assessment questionnaires asked patients if they had special dietary requirements or allergies, and if they had experienced weight changes or swallowing problems. Patients were also asked if they needed assistance with eating. This information was used to inform a nutritional risk assessment. The hospital used a recognised risk assessments tool, the malnutrition universal screening tool.
- Patients were advised of fasting times prior to surgery, at pre-assessment. Their pre-assessment guidance included what and when to eat and drink post-surgery. Staff outlined how they monitored patients for post-surgical vomiting or nausea. This was recorded in patient notes.
- Total parenteral nutrition (TPN) was available for patients when required. TPN is nutrition provided intravenously when patients should not, or cannot feed orally. Dietitian or speech and language therapy services were provided when required, from the local NHS hospital under a service level agreement.

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- Inpatients had a choice of meals for breakfast, lunch and dinner, and were offered additional snacks in the mornings and afternoons. They could request meals at other times, from a more limited range of options, and change their orders if they preferred.
- Patients had reported reduced levels of satisfaction with the food following a recent change to the catering contract. The hospital was addressing these concerns. One patient told us they found the choice and quantity of food offered for the evening meal was not to their satisfaction.

## Patient outcomes

- The hospital was part of a national study in assessing patient outcomes from its enhanced physiotherapy rehabilitation programme. This programme used special equipment to support orthopaedic and spinal patient recovery. Physiotherapists, patients and consultants were positive about the outcomes achieved. Patients were asked to complete online questionnaires to evaluate different orthopaedic treatments. This study started in January 2015.
- The hospital's readmission and 'return to theatre' rates were similar to those of other independent hospitals, indicating patient outcomes at this hospital were similar to those treated elsewhere.
- The hospital's readmission rates were within the expected range. The standardised 30-day emergency admission rates for cataract, hernia and knee replacement procedures were similar to those of similar independent hospitals for the period between October 2013 and September 2014.
- The hospital had five cases of unplanned return to theatre in the year to March 2015. This equated to approximately 0.2% of operations, which is relatively low. July to September 2014 there were no cases of unplanned return. 'Better than expected', compared to the other independent acute hospitals.
- There was a consistent rate of unplanned transfer of an inpatient to another hospital, in the reporting period (Apr 14 to Mar 15), 'similar to expected' compared to the other independent acute hospitals.
- Data analysis showed that patients treated for repair of inguinal hernia, carried out by laparoscopy, had similar outcomes to those patients treated in other independent hospitals.
- NHS patients provided information about their surgical outcomes for different procedures. This data was collected nationally, and called 'patient reported outcomes measures' (PROMS). For this hospital, NHS patients reported a higher than average 'health gain' when compared with the national result for groin hernia treatment.
- The hospital submitted PROM data for knee and hip procedures, but these were insufficient numbers to report on.
- The hospital had no data to show specific outcomes from patients who had undergone plastic surgery.
- The provider was working with the Private Healthcare Information Network to develop ways of reporting on patient outcomes, to be able to compare results with those reported by the NHS.

## Competent staff

- The hospital had systems for supporting staff with learning and developing, however in practice, few staff working in surgery had received an annual appraisal due to capacity constraints. There was a shortage of theatre staff and the manager was often required to work in theatre. Care staff and operating department practitioners had not received an appraisal in 2014, and less than 49% of nurses working in theatres had received an appraisal. This meant staff did not have the opportunity to discuss their development and training needs in a formal way. However, staff we spoke with in theatres said they felt well supported and listened to. There was a new BMI appraisal process and staff were required to attend training.
- Within theatres, staff were required to complete competency booklets and there were opportunities for new healthcare assistants to undertake a specific BMI foundation course for their role. Experienced staff reported good access to refresher courses and training days in topics such as preventing nerve damage and blood transfusions.
- Staff were encouraged to attend study days and present their learning back to colleagues. The theatre manager had recently set up 'lunch and learn' sessions, with presentations on topics such as hernias, Parkinson's disease and difficult airway management.
- Resident medical officers (RMOs) accessed training through their agency. RMOs developed their training plan with the agency and participated in annual

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appraisals. Within the hospital, they also attended courses provided by BMI, for example on siting Hickman lines (catheters used to administer chemotherapy or other medications into veins in the chest).

- The infection control lead reported good access to courses and conferences, as well as quarterly meetings with the BMI infection control lead to improve their knowledge and skills.
- The medical advisory committee (MAC) was responsible for granting and reviewing practising privileges for medical staff. New consultants were required to provide evidence of qualifications, training, and registration. The chair of the MAC gave examples of when they had refused admitting rights to consultants, or had set limits on their practice, based on their skills and competencies. Staff with practising privileges had to reapply and undergo reviews biannually, which included reviews of clinical outcomes, complications, and training and appraisal records. The hospital maintained a list of consultants showing their indemnity insurance and review dates, and all had submitted appraisals as required.
- All surgical staff, including nurses, allied health professionals and staff working under practising privileges held valid professional registration for their roles.

## Multidisciplinary

- There was effective multidisciplinary working, with systems in place for staff of different disciplines to discuss, plan and deliver integrated care for patients. This was confirmed by feedback from administrators, allied health professionals, housekeeping, medical, and nursing staff. Staff reported that systems for sharing information about patients were effective, commenting that this ensured patients' needs could be met across a range of treatments, therapies and support.
- The ward team held brief morning 'huddles' for departmental representatives to share information about surgical lists, patients and any events of importance that day.
- Records showed evidence that staff of different disciplines were actively involved in people's care.
- Physiotherapy services were planned to support effective recovery and rehabilitation, including follow up appointments at outpatient clinics.
- Clinicians reported effective working relationships with the local NHS hospital, in a wide range of contexts. This

included sharing information about consultants, obtaining specialist advice, training or equipment and contracting phlebotomy services. The specialist breast care nurse was involved in NHS hospital's multi-disciplinary meeting to discuss the care of all breast cancer patients.

- Patient's GPs received letters about patient's treatment and care, with patients' consent. Liaison with GPs occurred at pre-admission when staff had queries about a referral.
- Hospital staff maintained good links with the NHS trust, particularly in relation to breast cancer care.

## Seven-day services

- The hospital ward was staffed to provide nursing care seven days a week. The two main theatres were used for elective surgery between 8.30am and 8pm Monday to Friday, with theatre one available for lists on Saturdays between 9am and 4pm. Theatre 3 was used for limited procedures and operational on weekdays, 8.30am to 8pm.
- Consultants provided 24-hour on-call cover for their patients, or organised cover from a consultant colleague with practising privileges at the hospital, should they be unavailable at any time. Those with patients on the wards conducted daily ward rounds.
- An RMO was available and on-site all day, every day. Physiotherapists were available during the working day and also in evenings and at weekends.
- Pharmacy services were available during normal working hours, and outside these, the RMO was authorised to dispense medicines in exceptional circumstances, in line with BMI procedures. The hospital had a contract with a local night pharmacy for out-of-hours services if required.
- The hospital operated an on-call system for senior managers and theatres seven days a week.

## Access to information

- Records were completed in a timely way and observation records were kept in patients' rooms where they were accessible to patients and staff. Records were accessible to all staff involved in patient care, including physiotherapists and pharmacists.
- Consultant secretaries prepared letters for GPs on discharge, and patients for cosmetic surgery were asked for their consent for communication with their GP.

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- There were resource folders in the ward and theatre offices for reference. These included guidance documents and policies, audit reports and minutes of meetings.
- Medical records created by staff with practising privileges were kept in patient files for easy reference.
- Discharge packs were given to patients to take home, with information on how to access services post discharge. The consultants' discharge letters were sent to patients and their GPs.
- Staff liaised effectively with other services, including community services, to plan patient discharge.

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

- Patients consented for surgical procedures on the day of surgery. Our review of records showed consent had been obtained in each case. We spoke with five patients who confirmed they had a good understanding of the procedure, having discussed it with their consultant, and had time to consider the surgery before giving consent.
- Staff told us if patients appeared to lack capacity to consent to treatment they would assess capacity at different times of the day, as sometimes people could understand and retain information better at different times.
- Staff had received training in the Mental Capacity Act 2005 (MCA). Guidance and policy documents were available for reference. Staff understanding about mental capacity was variable, but this was a topic for further staff training scheduled for September 2015.
- Patients undergoing cosmetic surgery were given a two-week 'cooling off period' so they could change their mind before giving consent to the procedure.
- Monthly audits of patient records showed staff explained procedures and gained their consent before starting treatment.

## Are surgery services caring?

Good



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

Surgery services were caring. Staff treated patients with kindness and compassion and ensured they had time to ask questions and received reassurance. Patients were satisfied with their care and said they were involved in decision-making. We observed staff providing good emotional support to patients pre-surgery.

