

# Ashford and St. Peter's Hospitals NHS Foundation Trust

# Ashford Hospital

## Quality Report

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

## Ratings

### Overall rating for this hospital

Good



Medical care

Good



Surgery

Good



Outpatients and diagnostic imaging

Requires improvement



# Summary of findings

## Letter from the Chief Inspector of Hospitals

Ashford and St Peter's Hospitals became a foundation trust on 1 December 2010. As an NHS Foundation Trust there is greater freedom and scope to provide services for patients and the communities and more financial control of investments and expenditure.

The trust provides district general hospital services to a population of around 410,000 people living in the boroughs of Runnymede, Spelthorne, Woking and parts of Elmbridge, Hounslow and Surrey Heath. There are variations in the ethnic diversity between the populations served: in Spelthorne the average proportion of Black and minority ethnic residents is (12.7%) lower than that of England (14.6%), the average proportion of Black and minority ethnic residents in Hounslow (48.6%) is higher than that of England (14.6%). In Runnymede it is 11.0%, lower than that of England (14.6%). Deprivation in all three areas is the same as the England average, rates of children in poverty and statutory homelessness are higher in Hounslow than the rest of England averages but better than the England averages in Runnymede and Spelthorne.

At the time of this inspection there had been some recent changes within the executive team. The chief executive officer (CEO) had been in post since September 2014, having previously been the chief nurse since 2010. The chief nurse had been in post since October 2014, having previously been the deputy chief nurse and associate director of quality. The chair had been in post since 2008.

We carried out this comprehensive inspection as part of our in-depth inspection programme. The trust had been assessed as band 6 and 5 in our 'intelligent monitoring' system between March 2014 and July 2014. (The intelligent monitoring looks at a wide range of data, including patient and staff surveys, hospital performance information, and the views of the public and local partner organisations.) Our inspection was carried out in two parts: the announced visit, which took place on 3–5 December 2014; and the unannounced visit, which took place on 14 December 2014.

Ashford Hospital has been rated as good.

Our key findings were as follows:

### **Safety**

- We found areas that needed to improve safety in medical care and outpatients, diagnostics and imaging and surgery.
- We had concerns that patient confidentiality could be compromised as medical notes were left in corridors on trolleys, and computers in outpatient waiting areas were left unlocked and unattended.

### **Effective**

- We found all services inspected to be effective. Outpatients and diagnostic imaging is not currently rated for effectiveness.
- All staff we spoke to found appraisals useful and we saw data which indicated that a large proportion of appraisals had been completed.
- We saw good multidisciplinary working between all staffing groups in clinics we observed.
- Specialist pain nurses were available to support patients who had complex pain management requirements.

### **Caring**

- All services were found to be caring.
- All of the patients we spoke with were positive about the care they received at Ashford Hospital. One patient told us, "I am given whatever I need, they are very good", and, "they are first class here".
- One relative told us, "they are very compassionate and respectful, I could not want more", and, "the staff are delightful, I am extremely impressed, they are a fantastic team".

# Summary of findings

## Responsive

- All services were found to be responsive.
- The hospital was meeting its 18-week referral-to-treatment time targets, the average wait being 5.9 weeks. Targets for urgent referrals and cancer referral-to-treatment times were also being met.
- The rapid discharge team identified patients who could be discharged home and supported the discharge process to enable patients to go home or to community placements if spaces were available.

## Well-led

- Services for surgery and medical care were found to be well-led, however, outpatients, diagnostics and imaging were found to require improvements in this area.
- Staff said they were well-supported by their managers and regularly saw the chief executive officer and chief nurse on site. During these times, they had been approachable and listened to concerns.
- All staff we spoke with told us that Ashford Hospital was a lovely place to work in. They enjoyed their jobs and, although it was very busy, they would not like to work anywhere else.
- There was a lack of clarity among staff about how to access the risk register in medical services and outpatients diagnostics and imaging.
- Managers in medical services had been unable to attend the divisional governance meetings and had not received minutes, although there was a view that the divisional governance lead would inform them of anything pertinent to the Ashford site.

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

Importantly, the trust must:

- Take action to ensure that medications are being used and stored appropriately and are safe for use.
- Take action to ensure that records are secured appropriately to protect patient confidentiality.

In addition the trust should:

- Ensure that all relevant staff receive feedback and information from divisional governance meetings to be able to identify and address risks in their area of work.
- Ensure that outcome data enables identification of site-specific patient outcomes.
- Improve the storage facilities for equipment on the medical wards to reduce clutter and prevent the risk of patient falls.
- Ensure that all staff are up to date with mandatory training requirements including for the Mental Capacity Act 2005 and learning disability.
- Ensure that there is a robust process for the referral and handover when transferring patients from St Peter's to Ashford Hospital.
- Ensure, where the acuity (health needs) of patients increase, that there are sufficient staff to meet patients' needs.
- Ensure that all staff are aware of the process for alerting the emergency 'crash team' in the event of a patient becoming acutely unwell.
- Ensure that the systems for risk assessments and governance in the outpatient department are appropriate to identify and manage risk.
- Ensure that pharmacy staff have sufficient time to check medication prescription charts for errors in prescribing.
- Ensure that all staff are supported to attend training courses.
- Consider the arrangements for clinical nurse leader overview and support for theatres.
- Ensure that the reasons for 'as required' medications (drugs administered when needed) are clearly described on prescription charts.

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

# Summary of findings

**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?

Patients received compassionate care. We witnessed positive interactions between staff and patients. All staff we spoke with were positive about working at Ashford Hospital.

Safety in medicine was compromised because staff were not clear about the monitoring of risks to patients and staff. There were shortfalls in the number of staff attending basic life support and manual handling training. There were risks to patient confidentiality as care records were not consistently securely stored.

The trust monitored the effectiveness of care delivered at divisional level. We were not able to view data which was specific to Ashford Hospital and, therefore, could not be assured how the trust measured the performance of the hospital. The medical wards and the rapid access centre did not reach the trust's targets for appraisals.

There was confusion from ward staff on two wards about the changes to the level of care provided on their wards.

The clinical nurse leader for the medical wards was seen as a good role model and passionate about patient care, however, there was a lack of clarity about their other management duties.

### Surgery

Good



Patients received compassionate care at Ashford Hospital. We witnessed positive interactions between staff and patients.

There had been two recent Never Events (serious, largely preventable patient safety incidents which should not occur if the available preventative measures have been implemented) which had happened in theatres. Staff were able to demonstrate learning from the investigations and effective plans had been implemented to ensure there was no repeat of these incidents.

Appropriate infection control procedures were in place to prevent the risk of transmission of infection. Robust assessment procedures were used to ensure that it was appropriate for people to have their operations at Ashford Hospital.

# Summary of findings

Not all staff had received mandatory training to ensure they updated their knowledge to enable them to support patients appropriately. Information regarding patient outcomes was held at divisional level. We were not able to view data which was specific to Ashford Hospital and, therefore, could not be assured how the trust measured the performance of the hospital.

Not all staff were able to access further training to enable them to develop their skills. Staff in theatres told us they had difficulty accessing training courses. Patients reported that there was good access to care and that systems worked well. For example, they felt the flow through day surgery was well-organised. All staff were aware of the trust's values and all staff were aware of the potential increase of services to be offered at Ashford.

Governance was monitored at a divisional level and, although we were assured that there were robust governance arrangements overall, it was difficult for us to understand how the trust monitored governance on an individual site basis.

<Summary here>

## Critical care

### Outpatients and diagnostic imaging

#### Requires improvement



All staff we spoke with said they were encouraged to report incidents and learning was disseminated when required. In diagnostic imaging, World Health Organization (WHO) safety checklists were being used for interventional radiography and staff were clear of their responsibilities to Ionising Radiation (Medical Exposure) Regulations 2000 and Ionising Radiations Regulations 1999.

However, there were issues surrounding the security and confidentiality of medical records, as notes were left in corridors with patient names visible. We also found blood samples that were left unattended on a clinic reception desk.

There were concerns that some receptionist staff were unsure about their responsibilities if a patient deteriorated. Some could not locate where the crash trolley (for transporting emergency medication) was and didn't know the correct process for alerting the 'crash team' by telephoning 2222.

The diagnostic imaging department had integrated diagnostic reference levels into their practices as required by the Ionising Radiation (Medical Exposure) Regulations 2000.

## Summary of findings

In physiotherapy, patient outcomes were monitored using quality of life outcome measures, cost effectiveness analysis, and benchmarking these against best practice and National Institute for Health and Care Excellence (NICE) guidelines.

The outpatients and diagnostic imaging department were caring and considerate to patients, carers, and visitors. We observed that staff at all grades shared the same level of compassion and understanding of patients' needs and treated everyone with dignity and respect.

Although there were plans to improve the outpatients service, we were not provided with information about this until after the inspection. There was a positive working environment which was dedicated to putting the patient first, however, there was limited evidence of robust governance systems.