## Compassionate care

- Staff were observed to provide kind, polite and compassionate care at all times. They referred to patients in a caring way, and demonstrated a keen interest in ensuring they had a pleasant and comfortable experience.
- Patients were treated in an unhurried manner and there was a calm atmosphere in the recovery room and on the ward. Prior to surgery, we observed the anaesthetist chatting with the patient and helping them feel relaxed and comfortable.
- Patients consistently told us they were treated well, with dignity and respect. Two patients told us how reassured they had been by the health care assistant before surgery, who held their hand until they were asleep. They felt this was particularly comforting and thoughtful, and helped alleviate their anxiety. One patient commented that staff always knocked before entering their room. Another said the anaesthetist had been very understanding, and treated them as an individual.
- Three patients admitted for day-surgery reported they had chosen this hospital out of preference. Two said they would recommend it, from their previous experiences. One said, "Staff make you feel special, as they are so caring".
- Patient satisfaction levels were high. In the patient satisfaction survey from June 2015, 95% said the hospital care had been excellent and 100% of patients were satisfied with the care provided.
- Patients said they would recommend the hospital. Between October 2014 and March 2015 the 'friends and family test (FFT) results showed all patients would recommend all aspects of the hospital surveyed. The response rate was between 30% and 70% each month.
- In June 2015 91% of patients reported their care had been excellent and 100% were satisfied with their care.

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

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- Patients said they felt they were given sufficient information about their care and treatment, both at pre-assessment and on the day of surgery. They had discussed their care and received printed information and leaflets. Patients spoken with post operatively said they understood their care needs and what to expect after surgery.
- The hospital's patient survey showed a high rating for 'meeting patient expectations'. Overall, the most recent results for patient satisfaction, from June 2015, were 98.7%.
- Patients had 'Personal Information Folders' which included leaflets about pre-admission and what to expect at the hospital as well as their pre-operative assessment questionnaire. The packs also gave guidance on post-surgery after care such as physiotherapy.

## Emotional support

- The hospital staff provided a high level of emotional support to patients. The breast cancer nurse specialist and lead cosmetic nurse provided patients with skilled clinical and emotional support.
- The breast cancer specialist had extensive experience in her field and supported patients and their families emotionally as well as practically throughout their care.
- On the day of our inspection, staff explained they had admitted one patient overnight, to provide additional emotional support.
- For patients having cosmetic surgery, the pre-assessment nurse met with them at pre-admission, on the day of surgery and post operatively at outpatient clinics. This gave patients opportunities to ask questions, and for both the patient and clinical staff to identify any emotional support needs.
- Patients could not access specific psychological counselling services at the hospital. If staff considered patients required additional psychological support before consenting to treatment, such as cosmetic surgery, they refused or postponed treatment.
- Ward staff demonstrated sensitivity towards the emotional needs of patients and their relatives. At staff meetings we observed discussions included consideration of patients' anxieties and how best to provide support. Senior nursing staff also described how they took account of patients' wider family support when planning their discharge and overall care needs.

## Are surgery services responsive?

Good



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

Surgery services planned patient treatment to meet their specific needs. Pre-assessment nurses reviewed patients' needs prior to treatment and care was provided in a timely way. NHS and private patients' experienced the same levels of surgical care, except that NHS patients sometimes shared waiting facilities. Discharge arrangements were planned but flexible, and care was provided until patients could be discharged safely.

The hospital had a system for responding to and managing patients' verbal or written complaints; however, the guidance in how to make a formal complaint was not given consistently to all patients. There was evidence that learning was shared.

Clinical Commissioning Groups and the provider determined the range of surgical services provided.

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

- The hospital had developed NHS services through liaison with the Clinical Commissioning Group (CCG), for example to set up ophthalmology and orthopaedic surgical services.
- The CCG had an agreement with the hospital for it to provide specific treatments and care for NHS patients. The CCG checked the hospital provided NHS patients with services in line with agreed quality criteria at quarterly contract quality meetings.
- The hospital developed links with local consultants to provide services for insured and self-pay patients.
- All admissions were pre-planned so staff could assess patients' needs prior to treatment. This enabled staff to plan patient's care to meet their specific requirements, including those relating to any cultural, linguistic, mental or physical needs.
- The hospital used admission criteria for patients and only accepted patients for treatments with low risks of complication and whose post-surgical needs could be met through ward-based nursing care.

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- There were no facilities for emergency admissions, and commissioners, the local NHS trust and people locally understood this.
- The admission process for private and NHS patients were the same. There were some small differences in care for patients admitted for cataract surgery. NHS patients had seats in a shared room pre and post operatively, whereas the hospital offered private patients a single room. NHS patients were advised of this arrangement in advance.

## Access and flow

- Patients received surgical treatment in a timely way. In nine out of the 12 months to March 2015, 100% of NHS patients were admitted to treatment within 18 weeks of referral, as required by the waiting time rules set out by the Department of Health. For three months, this referral to waiting time dropped to 99% or 98%, which was well above the minimum target of 90%. The hospital staff aimed to book patients for surgery within 10 weeks of referral, to allow some flexibility for rebooking whilst achieving the target waiting time.
- The reasons why any patients waited longer than 18 weeks were monitored. These were due to patient requests for particular dates, reduced fitness for surgery or patients failing to attend re-booked appointments. Staff followed up any non-attendance with the patient and their GP.
- Private patients were generally booked for treatments within two weeks of referral, or onto a later date if that was their particular preference.
- Consultant surgeons and nursing staff planned and checked surgical admissions. To improve patient experience and overall efficiency, the hospital had recently implemented a 'five day rule', requiring all surgical lists to be planned and communicated five days in advance. This was to ensure the right staffing and equipment were in place to meet patients' specific needs on the day of surgery. If an operation was required more urgently, there was a 'fast track' procedure, to ensure relevant staff reviewed and approved any proposed changes to the surgical lists.
- Patient admissions were planned through the day to ensure patients did not experience extended waiting times. Staff admitted patients onto the ward prior to surgery to complete health checks and obtain consent.

They monitored patients' post-surgical recovery in the recovery room within the theatre suite, before escorting patients to the ward. Some surgery lists finished in the evenings, with surgeries running until 8pm or later.

- Staff planned discharge times from pre-admission information. Day-case patients were usually discharged before 11.30pm, but patients could be discharged after that time if they wished and if it was safe to do so. If day case patients needed to stay overnight, staff recorded this as an incident and data showed there were generally fewer than five incidents of this type per month. Nursing staff explained that in-patients stayed longer than expected for a variety of reasons. Sometimes patients required an extra day for recovery, and occasionally there was a delay in arranging home care packages for patients.
- Staff communicated planned changes to the surgical lists effectively. For example, the hospital had outsourced decontamination and sterilisation of endoscopy scopes for an interim period, and this affected how staff planned lists.
- The governance team monitored the number of cancelled operations and extended in-patient lengths of stay. In July 2015, there was one cancelled operation, and this was for clinical reasons.

## Meeting people's individual needs

- Staff described the support they provided to meet patients' specific needs, including those with a disability, particular physical or emotional support or patients with specific language requirements.
- Pre-admission nurses identified and discussed patients' care needs and planned their treatment in consultation with medical staff where necessary.
- Pre-assessment was used effectively to ensure the hospital only treated people if they could meet their needs. The pre-assessment nurse confirmed that all patients were pre-assessed for surgery in advance. Patients completed an assessment form prior to attending a pre-assessment meeting with a trained pre-assessment nurse. If the nurse identified any concerns, they had good communication links with the surgeons for further advice and discussion.
- The assessment process identified patients' specific requirements. For example, any allergies were noted and recorded as a 'flag' on the computerised patient information system. If patients were at particular risk of infections because of an impaired immune system, the

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hospital allocated a dedicated member of staff to provide care on the ward, to minimise the risk of cross infections. The hospital had some bariatric equipment for patients if necessary, and additional equipment could be hired from the local NHS trust. For patients admitted for end of life care, they were cared for in the oncology suite, with dedicated overnight nursing support.

- The hospital employed specialist breast care and cosmetic surgery nurses to provide individual patients with tailored advice, support and care.
- The hospital offered enhanced recovery and rehabilitation for orthopaedic patients, with a team of physiotherapists providing individualised care for patients. Physiotherapy treatments were planned into patients' care and account was taken of patients' particular mobilisation needs.
- Patients received information to assist them to recover post-operatively and gain independence and mobility. One patient however, commented that they felt the information was not sufficiently detailed and specific. For example, they had been advised to do a little exercise post-operatively, however this was open to interpretation, and they had not understood the description accurately.
- Patient focus groups had already identified a need to improve the consistency of patient information, and the administrator was addressing this issue.
- Relatives could stay with patients if they wished and the hospital had two rooms, which could accommodate an extra bed.
- Hospital staff could access language assistance if necessary from the local NHS trust.
- Staff provided examples of how they had respected patients' cultural needs, for example by recognising their specific dietary needs. They demonstrated knowledge of how they would respect the end of life care needs of patients from different cultures.
- Patients received written terms and conditions for their treatments. The hospital also sold physiotherapy equipment and issued price lists in patient information packs, if appropriate.

## Learning from complaints and concerns

- The hospital took complaints seriously, and there was an open and honest approach to complaints. Staff said they were encouraged to report verbal complaints and would deal with any concerns as they occurred. They

reported that any specific issues arising from complaints were discussed at team meetings. However, procedures for sharing and learning from complaints across the hospital were not robust.