Good



# Ashford Hospital

## Detailed findings

### Services we looked at

<Delete services if not inspected> Medical care (including older people's care); Surgery; Outpatients and diagnostic imaging

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# Detailed findings

## Background to Ashford Hospital

Ashford and St Peter's Hospitals NHS Foundation Trust had 628 beds and employed around 3,500 staff (1,145 WTE). The trust provided district general hospital services to a population of around 410,000 people living in the boroughs of Runnymede, Spelthorne, Woking and parts of Elmbridge, Hounslow and Surrey Heath. The trust also provided some specialist services, including neonatal intensive care, bariatric and limb reconstruction surgery.

Ashford Hospital is a registered location for Ashford and St Peter's Hospitals NHS Foundation Trust.

Ashford Hospital is situated on the A30 to the west of London, close to junction 13 on the M25 and Heathrow Airport. It provides the following services: medical rehabilitation, day case surgery, orthopaedic surgery, outpatients, radiology and imaging, and a chemotherapy suite.

The inspection team inspected the following three core services at Ashford Hospital:

- Medical care (including older people's care)
- Surgery
- Outpatients and Diagnostics and Imaging

## Our inspection team

Our inspection team was led by:

**Chair:** Gill Gaskin, Medical Director, University College London Hospitals

**Head of Hospital Inspections:** Mary Cridge, Head of Hospital Inspection, Care Quality Commission

The team of 42 included CQC inspectors and a variety of specialists: a consultant intensivist, a consultant vascular surgeon, a consultant paediatric surgeon, a consultant

obstetrician, a consultant in end of life care, two junior doctors in medicine, pharmacists, a director of nursing, an associate director of governance, specialist nurses in paediatrics, theatres, end of life care, surgery and accident and emergency (A&E), a midwife, a student nurse, an expert by experience, an occupational therapist, an associate director of nursing and safeguarding lead.

## How we carried out this inspection

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the trust. These included the clinical commissioning group (CCG) at North West Surrey, Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch.

We held a listening event in Chertsey on 27 December 2014, where 20 people shared their views and experiences of services provided by the trust. Some people who were unable to attend the listening event shared their experiences with us via email or telephone. We also met with a group of patient representatives from the Surrey Coalition of Disabled People who shared their experiences of using the trust.

We carried out the announced inspection visit between 3 and 5 December 2014 and the unannounced visit on 14 December 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, consultants, physiotherapists, occupational therapists, administrative staff, healthcare assistants and support workers. We also spoke with staff individually, as requested.

We talked with patients and staff from across the hospital, including ward areas and outpatient services. We observed how people were being cared for, talked with carers and family members, and reviewed patients' records of personal care and treatment. We interviewed

# Detailed findings

the chair and the chief executive, and met with a number of executive and non-executive directors, a number of the trust governors, senior leaders from the clinical divisions and managers.

## Facts and data about Ashford Hospital

Ashford and St Peter's Hospitals NHS Foundation Trust has 636 beds (553 inpatient and 83 day case) 55 of which were maternity inpatient and nine critical care inpatient. There were around 618 (537 wte) staff in post at Ashford Hospital

In 2013/14 the Ashford and St Peters sites had approximately 38,948 elective admissions of which 32,356 were day cases. The Trust had a further 23,906 emergency admissions and non-elective admissions and provided approximately 397,655 outpatient attendances. During the same year the emergency department dealt with 92,198 attendances. At Ashford hospital there were 14,221 elective admission and 12,600 day case admission for 2013/14. The hospital provided 13,257 outpatient appointments for the same period.

At Ashford hospital where the inpatient medical beds predominantly provide rehabilitation care, the average

length of stay if taken for Ashford alone is generally longer for non-elective procedures, but taken overall the average length of stay for Ashford and St Peters hospitals is generally shorter than the English average for non-elective procedures.

This trust had a much better rate for patients not attending appointments than the England average. The rate for patients waiting less than 31 weeks for their first cancer treatment was better than the England average. Two-week and 62-day waiting times for all cancers were similar to the England averages.

Outcomes of the patient-led assessments of the care environment (known as PLACE) for 2013/14 demonstrated higher-than-the-England-average scores for cleanliness and hygiene, food and facilities.

# Detailed findings

## Our ratings for this hospital







Our ratings for this hospital are:

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

### Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

# Medical care (including older people's care)

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

## Information about the service

Ashford and St Peter's Hospitals NHS Foundation Trust provides inpatient medical services at Ashford Hospital. There are three medical wards and a rapid access centre with 57 beds.

We visited Chaucer Ward, a 14-bed stroke rehabilitation ward, Wordsworth Ward, a 20-bed general rehabilitation ward and Fielding Ward, a 22-bed rehabilitation ward. Wordsworth and Chaucer wards were managed by one ward manager, and on the whole, run as one ward. However, we were told they were due to be split into two wards in the near future.

We also visited the rapid access centre, a 'one-stop shop' for patients who required a higher level of treatment than that available from their GPs.

We spoke with 20 members of staff, including doctors, nurses, healthcare assistants, speech and language therapists, physiotherapists and administrators. We spoke with 11 patients, two relatives and reviewed nine care records.

Before and during our inspection we reviewed the trust's performance information.

## Summary of findings

Ashford Hospital was rated as good overall. Patients received compassionate care and we witnessed positive interactions between staff and patients.

All staff we spoke with were positive about working at Ashford Hospital.

Safety in medicine was compromised because staff were not clear about the monitoring of risks to patients and staff. There were shortfalls in the number of staff attending basic life support and manual handling training. There were risks to patient confidentiality as care records were not consistently securely stored.

The trust monitored the effectiveness of care delivered at divisional level. We were not able to view data which was specific to Ashford Hospital and, therefore, could not be assured how the trust measured the performance of the hospital. The medical wards and the rapid access centre did not reach the trust's targets for appraisals.

There was confusion from staff on two wards about the changes to the level of care provided on their wards.

The clinical nurse leader for the medical wards was seen as a good role model and passionate about patient care, however, there was a lack of clarity regarding their other management duties.

# Medical care (including older people's care)

## Are medical care services safe?

Requires improvement



In two ward areas, patients' records were not stored securely to prevent unauthorised access.

Records showed that a significantly high number of staff had not attended basic life support training updates. This placed patients at risk because there were not enough suitably skilled staff to provide care if life support was needed.

There was a high level of vacancies on two of the medical wards which resulted in frequent use of agency and bank staff to ensure staffing numbers were maintained.

General ward areas were cluttered which put patients at risk of falls.

Staff maintained good infection control procedures and the ward environment was visibly clean.

Staff had good knowledge about what constituted abuse and the procedures to follow if they were concerned about a patient at risk.

### Incidents

- There had been no Never Events (serious, largely preventable patient safety incidents which should not occur if the available preventative measures have been implemented) in medical services.
- Staff throughout the hospital understood their responsibilities to raise concerns, to record safety incidents and near misses. However, most of the staff we spoke with told us they rarely received individual feedback after they had reported an incident.
- Incidents that affected the whole team were discussed at staff meetings on all of the medical wards. This was to ensure that lessons were learned from the incident investigation.
- Regular morbidity and mortality meetings were held at divisional level. These meetings enabled any trends to be identified and learning to occur from the presentation of case studies.

### Safety thermometer

- NHS Safety Thermometer information was not consistently displayed in the ward areas. The NHS Safety

Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm-free care. We saw that the Safety Cross system (for assessing risks of pressure ulcers and falls) was to inform staff, patients and visitors about how many falls and incidents had occurred during the month. However, other information, for example, pressure ulcers, cleanliness and hand hygiene were not consistently displayed.

- The ward manager on Fielding Ward told us that the Safety Thermometer information was recorded electronically. They said that staff would be informed of safety results in staff meetings and staff we spoke with confirmed this.

### Cleanliness, infection control and hygiene

- We saw staff adhering to the trust's infection control policy. Information was clearly displayed above sinks in ward areas to remind staff about correct hand-washing procedures. Staff were bare below the elbows, in line with recommended hygiene practice, and were seen washing their hands and using hand gel appropriately. Personal protective equipment was available and staff were seen changing gloves and aprons in between seeing patients to prevent the risk of cross-infection.
- Monthly hand-hygiene audits were undertaken to ensure that staff adhered to correct hand-washing techniques. Records showed that the medical wards consistently scored 100% in these audits.
- During our inspection the ward areas were visibly clean. Regular infection control audits were conducted by the specialist infection control nurses to ensure that ward areas were clean and met infection control standards. When areas for improvement were identified, an action plan was produced, with a date for completion.

### Environment and equipment

- Resuscitation equipment was available in all ward areas. We saw that all equipment had been checked regularly and was in working order.
- Clinical areas were well-maintained and storage was well-organised to allow easy access for staff.
- The patient-led assessments of the care environment (PLACE) assessment in May 2014 identified that all three ward areas were cluttered and untidy. An action plan was devised to address areas of concern, with a timescale for completion. However, general ward areas were cluttered with equipment, for example,

# Medical care (including older people's care)

wheelchairs and mobility aids. The ward sister on Fielding Ward told us they hoped to improve the lack of storage by removing a bath in an unused bathroom to allow equipment to be stored.

- We observed that equipment stored in corridors on all wards could cause a safety risk for patients who were being supported to mobilise.
- The waiting area for the rapid access centre was attractively decorated and welcoming for patients.

## Medicines

- Medicines were stored securely in all the medical wards to prevent unauthorised persons gaining access.
- Fridge temperatures were recorded to ensure that medicine was kept at the correct temperature. However, on Wordsworth Ward, we saw a poor response to the maximum fridge temperature being out of an acceptable range. We saw no action had been taken to remedy this since 15 November 2014 and staff did not know how to re-set the thermometer.
- Prescription charts had been accurately completed, however, we saw that, on some charts the reason for 'as required' medications (drugs administered when needed) was not clearly described.
- The medicine incidents database highlighted two occasions where the medicines ordered by 2pm on one day were not delivered to the ward until after 6pm the following day. This led to missed doses of medication and delayed patient discharges.

## Records

- On Wordsworth Ward patients' care records were kept in unlocked trolleys in an alcove by the main desk. There was a risk that notes could be accessed by unauthorised staff if the desk was unattended.
- On Chaucer Ward patients' records were stored in an unlocked trolley in the ward corridor.
- On Fielding Ward, the patients' records trolley was securely locked by the nurses' station.
- We reviewed nine care records which showed that risks to patients had been identified and an appropriate care plan developed. Some of these had been updated to show changes, but not all. For example, we saw a risk assessment had been completed for a patient who required support to mobilise. Staff told us the patient's

support needs had changed, however, the assessment had not been updated to reflect this. This could mean the patient may not get appropriate support to meet their needs.

- An assessment form was used, however, ward staff were not aware of this tool and we did not see any evidence of this form in the care records we examined.
- We were told by doctors that an assessment document was also used at St Peter's Hospital to ensure that patients were suitable for transfer to Ashford Hospital. Ward staff we spoke with were not aware of the document and we did not see any evidence of it in the care records we examined.

## Safeguarding

- All staff we spoke with were able to describe what constituted a safeguarding concern and were aware of their role and responsibilities to safeguard vulnerable adults from abuse. From records sent to us after our inspection, we saw that the majority of staff had attended safeguarding training. We read that, on Wordsworth and Chaucer wards, six members of staff needed to update their training to become compliant with the trust's policy on frequency of this training.
- Posters were displayed in all areas which explained the processes to follow if staff, patients or visitors believed someone was at risk of abuse.

## Mandatory training

- Training records sent to us after our inspection showed that not all staff had attended training updates to ensure they were suitably trained to care for patients in their areas.
- On Wordsworth and Chaucer wards we saw that, out of 34 ward staff, 14 had not attended manual handling updates and 10 had not attended basic life support updates at the frequency required by the trust.
- Training records for the rapid access centre showed that six out of nine staff members did not meet the trust's requirement for basic life support training.
- For Fielding Ward we saw that six out of 23 staff members had not attended manual handling updates, and five had not attended basic life support updates.
- This meant that a significant number of staff had not attended two-yearly updates for basic life support. This placed patients at risk because there were not enough suitably skilled staff to provide care if life support was needed.

# Medical care (including older people's care)

## Assessing and responding to patient risk

- All ward areas used an early warning score to determine if patients were at risk of deteriorating. In the patient records we reviewed, we saw that the Modified Early Warning Score (MEWS) system for acutely ill patients had been used appropriately.
- If patients became acutely unwell and required more complex medical treatment, they were transferred by ambulance to St Peter's Hospital. We saw that three patients were transferred to St Peter's during November 2014.
- Patients living with dementia were supported if they were at risk of falls. For example, staff were allocated to support patients on a one-to-one basis, to enable patients to walk safely around ward areas.

## Nursing staffing

- Staff from all ward areas told us they felt there was not enough staff to enable them to care for patients appropriately. Patients told us they felt that ward staff were "run off their feet" and at times they had to wait a long time for their buzzers to be answered.
- From data sent to us prior to the inspection, we saw there were no vacancies on Fielding Ward. On Chaucer and Wordsworth wards (managed as one ward) there were 15.% whole time equivalent (WTE) registered nurse vacancies and 3.% WTE additional clinical services vacancies, for example physiotherapists.
- Agency and bank staff had been used in all ward areas to ensure that enough staff were available to care for patients.
- Ward staff told us that agency healthcare assistants were often used to support patients living with dementia. One member of agency staff told us they had been shown around the ward and had been given a verbal handover and written information to enable them to care for patients in their allocated area. However, they were unable to give us any information about the patients they were caring for and were not aware of one patient's specific care needs. We reported this to the nurse in charge because patients may have been at risk if the staff were not aware of a patient's care requirements.
- Nurse practitioners provided 24-hours-a-day, seven-days-a-week cover. The nurse practitioners offered a wide range of support to ward staff, for example, care for patients with complex medical

conditions and admissions and discharges. Out of hours the nurse practitioner worked closely with the doctor on call to ensure that patients and ward staff were supported.

## Medical staffing

- Consultants conducted twice-weekly ward rounds and were available to contact by phone out of hours if required.
- During normal working hours, each ward had an allocated staff doctor, and Specialty and Associate specialist (SAS) level doctor.
- Out-of-hours cover was provided by one SAS doctor who covered the medical wards and the surgical ward. An anaesthetist was available between the hours of 8am and 8pm Monday to Saturday for support with medical emergencies.
- The rapid access centre was staffed by a consultant who was supported by SAS doctors.

## Major incident awareness and training

- The trust had a major incident and business continuity plan. The major incident plan identified staff responses to different types of incidents. Ward staff we spoke with were not consistently aware of their role in a major incident.

## Are medical care services effective?

Good



Best quality care indicators were displayed in all the ward areas. This was an assessment tool used by the trust to monitor the safety and quality of care delivered. Some of the areas covered in the audit were: infection control, manual handling, and falls assessment. All three of the ward areas achieved their targets.

Appraisal rates for staff on the medical wards fell below the trust's target of 98%. This meant that some staff had not had the opportunity to review their performance or discuss areas for further training.

Ward staff at Ashford Hospital did not consistently receive an adequate handover when patients were transferred from St Peter's.

## Evidence-based care and treatment



# Medical care (including older people's care)

- Best quality care indicators were displayed in all the ward areas. This was an assessment tool used by the trust to monitor the safety and quality of care delivered. Some of the areas covered in the audit were: infection control, manual handling, and falls assessment. All three of the ward areas had been identified as 'green'. This meant they had achieved their targets and were due to be audited in six months' time. In our discussions with the ward managers and the clinical nurse leader, it was unclear if there were systems to ensure regular audits were undertaken to maintain standards in the interim period between the six-monthly formal audits.
- Staff had access to information about National Institute for Health and Care Excellence (NICE) guidelines on the trust's intranet, and we saw these were discussed at the elderly care governance meetings which were held every other month.
- Physiotherapists and speech and language therapists told us they did not have enough staff to meet national stroke care guidelines

## Pain relief

- Patients we spoke with told us that staff responded quickly to requests for pain relief.
- We reviewed nine care records and saw that the majority of patients had documented pain assessments, helping ward staff to respond appropriately to requests for pain relief. However, two sets of care records did not include any assessments. This meant that staff may not be able to identify if the patients experienced pain and the correct medication to dispense to aid pain management.
- Specialist pain nurses were available to support patients who had complex pain management requirements. We saw in one care record that a patient had been referred to the specialist nurses for advice regarding pain management. We saw clear documentation for staff detailing how to administer effective pain management. We spoke with the patient who told us that their pain was "much better now".

## Nutrition and hydration

- There were protected meal times on the medical wards.
- Patients were assessed for their nutritional and hydration needs and referred to a dietician if required.
- Patients were mainly positive about the food provided at Ashford Hospital. One person told us the food was,

"lovely and we get plenty of choice", and another told us, "there is always plenty of food". One patient told us, "there was not enough choice and the food was too spicy".

- Lunch boxes were provided for patients in the rapid access centre if they were waiting for further tests over lunchtime or had missed a meal.

## Patient outcomes

- In the Sentinel Stroke National Audit Programme (SSNAP) for January to March 2014, the trust's stroke services attained an overall score of 'D' on a scale of A to E, with A being the best. Since then the trust's overall score has steadily improved; data for April to June 2014 showed a score of 'C', while data for July to September 2014 showed a score of 'B'. The data was trust wide and was not able to be split for Ashford as the stroke service was a pathway provided across the two sites.
- Stroke workshop meetings were held to discuss clinical outcomes data. The information was recorded across the trust and there was no separate data to demonstrate whether the wards at Ashford, particularly Chaucer Ward (a dedicated stroke rehabilitation ward) were performing.
- Monthly 'saving lives' audits were completed to ensure that ward staff delivered harm-free care. These included catheter care and cannula insertion. The medical wards regularly achieved a result of 100%.
- Physiotherapists told us they used specific care pathways for rehabilitation of patients. For example, the elderly mobility scale which allowed patients and physiotherapists to set achievable goals and measure the outcome at regular intervals during the patient's treatment. We saw examples of goal-setting in the care records we reviewed.
- The average length of stay for elective medicine was four days compared with the England average of five days. However, the average length of stay for non-elective medicine was 47 days compared to the England average of six days. Staff told us this figure was high because the wards were rehabilitation wards, and therefore patients may stay longer.
- Monthly meetings were held in the rapid access centre to discuss updates from the wards, work load, and to share information from St Peter's Hospital. We were told



# Medical care (including older people's care)

that the meetings were informal and not consistently minuted. We saw a copy of the minutes of one meeting; they were brief and we could not be assured of what had been discussed or actions taken.