- The hospital monitored complaints and reported 34 formal complaints in 2014. The complaints database showed there had been between zero and four written complaints per 100 admissions each year in the year to August 2015.
- The quality and risk manager acknowledged verbal and written complaints, including those made via NHS Choices. They organised complaints investigations and the registered manager wrote responses to complaints in a timely way. Clinical staff investigated complaints of a clinical nature, however, their quality of investigation and root cause analysis was variable.
- Issues raised in complaints were discussed at the bimonthly clinical governance and medical advisory committee meetings. The chair of the MAC sent consultants the details of clinical complaints related to their practice, although we found one complaint where this could not be evidenced.
- We reviewed complaints and one from a day-patient reported a lack of privacy and security for their belongings. Patients having cataract surgery on the day of our inspection told us there were no arrangements for storing their clothes safely whilst they were having surgery. There were lockers and wardrobes available, but this had not been communicated to patients.
- Three patients said they were not aware of the complaints policy and had not been given any information about complaints management, but said they would be happy to raise concerns if they had any. The standard documentation given to patients on admission and on discharge did not provide guidance on how to make a complaint, however there was guidance in a patient guide for inpatients.

## Are surgery services well-led?

Requires improvement 

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

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The leadership team was accessible to staff and there was a positive, open culture within the service which meant staff challenged poor practice. Staff valued their leaders; however, there was a lack of capacity for managers to carry out their managerial tasks. Within surgery, the staff appraisal rate was low and there were significant staff vacancy rates. These issues were not included on the hospital's risk register. Team leaders shared information informally, as well as at meetings, and staff demonstrated pride in the quality of their work.

The leadership team did not manage governance arrangements and risks consistently to identify and implement improvements. Some managers did not have the capacity to attend meetings and some meetings were held less frequently to compensate for this. Meeting minutes and action plans did not clearly identify issues for staff to address and report on at subsequent meetings. There were also gaps in the audit programme. Departmental leaders did not capture the key risks for the organisation on risk registers, for priority, escalation and review. This meant there was a risk that issues of importance, or trends would not be addressed.

Although staff reported incidents, leaders were not skilled in investigating them using root cause analysis to fully understand causal factors. The incident categorisation system lacked clarity and there was a risk from staff classifying patient falls as non-clinical incidents.

## **Vision, strategy, innovation and sustainability for this core service**

- The hospital's registered manager outlined the BMI corporate vision, to deliver the highest quality outcomes, the best patient care and the most convenient choice for patients. BMI had focused on the principles of the '6 C's', initiated within the NHS, to put their vision into practice. These were to demonstrate commitment, courage, communication, care, compassion and competence. It was not clear how the vision was translated into the hospital and departmental strategies but staff were familiar with the 6 C's and were passionate about delivering a high quality service.
- The corporate clinical strategy had been developed 18 months previously, with a focus on quality, enhancing patient experience and supporting staff. Directors of nursing were responsible for implementing the action plans, however at The Harbour, the director of nursing

had left and the new appointment was not in place at the time of the inspection. Implementation of the clinical action plan had been postponed until the appointment of the new director of nursing.

- The priority for the surgical department was to fill vacant staff posts and establish a consistent appraisal process. The department's business strategy was to progress the refurbishment and replacement programme, as well as develop the orthopaedic surgery and rehabilitation services. It was not clear if this strategy had been formalised with measures, resources and timeframes.
- All the staff were positive about the caring values of the service. They all commented on working as a team to prioritise the needs of patients.

## **Governance, risk management and quality measurement for this core service**

- Risks identified relating to surgery had not been adequately captured on the hospital's risk register, and there was no other register local to the surgery department.
- The hospital's risk register was not managed effectively to: describe risks and any mitigating actions, score, prioritise, plan and allocate responsibility for each entry and to review progress.
- Risks were not identified and managed effectively and some key risks were not on the risk register. The high staff vacancy and sickness rates in the theatre department were not included, nor the risks from failing to have clinical hand wash sinks in the ward corridor. This issue was raised through repeated audit before action was agreed, through the infection control nurse, to bring it to the attention of the registered manager. This course of action prompted the purchase of suitable sinks. Although staff had commented that the records for different care pathways were not laid out consistently which meant there was a risk of inaccurate documentation, this was not on the risk register.
- There were only five items on the hospital risk register, some dating from 2011. The risk of using non-compliant endoscopy service had been added to the register in May 2014, but it had not been correctly assessed or managed prior to this. A compliant solution had not been implemented until August 2015. This approach to risk management placed patients, staff and the provider at risk of harm and reputational damage.

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- Arrangements for implementing and embedding learning from incidents across the hospital were not robust. Incidents were discussed but action plans were not developed, implemented and reviewed.
- Clinical incidents were not considered in terms of the level of harm they caused. The duty of candour regulation required actions to be taken dependent on the level of harm, which meant there was a lack of clarity in how to implement this regulation.
- There was a confused arrangement for classifying incidents. Staff did not record and monitor patient fall incidents accurately. The hospital classified incidents in terms of clinical incidents, non-clinical incidents and slips, trips and falls, which was a different classification from that described in their incident reporting and investigation policy. This policy defined incidents as clinical or non-clinical, and the incident reporting forms reflected this. By reporting on slips, trips and falls as a distinct category, the hospital was not following its policy, and was at risk from not investigating clinical incidents relating to falls. The policy defined a clinical incident as 'any event directly related to patient treatment or care which did, or could have resulted in an unplanned outcome'. A monitoring report of slips, trips and falls over a 12-month period to August 2015 showed there had been 11 incidents, of which five resulted in injury to a patient. Patients' falls could have an underlying clinical cause and might need to be categorised as clinical incidents.
- The governance structure included many subcommittees and clinical managers did not have adequate protected time for their management responsibilities, including attending governance meetings. This meant that meetings such as the clinical governance meetings were not attended consistently and other meetings, such as the pharmacy meetings, were held only quarterly. Infection control issues were not adequately covered. This had been identified and there had been recent decision to remove the infection control committee. The infection control lead would report directly to the clinical governance committee instead.
- Meeting minutes were not sufficiently detailed to capture discussions, any actions arising or to allocate responsibility to complete tasks. Action plans were not consistently reviewed at subsequent meetings.
- Staff understood their roles but acknowledged that some aspects could not be completed in a timely way.

For example, in theatres there was a low rate of staff appraisals due to difficulties in arranging these with staff. The audit programme devised for 2015 showed that audits were not completed consistently. Monthly audits such as the WHO surgical checklist were not carried out in January, February, March or May 2015 and the theatre audits were not completed in January, February, March or April 2015.

- The systems for underpinning improvement were not robust. Minutes of departmental meetings and interviews with staff showed that staff aimed to resolve issues at a local level to improve the quality of service for patients. For example, issues with implementing the WHO surgical checklist had been identified and strategies had been implemented to improve compliance. New algorithms had been implemented as part of learning from a patient bleed in theatre, however, it was not clear that staff used audits and action plans to promote improvement in practices.
- Some policies were out of date, needing review and correction. For example, the incident reporting policy had been due for review in January 2013 and the current policy did not reflect the recent duty of candour legislation. The cardiopulmonary resuscitation policy did not include information relevant for The Harbour Hospital, such as guidance on how to manage an emergency as some beds could not lie flat quickly for emergency CPR.
- The medical advisory committee (MAC) of consultants was generally well represented. The MAC had bimonthly meetings, scheduled a week after the clinical governance meeting. This arrangement enabled issues identified at clinical governance to be carried forward for discussion with the consultants. The MAC meeting minutes indicated that members raised and discussed key issues, such as incidents and complaints. There was a lack of evidence that members reviewed actions arising from the meetings. The chair of the MAC confirmed there was effective learning from complaints and incidents and they shared learning with relevant members; however, we did not see how this was achieved.
- The MAC had a role in reviewing consultant contracts maintaining safe practising standards amongst consultants and clinicians. Each consultant was required to complete biannual reviews with the MAC

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chair, where data on their clinical performance was discussed. The hospital also ensured that surgeons had appropriate professional insurance in place and received regular appraisals.

## Leadership/culture of service related to this core service

- Staff said the senior leadership team were visible and approachable, and they valued the skills and experience of their team leaders. Many of the staff had worked at the hospital a long time and said they enjoyed the collaborative, supportive working environment. Staff said there was an open and honest culture, and we heard comments such as “I love my job and wouldn’t want to work anywhere else”, “I really enjoy working here” and “I love it here, I feel involved”. This included positive feedback from staff working on night shifts.
- Staff reported the hospital was improving rehabilitation outcomes for patients as a result of new pathways. The hospital was part of a pilot to analyse the impact of new equipment on patient outcomes.
- Clinical leaders were valued by their staff and provided consistent, motivating leadership. We received this feedback from a range of staff. The resident medical officers (RMOs), who worked fortnightly shifts at the hospital were also positive about the culture and commented that all staff worked well together.
- Staff told us they were prepared to challenge poor practice. Nursing and operating department practitioners were empowered to challenge surgeons if they failed to follow safe practices, and were authorised to halt the list if the steps were not followed in full. A ‘positives and negatives’ board had been set up to gain staff views, first in theatres and then on the ward. In theatre, this initiative had led to improved communication and team working behaviours.
- No whistleblowing concerns had been reported to CQC in the last 12 months.

Staff were supported with access to occupational therapy and employee assistance programmes. One staff member with a long-term condition said they were supported effectively.