## Competent staff

- The ward manager on Chaucer and Wordsworth wards told us that, although the acuity (health needs) of their patients had increased, they felt the wards' staff were skilled to support the increased care needs. They told us that some staff had previously worked in more acute areas and were used to caring for patients with complex health needs.
- The ward manager on Fielding Ward told us that ward staff required further training to support the increased care needs of the patients on the ward. They told us there was a plan for staff to attend an acute illness management course; however, no staff had, as yet, attended.
- The trust's target rate for staff receiving an appraisal was 98%. Data from September 2014 showed that 81.8% of nursing staff on Fielding Ward and 79.4% on Wordsworth and Chaucer wards had received an annual appraisal. This meant that some staff had not been given an opportunity to discuss areas for improvement or further development in their role.
- Staff in the rapid access centre told us that training was available to enhance their skills and expertise. However, they did not always receive the management support to attend the training courses. We spoke with two members of staff in the centre: neither staff member had received an appraisal for over two years. We were told this was because of management changes.

## Multidisciplinary working

- One relative told us, "there is very good multidisciplinary team working here, everyone is involved".
- We saw integrated multidisciplinary team working across all the medical wards.
- We witnessed a daily 'board round' (here patients were discussed between the medical and nursing staff) that included all members of a multidisciplinary team, for example, nurses, doctors, physiotherapists and occupational therapist.
- We saw clear documentation in care records that detailed multidisciplinary input into patients' care.

- There was no pharmacy dispensing service at Ashford Hospital. The pharmacist visited Ashford Hospital from 9am to 12.30pm Monday to Friday. Both ward staff and the ward pharmacist stated that there was not sufficient time for the pharmacist to complete their work, particularly on a Monday when they often stayed later to ensure that their work had been completed. This had a knock-on effect if the pharmacist was expected back at St Peter's to visit wards there.

## Seven-day services

- Out-of-hours pharmacy support was provided from St Peter's Hospital. Emergency medication was stored at Ashford Hospital for patients who may have required urgent medication out of hours. Prescriptions could also be dispensed at an independent pharmacy located near the hospital.
- There was no access to x-ray or other imaging out of hours at Ashford hospital. If a patient needed urgent imaging out of hours, they were sent to St Peter's Hospital by ambulance and returned to Ashford afterwards.
- There was no speech and language therapy or physiotherapy services available out of hours.
- Consultants were available by telephone out of hours. Doctors we spoke with told us they always managed to contact a consultant if required.

## Access to information

- Staff told us there was not always enough information in care records to enable them to care for patients appropriately when they had been transferred from St Peter's Hospital.
- Staff told us they were informed if patients were being transferred to them from St Peter's Hospital via telephone and a verbal handover of the patient's medical condition and care requirements would be given at that stage. However, some staff said that patients often arrived on the ward without staff receiving information from St Peter's Hospital to enable them to care for the patient appropriately.
- Discharge summaries were provided to GPs to inform them of patients' medical condition and treatment they had received.

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

# Medical care (including older people's care)

- Ward staff were clear about their roles and responsibilities regarding the Mental Capacity Act 2005. They were also clear about the processes to follow if they thought a patient lacked capacity to make decisions about their care.
- The nurse practitioner was involved in assessing patients' capacity. Capacity assessments were often completed when a patient was ready for discharge home or to a community placement. We saw that capacity assessments had been completed appropriately and discussions had been held with the patient and those close to them.
- Staff in the rapid access centre described the consent process for patients with cognitive impairment. Staff gave an example of how they supported a patient with learning difficulties. One patient had attended without family support and a staff member had detected that the patient was unhappy, judging by their facial expressions and body language. Volunteer staff supported the patient who was encouraged to return the following day with family support, which they did. The examination and treatment was able to proceed without any further distress to the patient.
- One relative told us, "they are very compassionate and respectful, I could not want more", and, "the staff are delightful, I am extremely impressed, they are a fantastic team".
- During our inspection we observed that privacy and dignity was maintained. Patients told us that ward staff said "knock knock" and waited to enter if curtains were drawn around them.
- The average response rate for the NHS Friends and Family Test in England was 32%; both Wordsworth/Chaucer (run as one ward) and Fielding wards had a higher response rate of 35% and 38% respectively. Monthly results of the friends and family test between January and November 2014 showed that between 79% and 100% of patients on the Wordsworth Ward would be either likely or extremely likely to recommend the service.
- We saw that patients had their call bells within reach on all of the wards we visited. Although, some patients told us they had to wait a long time for their call bells to be answered. One patient told us "it's not their fault, [ward staff] are so busy", and another patient told us, "they always apologise if they have kept me waiting for a while".

## Are medical care services caring?

Good



Patients we spoke with were overwhelmingly positive about the care they received at Ashford Hospital. One patient told us, "apart from being a patient, spending a couple of days here is the best thing you can do", and another patient told us, "re-hab here is brilliant".

Some patients told us that the ward staff appeared to be very busy and there were times they had to wait a long time for call bells to be answered.

Patients received compassionate care and we witnessed positive interactions between staff and patients

### Compassionate care

- All of the patients we spoke with were positive about the care they received at Ashford Hospital. One patient told us, "I am given whatever I need, they are very good", and, "they are first class here".

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

- During our inspection we heard information being given to patients about their care. Information was provided sensitively and patients were given time to ask questions and contribute to future plans.
- We heard a consultant discussing treatment options with patients; they took time to ensure that patients understood and were able to ask questions if necessary.
- One relative of a patient on Chaucer Ward told us, "they were very honest with us and did not give false hope", and, "we know how my relative will progress; the team work with us".

### Emotional support

- One patient told us, "they treat me as a human being", and another patient told us, "I have been down a couple of times; they comforted me and supported me". All of the patients we spoke with told us staff were supportive, although there were times when staff appeared to be very busy and this affected their availability to support patients.

# Medical care (including older people's care)

- Patients' emotional and spiritual needs were documented in their care records.

## Are medical care services responsive?

Good



The rapid access centre responded promptly to referrals and were able to offer medical tests and treatment to prevent unnecessary admission to the emergency department or to hospital wards.

All of the patients we spoke with told us they had enough information about their care.

Patients on Chaucer Ward were able to attend a stroke club for activities and support.

There was confusion regarding the future service planning for Wordsworth and Fielding wards. Some staff were uncertain as to whether the level of care they provided was to be raised due to the need to take not just patients who required rehabilitation.

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

- The rapid access centre was a 'one-stop shop' for patients who needed a higher level of treatment than was available at their GP. The service had been planned to alleviate pressures in the emergency department and to prevent unnecessary admissions to hospital.
- There was some confusion about the service provided on Fielding and Wordsworth wards. Senior ward staff and some therapists from these wards told us that patients recently admitted to the ward were not necessarily appropriate for rehabilitation. This had been due to bed pressures at St Peter's Hospital. In light of this, they told us they had been formally told that the wards were no longer purely aimed at rehabilitation and they were now classified as sub-acute wards (a level of care needed by a patient who does not require hospital acute care, but who requires more intensive, skilled nursing care). The clinical nurse leader told us that a recent meeting had taken place but no formal decisions had been made regarding a change in the level of care delivered at Ashford Hospital.

### Access and flow

- Patients were admitted to Ashford from St Peter's Hospital for rehabilitation after a fractured hip, stroke or other medical conditions. Doctors told us there was an assessment form which was used at St Peter's to ensure that patients transferred to Ashford Hospital were suitable for rehabilitation.
- All of the ward staff we spoke with told us that, because of bed pressures at St Peter's Hospital, some patients who were transferred to Ashford Hospital were not suitable for rehabilitation because they required more intensive nursing.
- During our inspection we witnessed two patients admitted to the medical wards; on both occasions ward staff were not aware that the patients were due to arrive and did not have enough information to meet their care needs. In one case, there was no bed available for the patient because another patient was waiting to be discharged. The arriving patient was offered a meal. However, because of the lack of bed space, they had to eat the meal in the ward corridor.
- Staff told us that patients were ideally transferred from St Peter's to Ashford Hospital with a complete set of discharge medicines and discharge summary. However, staff said this does not always happen. They told us that staff try to order discharge medicines at least the day before discharge. If this does not happen, the pharmacist at Ashford faxed through prescriptions, including discharge medicines, to the pharmacy at St Peter's Hospital. This could be tracked via the pharmacy tracker, however, sometimes they had to chase up discharge medicines due to problems with the faxing process. This could delay a patient's discharge from the ward.
- The trust-wide bed occupancy since April 2014 had been between 90.7% and 91%. We were sent bed occupancy figures by the trust for October–November 2014. Research has indicated that bed occupancy rates of over 85% increase the risk of harm to patients. We saw that all three wards were consistently operating at 95% and above. Figures for Chaucer Ward in early November 2014 showed a bed occupancy rate of 114%. We were told that this was due to extra bed spaces being utilised. Staff told us that staffing levels had not always increased to meet the needs of extra patients. This put patients at risk of not receiving care that met their needs.
- The rapid discharge team identified patients who could be discharged home and supported the discharge process to enable patients to go home or to community

# Medical care (including older people's care)

placements if spaces were available. We saw that the date patients were due to be discharged was displayed on boards in the ward areas. We noticed that patients often stayed longer than had originally been expected. Staff told us this was often due to lack of availability of community placements.

- Patients were referred to the rapid access centre by their GPs, walk-in centres and, occasionally, the emergency department for a variety of tests and investigations, such as electrocardiogram (ECG) and chest x-ray. The aim was to see eight patients a day. Staff told us that, on average, they saw between five to nine patients daily.

## Meeting people's individual needs

- One patient told us, "I have been given a lot of leaflets", and another told us, "they give me all the information". All of the patients we spoke with told us they had been given enough information to enable them to understand their care and treatment.
- Staff told us that the acuity (health needs) of patients transferred to Ashford had increased. Some patients had complex needs and, at times, staff felt they did not have the necessary skills to care for some patients. Staff were able to access specialist nurses based at St Peter's Hospital for advice and support and the nurse practitioner was also available if needed.
- Leaflets and information were displayed. We were told that it was difficult to obtain printed information in other languages. Translation services were available if required.
- Ashford Hospital used the butterfly scheme to help identify patients with cognitive impairment. Blue butterflies were attached to the main ward board to alert staff that patients may need extra support with some areas of their care. White butterflies were displayed to alert staff that some patients were awaiting a diagnosis of cognitive impairment. However, patients did not always have further documentation to support their care. For example, the 'This is me' documentation was not always completed in a timely manner. The 'This is me' document details information about the patient's likes and dislikes, previous life history, hobbies and so on. The document is used to help staff to care for people who may have communication difficulties. One patient's relative told us that the 'This is me' document had only just been completed and their relative had been in hospital "a while".

- On Chaucer Ward, information was displayed about a stroke club, organised by previous patients, encouraging current patients on the ward to attend. The club organised activities and a member of the trust administration team helped to run the club.
- Staff at the rapid access centre received referrals for patients which detailed any special requirements the patient may have. For example, if patients required bariatric chairs for comfort while they were seated in the waiting room, staff were able to have them ready prior to the patient's arrival in the centre.

## Learning from complaints and concerns

- None of the patients we spoke with had any complaints about the care and support they received.
- Staff told us that they tried to resolve any complaints and concerns as they arose.
- We read in minutes from the trust quality report that complaints were discussed at a divisional level.

## Are medical care services well-led?

Good



The clinical nurse leader for the service was clearly passionate about high-quality patient care and was considered by staff to be highly visible, and an excellent role model. Staff were positive about working at Ashford Hospital. They portrayed a strong team spirit and felt they had supportive leaders.

However, there was a lack of knowledge among staff at all levels about governance and risk management which may have an impact on monitoring the quality of care delivered to patients.

Information regarding patient outcomes was held at divisional level. We were not able to view data which was specific to Ashford Hospital and, therefore, could not be assured how the trust measured the effective performance of the hospital.

There was confusion and no clear message for staff regarding the vision for Wordsworth and Fielding wards.

The rapid access centre was managed by a different division in the trust. Staff told us they did not feel valued and supported by their managers.

## Vision and strategy for this service

# Medical care (including older people's care)

- There was lack of clarity about the vision for two of the medical wards. Ward staff were confused about plans for Fielding and Wordsworth wards. The clinical nurse leader told us that an initial meeting had taken place to discuss potential changes to the service and nothing had formally been decided.
- All the staff we spoke with were able to tell us about the trust's values: the 'four Ps': Putting patients first, having a Passion for excellence, Pride in their teams and taking Personal responsibility. Staff told us the values were now linked to their annual appraisals to ensure they were "living the values".

## Leadership of service

- The leadership at Ashford hospital were passionate about good patient care and putting patients first and were highly regarded by all the staff we spoke with. We were told the clinical nurse leader was highly visible and easy to approach for advice and support. Staff thought the clinical nurse leader was a good role model and embodied the principles of the 'four Ps'. However, we found there was lack of clarity about the hospital site leadership responsibilities such as governance and risk management.
- Staff in the rapid access centre told us that they had been managed by three different managers in the last two years. They told us they were now managed by a senior member of staff based at St Peter's Hospital.

## Governance, risk management and quality measurement

- The trust participated in a number of national clinical audits. However, results were recorded at divisional level (across both Ashford and St Peter's) and, therefore, we were unable to determine how the measurement of patient outcomes at Ashford Hospital was monitored.
- Each ward had a risk file that documented generic risks for each ward area. Ward managers told us they did not have access to the trust's risk register and, if any further risks were identified, they would be told by senior members of staff based at St Peter's Hospital. Staff in the rapid access centre told us there was not a risk register for their area.
- Senior staff identified that staffing concerns may be listed as a risk to patient care; however, they were not

aware of any other areas of concern on the risk register and did not have access to the risk register. Staff told us that, if there were any areas for concern, the divisional clinical governance lead would inform them.

- Regular two-monthly governance meetings to discuss complaints, incidents and quality improvement measures were held at St Peter's Hospital. Both of the ward managers at Ashford Hospital were fairly new to their role and been in post about two months. Neither of them had been able to attend the governance meeting due to ward pressures, they and the clinical nurse leader had not seen minutes of the meetings. The clinical nurse leader told us that they aimed to be able to release the ward managers to attend the meetings in the future. The clinical nurse leader and ward managers told us that, if there was anything pertinent to their ward areas, the divisional clinical governance lead would inform them.
- Best care audits measured care against a wide-ranging set of criteria. Managers were required to present their findings and action plans to the chief nurse and head of patient safety. There was a lack of understanding of the programme of regular audits to ensure the medical wards maintained and improved on the results of the best care audits. The clinical nurse leader told us they did regular "walk-arounds" to observe care and the environment.
- Some staff were unsure about risk scores used to determine levels of risk to patients and staff using the risk matrix scores.

## Culture within the service

- All staff we spoke with told us that Ashford Hospital was a lovely place to work. They enjoyed their jobs and, although it was very busy, they would not like to work anywhere else.
- Staff in the rapid access centre felt they worked well as a team, but did not feel supported or valued by their managers.
- In order to thank the volunteers in the rapid access centre, staff raised money to take the volunteers out for lunch, contributing to the cost themselves.

## Public and staff engagement

- We saw NHS Friends and Family Test posters and cards in all of the ward areas to enable patients and their relatives to give feedback about the care and support they had received.

## Medical care (including older people's care)







- Staff felt they all worked well together as a team, however, most of the staff at Ashford Hospital felt they were not part of the main trust.

### **Innovation, improvement and sustainability**

- Chaucer and Wordsworth wards were due to be run independently. This was to ensure further development of the stroke rehabilitation work on Chaucer Ward.
- We were told that discussions were being held to introduce a frailty clinic in the rapid access centre.



# Surgery

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

## Information about the service

Ashford and St Peter's Hospitals NHS Foundation Trust provides inpatient and day case surgical services at Ashford Hospital. There is a day surgery unit which has two operating theatres, a recovery area and spaces for people to wait before and after their operations. There is a main theatre suite which has five operating theatres and a dedicated recovery area. Both of these areas are run by the theatres, anaesthetics, surgery and critical care (TASCC) division that operates trust-wide. There had been 14,221 elective admissions and 12,60 day case admissions during 2013/14.

Dickens Ward had 22 beds and was the only inpatient surgical ward at Ashford Hospital. The ward provided for patients requiring an inpatient stay after orthopaedic surgery and was run by the trauma and orthopaedic trust-wide division.

We spoke with 14 members of staff, 12 patients, three relatives or visitors and reviewed seven care records. Before and during our inspection we reviewed the trust's performance information.

## Summary of findings

Patients received compassionate care at Ashford Hospital. We witnessed positive interactions between staff and patients.

There had been two recent Never Events (serious, largely preventable patient safety incidents which should not occur if the available preventative measures have been implemented) which had happened in theatres. Staff were able to demonstrate learning from the investigations and effective plans had been implemented to ensure there was no repeat of these incidents.

Appropriate infection control procedures were in place to prevent the risk of transmission of infection.

Robust assessment procedures were used to ensure that it was appropriate for people to have their operations at Ashford Hospital. Not all staff had received mandatory training to ensure they updated their knowledge to enable them to support patients appropriately.