## Public and staff engagement

- Staff said they could suggest areas for improvement; however, they were not sure how effective the organisation was in implementing improvements when they required capital bids. For example, there had been delays in refurbishing the building.
- Staff provided examples of how they had improved the management of the service. For example, they said implementing the ‘five day rule’ for booking operations had improved the management of the duty rota and overall staff satisfaction.
- The breast care team were actively involved in improving patient outcomes. The specialist nurse was involved in patient education and founded a local breast care charity. They maintained effective links with other health professionals outside the organisation. The hospital had introduced good clinical and nursing practices for patients at risk of developing lymphedema.
- The last annual staff survey showed that 98% of staff would recommend the hospital for care and treatment, and 75% would recommend it as a place to work. Actions had been identified from the survey and the hospital reported on progress.
- Results of the latest patient survey showed a high level of patient satisfaction, with the hospital scoring 98.7%. Areas of concern, such as catering were being addressed. The hospital was third place across the BMI group for patient satisfaction scores.
- In March and April 2015, staff asked patient focus groups about their care. From the results, they implemented some improvements, such as different types of eye coolers for patients post eye surgery. This project was due for review in October 2015.

# Outpatients and diagnostic imaging

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

## Information about the service

Outpatient services at BMI Harbour Hospital are provided by a wide range of specialities, including Breast surgery, Cosmetic surgery, ENT (Ear Nose and Throat), Urology, General and Oral Surgery, Orthopaedics, Gynaecology, Ophthalmology, Pain Management, cardiology, dermatology, gastroenterology, neurology, optometry, respiratory medicine, rheumatology, spinal surgery and vascular surgery. Diagnostic imaging facilities provided by BMI The Harbour Hospital included X-Rays, ultrasound, digital mammography and radionuclide imaging. CT scans and MRI scans were available on site, but run by another provider and were therefore not included in this inspection process. Physiotherapy services are provided as an outpatient service and were included in this inspection process.

The outpatient clinic has eight consulting rooms, a general treatment room, a room for urodynamic procedures and a phlebotomy room. The outpatient clinic had access to the minor operation room located in the theatre complex for specific procedures and treatments. Consultation rooms were used for any speciality. Clinics were mainly consultant led, with the addition of specific nurse led clinics.

The physiotherapy department comprised of one gym, three examination bays and a hand therapy room.

In the period April 2014 to March 2015 there was 17,756 outpatient appointments, 7,401 of which were new appointments and 10,355 follow-up appointments. The

hospital provided a service for NHS patients though block NHS contracts. A total of 2,371 NHS patients were seen in outpatient clinics, 1,295 of these being first appointments and 1,076 being followed up appointments.

During our inspection, we visited the outpatients, physiotherapy and diagnostic imaging services. We spoke with 10 patients and 18 staff, including nurses, medical staff, healthcare assistants, physiotherapists, administrators, receptionists and managers. We reviewed information provided on 10 CQC feedback cards from patients using the service. We observed care being provided, reviewed patient records and staff training records. We reviewed information provided by the hospital prior to the inspection and during the course of the inspection.

# Outpatients and diagnostic imaging

## Summary of findings

Systems to keep patients safe were not fully effective. Patients, and staff, in outpatients (OPD) were not fully protected from the risk of harm. Staff had a good understanding of how to report incidents, but were not assured risks escalated were taken seriously by the hospital management team. A piece of equipment used in a treatment room produced a plume of smoke that guidance indicated was a risk to health of patients and staff and should be used with an extractor fan. There was no extractor fan. The fabric of the treatment room meant effective cleaning to reduce risk of cross infection was not assured. Staff in OPD reported low staffing levels and increased administrative tasks reduced clinical time to provide care and treatment to patients. Staff perceived this as a risk to patient safety. They reported, that although not normal practice, there were occasions when there was only a nurse or only two healthcare assistants on duty in the department, which posed a potential risks to patient safety. The hospital had not undertaken a recent assessment of outpatient staffing levels.

Individual departments did not maintain their own risk registers. In OPD where staff had identified risks, no assessments were completed to determine the level of risk posed to patients and staff. The hospital-wide risk register did not detail any risks that had been escalated from OPD.

Programmes were followed for staff to complete essential mandatory training. However, some staff reported difficulties in accessing practical mandatory training sessions due to workloads and cancelled training sessions. Some staff reported a lack of support in accessing further training they believed would enhance the care they provided to patients in their department.

Limited clinical audits were undertaken in OPD, which meant there was limited measurement of the effectiveness of the service provided.

The hospital had minimal numbers of patients who could not understand English. But staff were not aware of interpreting services, and when needed used translation 'apps' on their personal mobile telephone or

the patient's relatives to help with translation. Using relatives for translation purposes is not a recommended practice, as it cannot be assured the patient has given consent for their medical information to be shared with their family member. Information leaflets were available in written English, and not in other formats such as other languages, pictures or braille.

Staff reported confidence in and good support from their immediate line manager, but some were not assured senior management fully considered their views and opinions. There was a view among some staff that the hospital management relied heavily on the good will of staff and that good will was running out.

There was evidence of effective multidisciplinary working that included working across the hospital and in partnership with the local NHS acute hospital and other organisations. Services were planned to meet patient needs. Patients told us there was good access to appointments and at times that suited their needs. Staff demonstrated they were passionate about caring for patients and clearly put the patient's needs first, including their emotional needs.

There was evidence of innovation and development of services across all outpatient services. Innovation and development was an integral part of the running of the physiotherapy department.

# Outpatients and diagnostic imaging

## Are outpatients and diagnostic imaging services safe?

Requires improvement



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

Patients in the Outpatient Department (OPD) were not fully protected from the risk of abuse and avoidable harm. Staff had a good understanding of how to report incidents, but in OPD staff were not assured reported incidents or risks were taken seriously by senior management. A piece of equipment used in a treatment room produced a plume of smoke that guidance indicated was a risk to health of patients and staff and should be used with an extractor fan. There was no extractor fan. The fabric of the treatment room meant effective cleaning to reduce risk of cross infection was not assured. At the time of the announced inspection no action had been taken to mitigate these identified risks.

There were inconsistencies across the different outpatient departments with regard to receiving feedback and learning from incidents. OPD nursing staff said they did not receive feedback about incidents they reported. Both physiotherapy and diagnostic imaging staff did receive feedback and where appropriate, changes in practices were made in response to learning from incidents.

OPD staff reported current staffing numbers meant that there were occasions where there was only a nurse or only two healthcare assistants (HCA's) on duty in the department which posed a potential risks to patient safety. There were no assessments completed to identify the level of risk to patients or staff when this occurred.

Staff undertook appropriate mandatory training for their role. However, some staff reported difficulties in accessing practical mandatory training sessions due to workloads and cancelled training sessions.

Most clinical areas and waiting rooms were visibly clean and tidy. Appropriate equipment was available for patient procedures and tests. Equipment was maintained and tested in line with manufacturer's guidance. Infection

prevention and control practices were followed: these were monitored, to prevent the unnecessary spread of infections. Medicines were managed safely and stored securely.

Staffing levels and the skill mix of staff was appropriate for radiology and physiotherapy departments. OPD staff reported staffing levels and increased administrative work, meant they had less clinical time to attend to the needs of patients. There was no use of agency staff, with staff working flexibly as a team to cover additional sessions and staff shortages. Patient records were available prior to a patient being seen, but initial consultation records made by consultants were not always detailed on patient notes held by the hospital. Staff received simulation training, to ensure they could appropriately respond if a patient became unwell.

### Incidents

- All staff were aware of their responsibility to report incidents. Staff reported incidents on a paper incident report form, which their manager entered onto the electronic reporting system.
- OPD staff expressed a lack of confidence that all reported incidents were taken seriously by senior managers. They were not assured that incidents reported on the paper format were entered onto the hospital's electronic reporting system. They said they did not receive feedback about incidents they reported and were not aware of any learning from incidents across then hospital or organisation.
- In the diagnostic imaging department, there were clear processes for reporting incidents relating to the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).
- Diagnostic imaging and physiotherapy staff said they received feedback about incidents they reported. In radiology there were examples where changes to practice were implemented as result of learning from incidents. This included, following an X-ray being given outside local protocols, a full review of local protocols and radiation exposure factors. This resulted in new protocols that meant patients received a lower dose of radiation exposure.
- In the reporting period April 2014 to March 2015, there were 163 clinical incidents reported across the hospital. There was no breakdown of incidents by each department so it was not clear what the track record for incidents was in the outpatient services.

# Outpatients and diagnostic imaging

- Following BMI Healthcare processes, patient falls and sharps injuries were not classified as clinical incidents. This did not fully support the identification of risks to the quality of clinical care.
- The duty of candour legislation requires health care providers to disclose incidents that result in or could result in moderate or severe harm or death of a patient. Any such incident must be investigated and reported to the patient and/or any other relevant person within 10 days. Staff in OPD, including the team leader, had no knowledge of the duty of candour legislation. However, senior management of the hospital were clear on the importance of meeting patients, if mistakes happened, to explain and apologise. They described an example of when the duty of candour legislation had been followed, by meeting a patient and their relatives to offer explanation and an apology.