Information regarding patient outcomes was held at divisional level. We were not able to view data which was specific to Ashford Hospital and, therefore, could not be assured how the trust measured the performance of the hospital.

Not all staff were able to access further training to enable them to develop their skills. Staff in theatres told us they had difficulty accessing training courses.

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Patients reported that there was good access to care and that systems worked well. For example, they felt the flow through day surgery was well-organised.

All staff were aware of the trust's values and also of the potential increase of services to be offered at Ashford Hospital.

Governance was monitored at a divisional level and, although we were assured that there were robust governance arrangements overall, it was difficult for us to understand how the trust monitored governance on an individual site basis.

## Are surgery services safe?

Requires improvement



Surgical services were found to require improvement. There had been two Never Events in the surgical services which had happened just over a week apart and had both been related to eye surgery. Staff were encouraged to report incidents and learn from them. For example, staff in theatres and the eye ward shared learning and developed new procedures after two Never Events.

Compliance with the trust target for the WHO surgical safety checklist was not being met.

All surgical areas were visibly clean and appropriate infection control procedures were maintained.

Records were securely stored on Dickens Ward.

### Incidents

- There had been two Never Events in the surgical services which had happened just over a week apart and had both been related to eye surgery.
- The incidents had been thoroughly investigated and discussed by the divisional management team.
- Staff we spoke with in the eye department and theatres told us that learning from the investigations had been shared with the whole team and an action plan developed to prevent further events occurring. Staff in the eye department told us that extra checks had been built in to their initial patient assessments to ensure that all staff were aware of the correct procedures to follow. Staff in the operating theatres told us that they had also initiated extra checking procedures and they had attended further training to support them to raise concerns.
- Staff throughout the hospital understood their responsibilities to raise concerns, to record safety incidents and near misses. Staff on Dickens Ward and in the day surgery unit told us they regularly received feedback after they had reported incidents and information was shared with the whole team to ensure that learning took place.
- Staff in theatres told us that, if an incident was investigated by the senior member of staff based at Ashford, they received feedback. Incidents were discussed at their daily morning safety briefing.



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However, if a member of trust-wide staff not based at Ashford investigated the incident, they rarely received feedback and so were unsure what had been done as a result of their reporting.

- Staff on Dickens Ward told us that there was no formal communication from pharmacy staff to disseminate learning from medication incidents within the trust. They told us a 'lessons learned' newsletter was available which discussed overall incidents and how to access training, but most staff were not aware of the newsletter.
- Regular morbidity and mortality meetings were held at divisional level and for each of the surgical specialties. These meetings enabled any trends to be identified and learning to occur from the presentation of case studies.

## Safety thermometer

- NHS Safety Thermometer information was displayed in the ward area. The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm-free care. We saw that the Safety Cross system (for assessing risks of pressure ulcers and falls) was used to inform staff, patients and visitors about how many falls and incidents had occurred during the month. The Safety Thermometer also gave information about care given to patients, for example, catheter care and assessments for preventing venous thromboembolism (VTE or blood clots).

## Cleanliness, infection control and hygiene

- All the surgical areas we visited were visibly clean.
- We saw staff adhering to the trust's infection control policy. Information was clearly displayed to remind staff about correct hand-washing procedures. We observed staff were bare below the elbows, in line with recommended hygiene standards, and were seen washing their hands and using hand gel appropriately. Personal protective equipment was available and staff were seen changing gloves and aprons in between seeing patients to prevent the risk of cross-infection.
- Staff in theatres wore surgical 'scrubs' (gowns worn by surgeons) and hats to prevent the risk of infection before, during and after operations. There was a plentiful supply of clean scrubs and dirty scrubs were disposed of in a separate area to minimise the risk of cross-contamination.

- Monthly hand-hygiene audits were undertaken to ensure that staff adhered to correct hand-washing techniques. Records showed that all the surgical areas regularly scored 100% in these audits.
- Regular infection control audits were conducted by the specialist infection control nurses, who operated trust-wide to ensure that the ward area was clean and met infection control standards. We saw that, when areas for improvement were identified, an action plan was produced, with a date for completion.
- Staff in theatres carried out regular infection control audits, for example, in cleanliness of theatres and hand-washing, and submitted them to the infection control team for monitoring.
- Trust-wide figures showed the preoperative screening for Methicillin Resistant Staphylococcus aureus (MRSA) had reached 99% for elective surgical procedures across the whole of the trust. The data was not broken down to enable compliance at Ashford to be identified.

## Environment and equipment

- Resuscitation equipment was available in all surgical areas. We saw that all equipment had been checked regularly and was in working order.
- Equipment and medical devices were checked and maintained in accordance with trust guidelines. Staff we spoke with described the processes for reporting faults in medical equipment and told us repairs were actioned quickly.
- We saw, in all surgical areas, that battery-operated equipment was plugged in to the mains to ensure that batteries remained fully charged.
- Theatre corridors were clear and free from clutter to ensure a safe transfer from the operating theatre to the recovery area.
- There was no equipment sterilising service at Ashford Hospital. Staff at Ashford contacted the sterilising department at St Peter's Hospital via email to order operation sets and equipment. Ashford Hospital received five deliveries a day, Monday to Friday, to ensure sufficient supplies were available.
- Senior theatre staff checked the operating lists in advance to ensure they would have enough equipment to meet the needs of the patients they operated on. They reported no issues with availability of sterile sets.
- There was a tracking system for all equipment and for operating sets sent from the central sterilising department. Each item had a sticker attached which

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was removed and placed in patients' notes after use. This ensured that all equipment used during an operation was recorded and could be traced in the event of any problems that may occur afterwards. We saw evidence of these stickers in the patients' notes we viewed.

## Medicines

- Medicines were stored securely in the theatre areas. We observed the correct checking procedures for controlled drugs and saw that controlled drugs records were completed and up to date.
- Fridge temperatures were recorded to ensure medicine was kept at the correct temperature in all surgical areas.
- The room temperature of the treatment room on Dickens Ward had been recorded daily to ensure that medications were stored correctly. The temperature was consistently within the required range.
- We saw that there were no medicines reconciliation for seven patients on Dickens Ward. This could put patients at risk of medication errors if their prescription charts had not been checked by a pharmacist.
- On Dickens Ward, we saw that prescription charts had been accurately completed, however, on some charts, the reason for 'as required' medication was not clearly described.
- An emergency cupboard was available for staff on Dickens Ward for patients who may need additional medication.

## Records

- On Dickens Ward, patients' records were kept in a secure trolley behind the main desk.
- In theatres and day surgery, patients' records were kept with the patients to ensure that they could be accessed and completed in a timely manner.
- Records reviewed showed that risks to patients had been identified and an appropriate care plan developed. For example, we saw that risk assessments had been completed for all patients to assess if they were at risk of pressure area breakdown and plans put in place to address this risk.
- We saw that patients received comprehensive preoperative assessments to assess whether they were suitable to have their operations at Ashford. These assessments were included in the patient records we reviewed.

## Safeguarding

- All staff we spoke with were able to describe what constituted a safeguarding concern and were aware of their role and responsibilities to safeguard vulnerable adults from abuse.
- From records sent to us after our inspection, we saw that 85.3% of staff in theatres and the eye ward had attended safeguarding training.

## Assessing and responding to patient risk

- Patients attended a preoperative assessment clinic and underwent all the required tests – for example, MRSA screening and any blood tests – to ensure that they were suitable for surgery at Ashford.
- All patients had an assessment for the risk of VTE and records documented actions taken as a result of any risks that had been identified.
- On Dickens Ward a Modified Early Warning Score (MEWS) was used to determine if patients were at risk of deteriorating. We saw in the patient records reviewed that the MEWS system had been used appropriately.
- Staff told us that, if patients deteriorated and they needed more support than was available at Ashford, they were transferred to a ward at St Peter's Hospital by ambulance. We saw from records that three patients were transferred from Dickens Ward to St Peter's Hospital during November 2014.
- Staff in recovery used an assessment tool which enabled them to monitor patients' conditions and gave clear information about who to contact for further advice and support if they had concerns.

## Mandatory training

- Records sent to us after our inspection showed that not all staff had attended training updates to ensure that they were suitably skilled to care for patients in their areas. We saw that, although 100% of staff in theatres had attended training for health and safety, incident management and conflict resolution, other courses had not achieved the trust's target of 90% attendance. For example, 84.85% had attended infection control training and only 78.79% had attended medicines management updates. Overall figures for attendance for mandatory training for day surgery were 91.6%, theatres 89.4% and

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the eye ward 80.4%. We do not have the individual figures for Dickens Ward, however, the overall attendance for the trauma and orthopaedic division across both hospitals was 78.2%.

## Surgical Safety

- We observed the use of the World Health Organization (WHO) surgical safety checklist in the theatres we visited. The National Patient Safety Agency recommended that the WHO surgical safety checklist should be used in any operating theatre environment. It is a tool for the relevant clinical teams to improve the safety of surgery by reducing errors and complications. We saw there had been a trust-wide audit of the WHO checklist in September 2014: 94% of WHO documentation had been completed correctly. The trust target was 100%. The divisional management team told us they had re-launched the WHO checklist into the theatre division. The checklist had been renamed “How to WHO” and its importance had been communicated to staff. This had only taken place a few weeks prior to our visit and the results were not completed at the time of our inspection.
- Staff in theatres held an early morning meeting every day to discuss any concerns about the operating lists and to ensure that they had enough staff and equipment for each theatre.

## Nursing staffing

- There were staffing vacancies throughout the whole of the surgical services at Ashford Hospital. Staff told us it was difficult to recruit and keep staff because of their location.
- Dickens Ward had 15% whole time equivalent (WTE) vacancies. The eye ward had 8.10% WTE vacancies and the day surgery unit had 11.60% WTE vacancies. Staff in all areas told us that agency and bank (overtime) staff had been employed to cover the shortfall in staff to ensure that patients’ needs were met.
- Operating department practitioners in theatres were managed and allocated by a member of staff based at St Peter’s Hospital. The manager told us it was often difficult to visit staff at Ashford due to work commitments at St Peter’s.
- Staff in the eye ward told us they were understaffed and this had impacted on increased waiting times for

patients. Staff worked extra hours to ensure that staffing levels were met. However, we were told that some nurse-led clinics had to be cancelled to allow registered nurses to be available for other clinical duties.

- We observed the nursing handover between theatre and recovery staff. Sufficient information was given to enable recovery staff to support patients’ care needs appropriately.

## Surgical staffing

- Surgery at Ashford Hospital was consultant-led for all types of surgery, for example, gynaecology and orthopaedics.
- A consultant was available by telephone out of hours if staff on Dickens Ward needed further advice.
- An anaesthetist was available until 9pm during the week for patients on Dickens Ward.
- There was no on-site surgical cover available out of hours. Out-of-hours cover on Dickens Ward was supplied by the medical doctors who covered the medical and surgical wards.

## Major incident awareness and training

- The trust had a major incident and business continuity plan. The major incident plan identified staff responses to different types of incidents.
- We saw from records that some staff had attended incident training but not all staff were consistently aware of their role in a major incident.

## Duty of Candour

- Staff were able to tell us about the principles of the Duty of Candour, although they were unaware of the specific requirements of the new regulations (which had just come into force in November 2014). They told us the trust was open and honest with patients following incidents. We were told that further training for staff would be available from January 2015.

## Are surgery services effective?

Good



Staff clearly described how to maintain high-quality effective care.

Enhanced recovery protocols were available for some patients on Dickens Ward.

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We saw evidence of good multidisciplinary team working in the patient records we reviewed.

Information regarding patient outcomes was held at divisional level. We were not able to view data which was specific to Ashford Hospital and, therefore, could not be assured how the trust measured the performance of the hospital.

Staff in theatres were unable to access further training to expand their knowledge and expertise.

Patients received adequate pain relief and had their nutritional and hydration needs met.

There were no out-of-hours x-ray facilities available on site

## Evidence-based care and treatment

- Best quality care indicators were displayed on Dickens Ward. This was an assessment tool used by the trust to monitor the safety and quality of care delivered. Some of the areas covered in the audit were infection control, manual handling and falls assessment. Dickens Ward had been identified as 'green' and had scored 98%. This meant they had achieved their targets and were due to be audited in six months' time. Staff we spoke with told us that continual monitoring took place to ensure that they maintained this standard.
- Staff in theatres and day surgery told us they used the best quality care indicators assessment tool. Day surgery had scored 98% and was ranked as 'yellow' which meant current practices were to be reviewed and checked. Theatres scored 98% and 'yellow' meaning an action plan was to be formulated and reviewed in one month's time. We were told the percentage score related to the actual care in practice and the colour variations reflected areas that may have been out of staff members control, for example, nursing vacancies or appraisals.
- Staff had access to information about National Institute for Health and Care Excellence (NICE) guidelines on the trust's intranet
- Enhanced recovery protocols were used for some patients on Dickens Ward to enable them to be discharged home more quickly. Enhanced recovery protocols ensured better outcomes and a reduced length of stay in hospital. The protocols were founded on the most current evidence-based care and ensured that patients were active participants in their recovery. For example, patients were encouraged to mobilise as soon as was appropriate after their operation.

## Pain relief

- All of the patients we spoke with told us that staff responded promptly to requests for pain relief.
- We saw in patients' care records, that preoperative pain assessments had been performed to assess which pain relief was most appropriate for individual patients. One person told us, "they discussed with me what sort of pain to expect and which painkillers worked best".
- Ward staff were able to access further advice and support from the hospital pain team if they were unable to meet patients' needs.

## Nutrition and hydration

- There was a protected meal time on the surgical ward.
- Patients were assessed for their nutritional and hydration needs and referred to a dietician if required.
- Patients on Dickens Ward were positive about the food provided at Ashford Hospital. One person told us, "there is always plenty of choice".
- Patients in the day surgery department told us they were offered a choice of food and drink after their operations.

## Patient outcomes

- The trust contributed to national audits on a trust-wide basis. For example, patient reported outcome measures (PROMS) for hip and knee replacement, groin hernia and varicose vein operations.
- The average length of stay for trauma and orthopaedics, breast surgery and upper gastrointestinal surgery was the same as, or less than, the England average.
- Ashford Hospital had less readmissions due to emergencies for their top three specialties: ophthalmology; trauma and orthopaedics; and upper gastrointestinal surgery.

## Competent staff

- Staff on Dickens Ward, day surgery and the eye ward told us they had access to further training to expand their knowledge and skills.
- Staff in theatres told us that, although training courses were available, they were frequently unable to attend them. Three members of staff told us they had been waiting nearly three years to attend further training courses, for example, in theatre and recovery. Other staff

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in theatres told us they felt they had no opportunity to develop their skills and knowledge and they had received no training other than the mandatory training required by the trust.

- Appraisals for the staff in the surgical areas fell below the trust's target of 98%. Staff on Dickens Ward told us they had received regular appraisals to ensure they had the opportunity to discuss their work. Figures for September 2014 showed that 96.2% of staff had received an appraisal.
- Figures showed that 77.4% of staff in day surgery and 90.2% theatres had received appraisals. This meant that some staff may not have been given an opportunity to discuss areas for improvement or further development in their role.
- Consultants told us they had received their appraisals and revalidation.

## Multidisciplinary working

- We saw clear documentation in patients' records on Dickens Ward of detailed multidisciplinary team working. For example, information from physiotherapists regarding plans to help patients to mobilise.
- Staff across all surgical divisions told us that they felt they worked well as a team.
- There was no pharmacy dispensing service at Ashford Hospital. The pharmacist visited the hospital from 9am to 12pm Monday to Friday. The ward pharmacist stated that there was not sufficient time to complete all the required work, which sometimes had a knock-on effect if they were expected back to visit wards at St Peter's Hospital. If the pharmacist was not available, prescriptions were faxed to the pharmacy at St Peter's Hospital. However, we were told that there were sometimes issues with the dispensing of discharge medications because of problems with the faxing process, which could cause delays.

## Seven-day services

- Out-of-hours pharmacy support was provided from St Peter's Hospital. Emergency medication was stored at Ashford Hospital for patients who may have required urgent medication out of hours. Prescriptions could also be dispensed at an independent pharmacy located near the hospital.

- There was no access to x-ray or other imaging out of hours at Ashford hospital. If a patient needed urgent imaging out of hours, they were sent to St Peter's by ambulance and returned to Ashford Hospital afterwards.
- The medical doctors told us they had undergone further training to enable them to support the needs of surgical patients. The medical doctors told us that, because Dickens Ward only had elective patients and they had been thoroughly assessed prior to admission, ward staff felt competent to support patients if needed. A consultant was available by telephone out of hours for further advice and support. Doctors we spoke with told us they were always able to contact a consultant if required.
- A site nurse practitioner was available out of normal working hours. They supported the doctor on call and ward staff if they had concerns about a patient's condition.

## Access to information

- All patients received a thorough pre-assessment check prior to their operation to enable staff to have enough information to support them effectively at the time of their surgery.
- All information relating to patients' operations was recorded in their care records and also handed over verbally when patients were transported between care settings – for example, when transferred from the operating theatre to recovery.
- Discharge information was sent to patients' GPs to ensure that they were aware of the treatment and medication they had received while at Ashford Hospital.

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

- Staff were clear about their roles and responsibilities regarding the Mental Capacity Act 2005. They were also clear about processes to follow if they thought a patient lacked capacity to make decisions about their care.
- All of the patients we spoke with told us they had been given enough information to make an informed decision to consent to their operation.
- We saw examples of completed consent forms in patients' records. These had been fully completed and detailed all the relevant information patients should be



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aware of prior to consenting to an operation. For example, we saw (for a knee operation), a list of possible risks during the operation and conditions that may occur afterwards.

## Are surgery services caring?

Good



Patients we spoke with were overwhelmingly positive about the care they received at Ashford Hospital.