## Cleanliness, infection control and hygiene

- OPD staff identified areas of OPD that could not be cleaned effectively. The fabric of the general treatment room, used by nursing and consultant medical staff carrying out clean and dirty procedures, was not easy to clean and increased the risk of cross contamination and spread of infection. The flooring was scuffed and scratched in several areas. The wall had cracks in the paintwork. There were holes in the wall where screws had previously held items to the wall. Paint on wooden painted panels covering pipe work below a sink was blistered and peeling. There were stains on the walls around the sink areas that looked like they were the result of water running down the wall.
- The treatment room also had a storeroom for equipment that was used throughout OPD. Staff said that occasionally staff accessed the storeroom by walking through the treatment room, when patients were being treated. This traffic through the treatment room posed a risk of cross contamination occurring.
- An infection prevention and control audit completed in August 2015 identified areas of concern within OPD relating to the fabric of some consulting rooms and the general treatment room. Comments in the report of this audit about the treatment room included “wooden skirting boards bare and not waterproof. This is unacceptable.” The report also identified the covering of some chairs in consulting rooms and the carpets were of a material that compromised effective cleaning. An action plan attached to the report detailed progress for refurbishment of the treatment room was to be discussed at the next clinical governance meeting and the replacement of chairs and carpets was included in an on-going work plan.
- In a second treatment room that was used for urodynamic studies, the washbasin was situated behind closing doors. Staff had to negotiate using the door handle to open the door with clean hands. A member of staff identified this to us as a risk of contaminating clean hands. However, this had not been escalated as a risk to managers.
- Monthly assessments were completed of the OPD environment. These were not specific to individual rooms and failed to identify and detail risks to health and of cross infection associated with the general treatment room and hyfrecator.
- At the unannounced inspection on 17 September, staff said some action had been taken to address the environmental issues in the multifunctional treatment room. The wooden skirting boards had been repainted to aid effective cleaning processes. A member of the OPD staff informed us that an assessment had been made by an architect regarding the possibility of accessing the storeroom from the corridor rather than through the treatment room.
- Physiotherapy and diagnostic imaging departments were visibly clean and tidy.
- Equipment was visibly clean Processes were followed to ensure equipment such as probes and nasoendoscopes were cleaned and decontaminated following national guidance. Audit trails were maintained for the cleaning and decontamination process.
- Hand sanitizers were widely available to encourage hand hygiene. Staff adhered to the ‘bare below the elbow’ guidance to enable thorough hand washing and reduce risk of cross infection.
- Personal protective equipment (PPE), such as gloves and aprons, was readily available for staff in all clinical areas, to ensure their safety and reduce risks of cross infection when performing procedures.
- Each department had a member of staff identified as an infection control link, who was supported by the hospital’s infection control nurse in order to complete audits such as hand hygiene audits. The infection control nurse worked with medical staff, challenging their clinical practices to ensure current infection control practices were adhered to. They gave an

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example of antibiotic prescribing being discouraged unless a patient was symptomatic, with outpatient staff checking results of swabs when patients returned to have sutures removed, prior to antibiotics being prescribed.

## Environment and equipment

- A piece of equipment called a hyfrecator was used in the multifunctional treatment room. This equipment let off a plume of smoke when in use which research and associated literature identified as a risk to health of patients and staff. Guidance indicated to reduce risks an extractor fan should be used when the equipment was in use. The treatment room did not have an extractor fan. We raised staff concerns regarding this piece of equipment with the registered manager during the announced inspection following which the equipment was removed from the room.
- During the unannounced inspection on 17 September 2015, OPD staff said the hyfrecator had been moved to the minor surgery room in the main theatre complex.
- There was an air exchange system in this room, but not the recommended extractor fan system. Nursing staff said that in response to demands from medical staff, the duration of use of the hyfrecator had increased from 40 minutes to 60 minutes per patient session. Nursing staff had not been consulted about this change in practice. There was no evidence that the impact of increased length of use time, on the health and safety of patients and staff, had been considered.
- Items of equipment we checked were labelled with the last service date and review date and had an asset number to enable easy tracking of the item, if it required servicing or maintenance. Portable appliance testing was undertaken. Staff we spoke with were clear on the procedure to follow if they identified faulty or broken equipment, and who to report this to, ensuring the item was removed from the clinical area to prevent further use.
- In the diagnostic imaging department, specialised personal protective equipment was available and used in radiation areas. Staff wore personal radiation dose monitors.
- The X-ray table did not lower sufficiently to enable easy access for patients with restricted mobility difficulties. Risk assessments were in place, which included action to be taken to mitigate the identified risk.

- Signage in the diagnostic imaging department identified when X-rays were being taken and not to enter that room.
- Resuscitation equipment, that included paediatric emergency airway equipment, was located in OPD. Equipment was sealed with tags. Daily checks ensured tags had not been breached. Once a week, tags were broken, all equipment was checked for integrity and use by date and a full clean was completed of the emergency trolley. Records confirmed this occurred.
- Emergency call bells were in all clinical areas and consulting rooms. There was no formalised process in OPD for checking the functioning of the call bells, but checks were recorded in the unit diary. We checked the emergency call bell in one of the consulting rooms and evidenced it was working and staff responded promptly to provide assistance.

## Medicines

- Medicines in all areas were stored securely. We checked a random sample of medicines in OPD and radiology, all of which were in date.
- No controlled medicines were kept within OPD and radiology. No medicines were kept in the physiotherapy department.
- Processes were followed to ensure prescription pads were secure, and an audit trail was kept detailing which consultant had prescribed, and the patient the prescription was for.
- There was a pharmacy on site where patients could collect their medicines from during the week between the hours of 8am to 4pm. Out of hours arrangements had been made with a local pharmacy where patients could collect their prescribed medicines. This included patients treated on the NHS which ensured they were not charged for their medicines.
- In OPD, staff sent patients home with medicines to take in preparation for certain procedures. Staff in OPD believed they were administering them under a Patient Group Directive (PGD). A PGD provides a legal framework that allows some registered health professionals to supply and/ or administer a specified medicine(s) to a pre-defined group of patients, without a prescription by an authorised prescriber, such as a doctor. A PGD is used in situations that offer an advantage to patient care, without compromising patient safety. After discussion with the pharmacist it was evidenced there

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was not a PGD for this group of medicines and patients. The pharmacist took immediate action to address this so the medicines could be given to the patients as tablets to take home. This included processes to track and audit the prescriptions and medicines given to patients.

## Records

- Clinic lists for OPD were faxed to the department 48 hours prior to the clinic. The fax machine, situated in the nursing office, was accessible only to the nursing and administrative staff. The fax machine was switched off when the department was closed, to protect confidentiality of patient details.
- Records for private patients seen for the first time in OPD were made available in a timely manner by the individual consultant's secretary.
- Records held by the hospital were held securely on site by the records medical department. When records were in the department they were either held in the consulting/treatment room with the relevant practitioner, or stored in secure areas the department.
- Staff said records were always available for scheduled appointments.
- A random sample of 13 patient records was reviewed during the inspection process. For some private patients record of the initial consultation was not held in the hospital patient records. Staff explained that some consultants kept the initial consultation records in their private patient records. This meant there was a risk when patients were admitted for treatment nursing staff and the RMO were not aware of the discussion and decision-making process that had taken place between the patient and the consultant.
- The hospital used a nationally recognised electronic system to report and store patient's radiological images. The hospital had access to the same system at the local acute NHS trusts hospitals, access to these records meant patients who had previously had X-rays in the NHS did not need them repeated, and so were not exposed to unnecessary X-rays.

## Safeguarding

- Staff confirmed in conversations that safeguarding vulnerable adults was included in their mandatory training. Staff that we spoke with demonstrated a good

understanding about safeguarding processes. They knew what actions they needed to take if they suspected a patient or a visitor to the hospital had been subject to abuse.

- Processes were in place and followed to ensure the right patient received the correct radiological scan at the right time.

## Mandatory training

- Mandatory training included prevention of extremist radicalisation, data protection, blood transfusion, equality and diversity and moving and handling. Training was delivered through the BMI online learning package followed by face to face teaching and practical sessions. Staff reported they completed online learning and booked dates for the practical/ face-to-face teaching sessions. Some expressed frustration that that due to staffing numbers and workloads their practical/ face to face training sessions were frequently cancelled. This meant they did not complete their mandatory training and achieve the targets set by BMI. However, staff did not have any statistical data to demonstrate the frequency of this occurrence.
- BMI set a target of 90% compliance with mandatory training. Records provided by the hospital showed that at the time of inspection the compliance rate for OPD staff was 73%, for diagnostic imaging staff 99% and for physiotherapy staff 95%.
- The hospital had started a 100% club to encourage 100% compliance with mandatory training. A list of successful staff was displayed on the training notice board.
- Consultants completed their mandatory training at the NHS establishment they routinely worked at. They were required to provide evidence of completion of mandatory training to the hospital and medical advisory committee (MAC).

## Assessing and responding to patient risk

- Staff in all departments knew how to respond to patients who became unwell and how to obtain additional help from colleagues, to help them care for the patient. Staff had training in basic life support, with some staff trained in intermediate and advanced life support.

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- Staff completed scenario-based training, including resuscitation simulation, at least every six months. Teams were not aware when the training would take place.
- There was always a registered medical officer (RMO) on duty, who was trained in advanced life support. They provided support to the outpatient's staff if a patient became unwell. Patients who became medically unwell could be transferred to the inpatient ward or to the local acute NHS Trust in line with the treatment centre emergency transfer policy.
- The phlebotomy clinic was always held in a clinic room with a bed, to ensure appropriate management and support for patients who felt faint and became unwell.
- The appointed Radiation Protection Adviser was provided through a service level agreement with the local acute NHS hospital. There was an appointed and trained Radiation Protection Supervisor. Their role was to oversee equipment safety and quality checks, and ionising radiation procedures, in accordance with national guidance and local procedures. Imaging request cards included pregnancy checks for staff to complete to ensure women who might be pregnant informed them before exposure to radiation.

## Nursing staffing

- Both diagnostic imaging and physiotherapy departments reported they had sufficient numbers of staff to meet the workflow and patients' needs in a safe manner. Diagnostic imaging staff said if there was an unplanned shortage of staff, they could be requested from other local BMI hospitals.
- OPD nursing staff considered safe staffing levels one of the department's main risks. They understood that, how, as staff left, vacant posts were not filled, with the post being made no longer available. Two regular bank nurses worked in the department on a part time basis and if needed available nurses from the inpatient ward helped in OPD.
- There were no set guidelines on safe staffing levels for OPD. Although there was a schedule of regular clinics held during the week, the number of patients attending and confirmation of those clinics was only received by the department 48 hours prior to the clinic occurring. Consultants could also contact the department at any requesting an 'ad hoc' clinic to be held. If there was an

available consulting room this was possible. These practices exacerbated difficulties with planning staff rotas to ensure adequate members of the nursing teams were available.

- The business centre at the hospital had been closed. This meant health care assistants (HCA) in OPD now had an administrative role to complete cost-coding documents. They reported this took several hours each week, during which time they were not able to attend to patient needs.
- Nursing staff described incidents when the majority of their shift was taken up with administrative tasks, such as coordinating clinic rooms and answering telephone enquiries. They were not provided with administrative time to complete these tasks and it reduced their clinical time for meeting the needs of patients.
- HCAs reported, that although not normal practice, there were occasions when they were the only member of the nursing team in the department. In these situations, nursing support was available from the inpatient ward, but there was no nurse in the department supervising and providing support for the HCAs. Nurses described incidents when they were the only member of staff in the department. This meant if they had to chaperone a patient, or provide assistance during a clinical procedure, there was no other member of staff to attend to a patient if they required assistance.
- Staff reported there were sometimes delays in providing chaperone services because of lack of staff. Conversations with a consultant confirmed that sometimes they had to wait for nursing staff to be available for chaperoning before they could continue with the consultation and examination of a patient.

## Medical staffing

- There was a RMO on duty 24 hours a day to provide medical support to the outpatient and radiology areas.
- In the diagnostic imaging department, there was a service level agreement (SLA) for consultant radiologist support from the local NHS acute trust hospital.

## Major incident awareness and training

- Business continuity plans were accessible on the hospitals intranet and in paper format held in the individual departments. Instructions and flow charts

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instructed staff of the actions they needed to take in the eventuality of situations such as electrical failure and water shortages. Staff knew where to access this information.

- A generator was available for use in case of power failure, and was tested monthly to ensure it was in working order.
- Fire evacuation drills were held three times a year.

## Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

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

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

National guidelines were used. Audit of the service, and patient outcomes, was carried out in diagnostic imaging and physiotherapy services but this was limited in OPD. This meant there was minimal measurement of the effectiveness of the service provided.

Staff were supported in their role through appraisals, though some described the appraisal process as being complicated. Generally, staff felt encouraged to participate in training and development to enable them to deliver good quality care. However, some staff reported a lack of support in accessing training they believed would enhance the care they provided to patients in their department.

There was evidence of multidisciplinary team working across the hospital and with the local NHS acute trust. The consent process for patients was well structured, with written information provided prior to consent being given.

Patients pain needs were met appropriately during a procedure or investigation.

### Evidence-based care and treatment

- Staff in OPD reported they followed national or local guidelines and standards to ensure patients received effective and safe care. As a department, they did not undertake audits to review performance against these guidelines.
- Outcome data for all consultants was monitored and reviewed by the Medical Advisory Committee (MAC) as part of the biannual review of consultant's practising privileges.
- In the diagnostic imaging department, there was good evidence that compliance with national guidelines was audited including audits against radiation exposure. Changes were made to practices in response to audit findings. The department was working towards registration with the Imaging Services Accreditation Scheme (ISAS). ISAS is a patient focused development scheme that help imaging services improve continuously.

### Pain relief

- In OPD, staff discussed options for pain relief with the patient, during their consultation prior to any procedure being performed. Many procedures could be performed with the use of local anaesthetic, enabling the patient to go home the same day. Patients were given written advice on any pain relief medications they may need to use at home, during their recovery from their procedure.
- Patient records evidenced pain relief was discussed and local anaesthesia was used for minor procedures.
- A member of staff in the inpatient ward acted as a pain relief specialist nurse whom the departments could access if further advice and support regarding pain relief was required.

### Patient outcomes

- Limited data was available on patient reported outcomes for patients seen in OPD. Staff in OPD could not describe any methods in which patient outcomes were measured, other than patients chose to return to the hospital for further treatment. Staff said the individual consultants would have details about patient outcomes.
- The MAC monitored outcomes for individual consultants. This included readmission rates, development of VTEs and hospital acquired infection.
- The physiotherapy department actively engaged patients in monitoring and assessing outcomes. They

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had started using an electronic tool developed by Imperial College, London that promoted patient engagement in setting personal goals and measuring their outcomes following orthopaedic procedures.

## Competent staff

- Patients told us that they felt staff were appropriately trained and competent to provide the care they needed.
- The regional director of nursing said the organisation was committed to Continuing Professional Development (CPD), providing support for staff to attend courses if they were relevant to their role. They said CPD was seen as a partnership. Each case was negotiated with the registered manager. In some circumstances courses were paid by the organisation, but attendance was in the staff members own time. However, this was not experience shared by all staff.
- OPD nursing staff spoke about difficulties accessing training other than mandatory training. One example was a nurse had requested to attend a Tissue Viability training session, but was told they could not attend this because it was not relevant to the needs of OPD. However, the nurse said, they were treating an increased number of wounds in the OPD.
- Staff in both OPD and the diagnostic imaging department spoke about the appraisal process being cumbersome and unwieldy. Comments made about the process were that it was “complicated” and “mind boggling.” Some felt the process was taken over by documentation, with no time for discussion on future personal development or career progression. Others stated that even if future personal development and career progression was discussed, the organisation did not support them to attend courses to support their personal development.
- Appraisal rates for the year January to December 2014 were 33% for nursing staff in OPD, 100% for HCA in OPD and 78% for allied health care professionals, which included physiotherapists and radiography staff. OPD nursing staff, said they had completed an appraisal in the past 12 months, indicating compliance with annual appraisal rates had improved.
- Health care assistants in OPD commented they received sufficient training to equip them with the skills required in OPD. This included phlebotomy training with annual competencies of this skill and attending an acute medicine course at the local acute NHS trust.

- Monthly physiotherapy team meetings included a rolling training programme, this ensure staff were updated about current physiotherapy and rehabilitation practices. The department had organised a training fund that provided support for physiotherapy staff to attend training courses relevant to their role at the hospital.
- A process was followed by the Medical Advisory Committee to ensure all consultants who had practising privileges at the hospital had the relevant competencies and skills to undertake the treatment they were performing at the hospital. The competencies and skills were reviewed biannually.

## Multidisciplinary working (related to this core service)

- There was a service level agreement between the hospital and the MRI/CT department (which was part of another organisation and not subject to this inspection process). Patients could get their MRI/CT scans as well as other X-ray procedures carried out by the hospital on the same day as their appointment. Results were available electronically for consultants to view in the clinic.
- There were a number of service level agreements with the local acute NHS Trust, for support services to the hospital. This included processing and reporting on samples and biopsies, radiology monitoring, and support with life support training including the provision of emergency scenarios.
- The departments had access to specialist breast care, cosmetic and pain nursing staff employed by the hospital.
- From the care we observed, there was effective team working, with strong working relationships between all staff groups

## Seven-day services

- OPD ran clinics Monday to Friday from 8am until 8pm.
- The radiology department ran from 8am till 8pm, with an on-call service available at the weekend. Any patients requiring urgent radiological procedures were transferred to the local acute NHS hospital for treatment at weekends.

## Access to information

- Staff we spoke with reported timely access to test results such as from bloods and diagnostic imaging.

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Results were available for the next appointment or for certain clinics, during that visit, enabling prompt discussion with the patient on the findings and treatment plan.

- Many of these results were reported electronically, accessible by the clinician at the treatment centre, with a written copy also being sent.
- There were appropriate systems in place to ensure safe transfer and accessibility of patient records if a patient needed to be transferred to another provider for their treatment.
- Patient notes were always available to ensure continuity of care.
- Individual consultant secretaries ensured patients' GPs received communications about their care and treatment. We saw copies of letters to GPs in patient records.

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

- Information about the Mental Capacity Act 2008 and associated Deprivation of Liberty Safeguards was covered in the mandatory safeguarding training. Staff demonstrated in conversations a good understanding about their role with regard to the Mental Capacity Act.
- Consent forms were completed for all minor surgical and interventional radiology procedures. A monthly audit of completed consent forms was carried out. These showed good compliance with full and accurate completion of consent forms.
- The majority of general X-ray procedures, OPD procedures and physiotherapy treatments were carried out using verbal consent from patients.

## Are outpatients and diagnostic imaging services caring?

Good



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

During the inspection we saw and were told by patients that staff, in all outpatient areas, were caring and

compassionate. Patients and relatives commented positively about the care provided from all of the outpatient staff. Staff treated patients courteously and respectfully.

Staff maintained patient privacy and dignity. Patients were able to make informed decisions about the treatment they received. Staff listened and responded to patients' questions positively.

Staff demonstrated they were passionate about caring for patients and clearly put the patient's needs first, including their emotional needs.

## Compassionate care

- We observed that staff took all possible steps to promote patients' dignity and they were afforded privacy at all times. We observed all clinical activity was provided in individual consulting rooms and doors were always closed, to maintain privacy and confidentiality.
- Signs offering patients a chaperone were clearly displayed in waiting areas and clinical rooms. However, in OPD due to staffing levels, patients sometimes had to wait for a member of the nursing team to be available to provide a chaperone service for them.
- Throughout the inspection, we saw staff speaking in a calm and relaxed way to patients. Patients told us staff were helpful and supportive.
- The physiotherapy department recorded consistently high friends and family test scores above 98 (out of 100). OPD did not use the friends and family test. Staff in the department received limited feedback about the patient the corporate patient satisfaction surveys that were used, so did not know whether patients considered they received compassionate care from the department.

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

- All patients we spoke with told us they had been provided with the relevant information, both verbal and written, to make an informed decision about their care and treatment. There had been sufficient time at their appointment for them to discuss any concerns they had.
- Comments from patients who received physiotherapy indicated they were fully involved in their plan of treatment. Comments included "I have been treated by x in physio who has listened to my personal situation and taken into account when prescribing exercise/ treatment", "Treatments were discussed and the

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rationale behind them explained. I felt reassured and confident that the necessary progress would follow,” and “I was listened to and exercises amended where necessary.”

## Emotional support

- When having conversations with staff it was clear they were passionate about caring for patients and clearly put the patient’s needs first, including their emotional needs.
- Staff told us that they always offered to chaperone patients undergoing examinations and we saw records that showed patients were supported in this way.

## Are outpatients and diagnostic imaging services responsive?

Good



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

We rated ‘responsive’ as good.

Services were planned and delivered in way, which met the needs of patients. Clinics were held on weekdays. Patients told us that there was good access to appointments and at times that suited their needs. Waiting times, delays and cancellations were minimal, physiotherapy and X- ray appointments were on time and patients were kept informed of any delays in outpatient clinics.

Some aspects of the environment in outpatient department did not fully support effective service provision. Staff had to access a storeroom through the general treatment room. This had a possible impact that equipment would not be accessible for clinics if a patient was receiving treatment in the room

There was information on specific procedures or conditions, this was in English and not in other languages or formats, such as braille. The hospital had minimal numbers of patients who could not understand English. Staff made use of translation ‘apps’ on their personal mobile telephones and were not aware of interpreter services available. In outpatients, relatives were sometimes asked to help with translation.

There was a complaints process, although not visibly on display in outpatients. Staff were knowledgeable about the process and confident that complaints were investigated, but they did not receive feedback. .

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

- Services were planned around the needs and demands of patients. OPD clinics were arranged in line with the demand for each speciality. If consulting space was available, consultants could arrange unscheduled appointments to meet patient needs.
- Clinics were held Monday to Friday 8am to 8pm, with some occasional outpatient clinics held at weekends to meet patient’s needs.
- There was a combined waiting area for OPD and the physiotherapy department, a range of different style chairs meant patients could chose a chair that was comfortable for them whilst waiting. In the diagnostic imaging department there was limited seating for patients. However, patients were usually seen immediately for their X-ray procedure and did not have to wait in the department.
- Patients were sent appropriate information prior to their first outpatient attendance. This contained information such as the consultant or clinic they were to see, length of time for the appointment and written information about any procedures that might be performed at the first appointment. Reception desks were sufficiently away from waiting areas so patients could speak to receptionists and staff, without their conversation being overheard.
- The general treatment room in OPD had a storeroom that could only be accessed through the treatment room. This meant if a patient was having a procedure in the treatment room, there was a risk that staff would not be able to access equipment needed for use in other consulting rooms. To mitigate the risk of this occurring staff collected equipment required for the other clinics and the beginning of morning and afternoon sessions.

## Access and flow

- There were systems to manage the scheduling of clinics. There was a two-week plan for outpatient clinics. Consultants were required to give 48 hours’ notice

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about whether their clinic was going ahead and how many patients were attending, so appropriate staffing could be ensured to support effective flow of patients through the department.

- Patient's appointments were arranged through the consultant's individual secretaries.
- All patients we spoke with felt the availability of appointments was good and appointments were provided at times that fitted in with their needs. The majority of patients left with their next appointment date of if appropriate, admission date for surgery. Patients were very complimentary about the efficiency of the service as a whole.
- Physiotherapy and X-ray clinics usually ran to time. Staff told us if there were delays, they would speak to patients and keep them informed. If patients required procedures such as X-ray or ultrasound or scans these could usually be carried out at the same time as their OPD appointment, reducing the number of visits they had to make to the hospital.
- Staff in OPD reported that it was not unusual for clinics to run over their time allocation. They reported that afternoon/ evening clinics sometimes ran on until 9pm rather than the 8pm finishing time. Nursing staff stayed on duty, working over their rostered hours to ensure patients had their consultation. There was no data to demonstrate how frequently clinics ran late or how long patients had to wait in the waiting area for their consultation.
- For NHS patients the six-week diagnosis targets were consistently met.
- OPD had two treatment rooms. One was a general treatment room used for minor procedures such as removal of sutures, wound dressings and at the time of the announced inspection removal of skin lesions. The second was mainly used for urodynamic studies. When the urodynamic study room was free, it could be used for other treatments and clinics. However, staff reported, that some consultants were reluctant to use this room for their procedures and treatments.
- The general treatment room had a storeroom that could only be accessed through the treatment room. This meant if a patient was having a procedure in the treatment room, either equipment was not accessible or patient's privacy was disturbed whilst staff accessed the storeroom through the treatment room. To mitigate the

risk of this occurring, curtains were drawn round to protect patient privacy and staff collected equipment required for the other clinics and the beginning of morning and afternoon sessions.

- OPD staff commented that sometimes consultants had to wait to use the treatment room as there was another patient being treated in there. One consultant told us that although they provided consultations at the BMI Harbour hospital a lack of treatment room facilities meant they provided some treatments at an alternative independent hospital.
- For the reporting period April 2014 to March 2015, the hospital consistently met the target of 95% of non-admitted patients beginning their treatment within 18 weeks of referral.

## Meeting people's individual needs

- Staff recognised the need to support people with complex or additional needs and made adjustments wherever possible. However, staff noted there were rarely patients who had complex or additional needs.
- There was ample seating in the waiting area. There was access to tea and coffee in the waiting area. Outpatients, diagnostic imaging and physiotherapy were sign posted from the main reception desk.
- All written information, including pre-appointment information and signage was in English. These were not available in other formats such as other languages, pictorial or braille. Staff described there were rarely patients whose first language was not English. There were established process for accessing translation services; however staff were unaware of these. Staff described occasional circumstances when foreign patients had consultations in OPD. They described using translation 'apps' on their personal mobile telephones or patient's relatives to assist with translation. Using relatives for translation purposes is not a recommended practice, as it cannot be assured the patient has given consent for their medical information to be shared with their family member.
- There were written information leaflets in the reception area about general health and wellbeing and services offered by BMI Healthcare. Specific information about patient's treatment was provided by the consultant or nurses during pre-admission assessments that were completed on the ward area.

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- In diagnostic imaging, a range of leaflets was available and provided to patients in relation to diagnostic imaging procedures.
- There was a risk that patient privacy was not protected by staff having to access the store cupboard through the treatment room in OPD. To mitigate the risk of patient privacy not being protected, curtains were drawn round the patient whilst they were having treatment. However, staff said the situation still occasionally occurred when a member of staff would access the storeroom while a patient was having treatment and patients would be aware that someone was walking through the room and could overhear conversations and treatment.

## Learning from complaints and concerns

- There was no information displayed about how to make a complaint. There was information about the complaints procedure on the provider's website. However, this was not easy to access and could only be found using the website's search engine.
- Staff we spoke with were aware of the complaints procedure and to whom to report any concerns. There were confident complaints were investigated, but said they did not always receive feedback about the outcome of complaints.

## Are outpatients and diagnostic imaging services well-led?

Requires improvement 

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

There was a corporate clinical strategy and although staff did not know the details of the strategy, they exhibited the ethos of the strategy in their commitment to provide quality and compassionate care for patients in an effective and efficient manner.

Governance processes and management of risks did not provide assurance that risks to the service and patients were monitored and appropriate mitigating action taken. Individual departments did not maintain their own risk registers. Risks identified by OPD were not included on the

hospital risk register. There was no assessment of risks identified by OPD to determine the level of risk posed to patients and staff. Though staff in OPD stated they had escalated safety concerns to the management of the hospital there was no audit trail to demonstrate when concerns had been escalated.

Staff had confidence in their immediate managers, but some lacked confidence that senior management considered their views and opinions. There was a lack of feedback from OPD patient satisfaction questionnaires so they were not able to develop the service in response to patient staff views. There was a lack of feedback for OPD staff from staff satisfaction surveys, which made staff feel undervalued. Some staff felt hospital management relied heavily on the good will of staff and that good will was running out.

There was evidence of innovation and development of services in the physiotherapy and diagnostic imaging departments. This included new methods to monitor patient outcomes in physiotherapy services and working towards ISAS accreditation. In OPD, the team leader had introduced a requirement that consultants confirmed 48 hours prior to clinic times that the clinic was happening and how many patients were attending so staffing could be planned effectively.

## Vision, strategy, innovation and sustainability and strategy for this core service

- During the inspection, the regional Director of Nursing described the strategic vision of the organisation being "We aspire to deliver the highest quality outcomes, the best patient care and the most convenient choice for our patients and partners as the UK leader in independent health care."
- The regional DoN told us a corporate clinical strategy had been developed 18 months ago by the corporate multidisciplinary leads. They said the main aim of the strategy was to ensure there was a focus on quality, enhancing patient care and supporting staff. The DoNs at each hospital were tasked with coordinating the action plan to fulfil and meet the strategy's aims and objectives.
- The interim DoN had not been involved in the development of the clinical strategy action plan, but

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told us about the ambition to embed the values of the “6C’s” across the nursing teams at the hospital. The “6C’s” are care, commitment, courage, compassion, communication and competence.

- Although staff in the individual departments could not detail the corporate strategy, all demonstrated a commitment to providing quality and compassionate care for patients in an effective and efficient manner.

## **Governance, risk management and quality measurement for this core service**

- There was defined governance and reporting structure in the hospital, which fed into the organisations governance processes. Departments held their own team meetings, in which information could be fed back from hospital governance meetings and issues affecting the running of individual departments were discussed.
- Staff we met in each department described the top risks associated with their department. In ODP all staff we spoke with described the top risks were staffing numbers, the treatment room environment and the use of the hydrofractor. These risks were not detailed on the hospital’s risk register. Staff did not consider their concerns about these risks were being listened to or taken seriously by the management of the hospital.
- We reviewed the records from the last two ODP team meetings, dated 1 June 2015 and 23 March 2015. There was no reference made in the records to the top three risks that had been identified by staff.
- Individual departments did not maintain their own risk registers. If a risk was not identified on the hospital risk register there was no structured process to monitor the impact of the risks on the service or the effectiveness of any mitigating actions.
- Despite OPD staff identifying risks to their department, there were no assessments or monitoring to identify the level and frequency of risk posed to the department, patients and staff. There was no monitoring of the frequency of the nurse being or HCAs being the only members of staff in the department, there was no monitoring of the frequency of delays of provision of chaperones due to staffing numbers. There were no audit trails of the impact these incidents had on the service and the safety of patients and staff.
- We saw minutes from hospital governance meetings, which included feedback from complaints, investigations of reported incidents and details about risks to the hospital. However, there was no evidence the risk register was reviewed and that risks identified by staff in departments were considered.
- The OPD did not have their own audit programme so could not monitor the quality or effectiveness of the service they provided. The radiology and physiotherapy departments audited their service to identify patient outcomes and areas for improvement. The physiotherapy department was using an electronic system developed by Imperial College London to measure patient outcomes after orthopaedic procedures. This system promoted measurement of outcomes against patient’s individual goals, rather than generic goals.
- The medical advisory committee (MAC) was generally well represented by consultants from across specialities. The MAC had bimonthly meetings, scheduled a week after the clinical governance meeting. This arrangement enabled issues identified at clinical governance to be carried forward for discussion with consultants. The MAC meeting minutes indicated that members raised and discussed issues, such as incidents and complaints but outpatient environment and equipment issues were not raised. The chair of the MAC confirmed there was effective learning from complaints and incidents and they shared learning with relevant members; however, we did not see how this was achieved.
- The MAC had a role in reviewing consultant contracts maintaining safe practising standards amongst consultants and clinicians. Each consultant was required to complete biannual reviews with the MAC chair, where data on their clinical performance was discussed. The hospital also ensured that consultants had appropriate professional insurance in place and received regular appraisals.

## **Leadership/culture of service**

- At the time of the inspection the OPD manager, who was also the ward manager, had the role of interim DoN. Staff in OPD reported that when not taking on the role of DoN, the manager was not clinical and was generally not visible in the unit. OPD staff said they reported concerns to the manager, but they were not clear what action was taken once the concerns were escalated.

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- There was a team leader for OPD, who took on the role for managing the department. Staff spoke highly of the support and leadership provided by the team leader. Comments included that they were a “fantastic team leader.”
- Managers in the radiology and physiotherapy departments had a clinical role and were easily accessible. Staff reported good support and guidance from their managers.

## Culture within the service

- Most staff said they felt listened to and respected. They felt they could raise concerns and they would be investigated and actions taken as a result. However, staff in OPD felt the senior management of the hospital were not taking their concerns seriously.
- There was a positive attitude amongst staff with regard to wanting to share learning from incidents across the hospital and organisation. However, not all felt the management of the hospital fully supported shared learning across the hospital and organisation.
- Some staff felt the hospital management relied heavily on the good will of staff and that the good will was running out. Comments included the “well of good will was drying up,” and that staff were “swimming against the tide.”

## Public and staff engagement

- Patients were encouraged to leave feedback about their experience by the use of a patient satisfaction questionnaire and for NHS patients by the Friends and Family Test. Staff in OPD commented they received no feedback from the patient satisfaction survey. Staff in radiology commented that questions asked on the patient satisfaction survey were not relevant to the

service provide in radiology. In the physiotherapy department, the Friends and Family test results showed that 100% of patients would recommend the service to family and friends.

- The hospital and organisation undertook staff engagement through various mechanisms. Staff surveys were completed annually, though staff were not able to describe any changes made in the running of the service in response to staff surveys. Staff working in OPD reported they did not receive feedback from staff surveys. Monthly governance newsletters were displayed on the notice board by the staff canteen. However, from conversations with staff it was not evident these newsletters were read by staff. Department and team meetings provided opportunity for messages between the staff and the management of the hospital to be communicated. However, as previously discussed, not all staff felt their concerns were listened to by the hospital management.

## Innovation, improvement and sustainability

- Most staff reported the hospital supported innovation.
- The physiotherapy department was working with Bournemouth University to develop tools to improve outcomes for patient’s recovering from orthopaedic procedures. In partnership with Bournemouth University, they were trialling the use of a piece of equipment that stimulated muscle action to reduce swelling and reduce risk of deep vein clots in patients postoperatively.
- The diagnostic imaging department was working towards ISAS accreditation.
- The OPD team leader had introduced a process where consultants had to provide 48 hours notification of confirmation of their clinic and number of patients that would be seen at the clinic.

# Outstanding practice and areas for improvement

## Areas for improvement

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

The provider must ensure:

- incidents and complaints are appropriately investigated, for example through root cause analysis and learning identified
- learning from investigations is appropriately shared across the hospital
- risks are identified, assessed and managed effectively across all areas of the hospital
- there are processes in place to effectively monitor the service provision and identify areas for improvement
- the outpatient environment is assessed and actions taken to reduce risks of cross infection
- risks associated with use of hyfrecator and any other equipment is assessed and appropriate action taken to reduce any identified risks
- a record of decision-making discussions held between consultants and their patient is maintained in hospital records, as well as private patient records
- an assessment is made of the staffing levels in outpatients to ensure they are sufficient to meet the needs of patients and reduce risks to patients and staff

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

In addition the provider should ensure :

- accessible guidance on how to make a complaint is available to all patients
- all staff have the opportunity to contribute to annual appraisals
- staff are aware of the practical implications of the duty of candour regulation
- patient record templates are clear, consistent and easy for staff to use
- policies are up to date and reflect current guidance, legislation and best practice
- a cleaning list is maintained in endoscopy theatres that clearly demonstrate the equipment that has been cleaned, date and time when it happened, and the products used.
- the equipment stored in the endoscopy theatre is stored elsewhere to avoid clutter and minimise risks
- an assessment of the suitability of the outpatient environment is completed and adjustments made so that access to the storeroom is not through the treatment room.
- translation and interpreter services are available and relatives are not used to translate in medical consultations.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

#### Regulated activity

#### Regulation

Treatment of disease, disorder or injury

Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control

Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014: Safe care and treatment

How the regulation was not being met:

- Hyfractor equipment was not used in a safe way Regulation 12 (2)(f)
- There was insufficient assessment of risk and preventing the spread of infection in outpatient treatment room Regulation 12 (2)(h)

#### Regulated activity

#### Regulation

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014: Good Governance

How the regulation was not being met: Systems were not in place to

- Assess, monitor and improve the quality and safety of the services provided. Regulation 17 (2)(a)
- Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (2)(b)
- Assess the sufficiency of staffing in the outpatients department. Regulation 17 (2)(b)
- Maintain records of decision-making discussions held between consultants and their patient in hospital records. Regulation 17(2)(c)