Patients told us they were treated with dignity and respect and one patient told us, “the staff go above and beyond to care for me”.

Patients received compassionate care and we witnessed positive interactions between staff and patients.

### Compassionate care

- All of the patients we spoke with told us the care they received at Ashford Hospital had been very good.
- One patient on the day surgery unit told us, “they are gentle and caring and always ready to assist. Although I am in hospital, they make you feel as if you are at home”.
- One patient on Dickens Ward told us, “the care and sensitivity really is outstanding”. Another patient in recovery told us, “they really are very kind, nothing is too much trouble”.
- We observed during our visit to all surgical areas that curtains were pulled around patients to avoid compromising privacy and dignity.
- Monthly results of the NHS friends and family test between January and November 2014 showed that between 86% and 100% of patients on the Dickens Ward would be either likely or extremely likely to recommend the service.

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

- Staff in the day surgery unit told us they understood that patients could be nervous prior to having an operation so they made sure that information was provided at a suitable pace and that patients were given time to ask questions.

- Patients we spoke with in day surgery confirmed that staff had taken time to explain the process and that they had been given enough information about their operations. They told us they understood what the operation entailed and how long their recovery period would be.
- Throughout our inspection we heard information being given to patients about their care. Information was provided in a sensitive manner and patients were given sufficient time to ask questions.
- We observed a patient’s discharge from day surgery. Information was given and the patient was allowed time to ask questions and raise any concerns.

### Emotional support

- Patients told us that staff were very kind. We observed patients on Dickens Ward: they were laughing and joking together and there was a jovial atmosphere. The patients told us that staff encouraged them to “have fun”.
- We observed in the day surgery unit and in theatres that staff took time to reassure patients if they were anxious prior to their operation.

## Are surgery services responsive?

Good



All of the patients we spoke with told us they had enough information about their care.

Patients told us there was good access to care and the day surgery unit ran smoothly.

Dickens Ward responded positively to complaints from patients.

None of the patients and relatives we spoke with had any complaints about the service they received.

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

- Staff we spoke with told us there were plans to increase the amount of elective operations performed at Ashford Hospital and to expand the day surgery facilities to accomplish this. Staff felt that, by moving most of the remaining elective surgery operations to Ashford

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Hospital, they would be able to offer an improved service to patients. This was because operations were less likely to be cancelled or timings altered because they did not perform any emergency surgery at Ashford.

## Access and flow

- Most of the surgery conducted at Ashford Hospital was day surgery. Patients were admitted to the day surgery unit and discharged from the unit after their operation. If a patient had not recovered sufficiently to be able to go home on the same day, they were either admitted to Dickens Ward or transferred to St Peter's Hospital (although staff we spoke to told us this very rarely happened).
- Admissions to Dickens Ward were planned. Orthopaedic patients were assessed as being suitable for surgery at Ashford and admitted to the ward after their operation. The senior nurse told us that they also admitted some breast surgery patients after their operation if staff thought they had not recovered sufficiently to be discharged home on the day of their operation.
- During our unannounced inspection, we were told that patients' discharges were being delayed because of a shortage of staff due to sickness and also because of the care needs of some of the patients on the ward.

## Meeting people's individual needs

- Four patients on Dickens Ward told us that they had been given "very informative" leaflets about their operations and how to look after themselves when they were discharged home.
- Leaflets and information were displayed throughout day surgery unit, Dickens Ward and the eye ward. We were told that it was difficult to obtain written information in other languages, although translation services were available if required.
- Staff in the day surgery unit told us how they ensured that patients who had learning disabilities or who were living with dementia were supported during their visit to Ashford Hospital. Staff told us relatives and carers were encouraged to stay as long as possible and they had access to a private room for patients who found public areas distressing.
- Senior staff on Dickens Ward told us that some staff members had undertaken training to enable them to meet the needs of patients living with dementia.

- Staff in the day surgery unit contacted patients at home the day after their operation to check on how they felt and to give them an opportunity to ask further questions.

## Learning from complaints and concerns

- None of the patients we spoke with had any complaints about the care and treatment they had received at Ashford Hospital.
- Dickens Ward had a clearly displayed 'You said, we did' noticeboard. The board detailed comments and suggestions made by patients and their relatives and how ward staff had addressed them. For example, we saw comments relating to uncomfortable chairs in the waiting area on the ward. The ward had responded by providing more comfortable chairs and further soft furnishings for better patients and relatives.
- Complaints were discussed at the trust-wide divisional level governance meetings.

## Are surgery services well-led?

Good



All staff were aware of the trust's values and were also aware of the potential increase of services to be offered at Ashford Hospital.

All staff were positive about the new chief executive and the individual leadership in each surgical area.

Theatre staff felt they were not included in day-to-day and long-term decisions about their work.

Regular governance meetings were held to monitor the quality of service provision, however, they were held at divisional level. It was difficult for us to view data that was specific to Ashford Hospital in order for us to understand how the trust monitored governance on an individual site basis.

## Vision and strategy for this service

- All the staff we spoke with were able to tell us about the trust's values, the 'four Ps': Putting patients first, having a Passion for excellence, Pride in their teams and taking Personal responsibility. Staff told us the values were now linked to their annual appraisals to ensure that they were "living the values".

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- The associate director of nursing for the trauma and orthopaedic division told us there was a clear vision for the development of the service at Ashford Hospital. The division was working towards a two-year development plan to encourage the ward staff to further their skills by working across both Ashford and St Peter's sites. They told us the development plan would enable staff to enhance their skills and gain further competencies because some of the patients at St Peter's would have more complex care needs than at Ashford. Staff on Dickens Ward were aware of the plan and told us they had been included in the discussions and asked their opinion about working across both sites.
- Staff in theatres told us they felt decisions made about their service were often made by staff based at St Peter's. They told us they were rarely involved or consulted about day-to-day changes or plans for the future of the service.
- There were plans to increase the surgical service to provide access to operating theatres 23-hours a day which would enable an increase in day surgery and elective procedures undertaken at Ashford Hospital.
- We were told that cost improvement plans had been developed to investigate the possibility of developing a high dependency area on Dickens Ward.
- All of the staff we spoke with were positive about the new chief executive and told us there was regular communication from them via a weekly email.
- Staff in all surgical areas had a file which documented generic risks for their areas. Most staff were not aware of any specific risks for their areas and some staff did not have access to the risk register. This meant that staff may not have been aware of risks to patient safety in their area of work.
- Staff in the eye ward were aware that staffing issues were documented on the surgical division's risk register and there was an action plan to address the concern about staffing. For example, there were plans to conduct some operations at St Peter's Hospital day surgery to prevent patients' operations from being cancelled.
- The surgical division's risk register documented risks to patient care in surgical areas trust-wide. For example, improvements needed for the ventilation systems in two of the theatres for Ashford Hospital to ensure they operated efficiently.
- The associate director of nursing for trauma and orthopaedics told us there were no specific risks pertinent to Dickens Ward and that senior staff had access to the risk register. Senior staff confirmed this.
- Staff in theatres and day surgery told us they were able to attend the quality and safety half-day training sessions. These meetings were held on a regular basis to discuss quality and governance issues.

## Governance, risk management and quality measurement

- Best care audits measured care against a wide-ranging set of criteria to ensure the quality of the service was maintained. These were monitored and reported to the chief nurse and head of patient safety.
- Specialty governance meetings were reported monthly and the division undertook quarterly governance meetings which reported to the trust quality governance meetings. These meetings took place at St Peter's Hospital and staff told us they felt the meetings should be shared between the two sites to enable more staff to attend. Governance was monitored at a divisional level and it was difficult for us to view information specific to Ashford Hospital. Although, we were assured that there were robust governance arrangements overall, it was difficult for us to understand how the trust monitored governance on an individual site basis.
- Staff on Dickens Ward spoke very positively about the associate director of nursing for trauma and orthopaedics who was based at St Peter's and visited the ward a minimum of once a week. They told us the local and divisional leadership of the service saying staff were approachable, listened to them and were always available for further advice and support.
- Staff on day surgery told us their clinical nurse leader exemplified the trust's '4 Ps' values, listened to staff and patients, and was passionate about encouraging staff to develop further.
- Theatre staff told us they no longer had a clinical nurse leader for their service. All staff we spoke with told us that the senior nurse based at Ashford was "brilliant".
- Some staff told us that at times they felt support for some decision making in relation to the day to day operational running of the theatres was not always easy to access from more senior Divisional staff based at St Peter's.

## Leadership of service

## Culture within the service



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- Staff in all the surgical areas were positive about working at Ashford Hospital.
- It was evident during our inspection that staff on Dickens Ward were very happy working on the ward and they were a close-knit, supportive team.
- Staff in theatres told us they worked very well as a team and that the senior nurse worked hard to ensure the team worked well together.
- Most of the staff in theatres we spoke with told us they felt separated from St Peter's Hospital and not part of the main trust.







## Public and staff engagement

- Some staff we spoke with told us they had been involved in formulating the '4 Ps' values.
- We saw NHS Friends and Family Test posters and cards in the ward area to enable patients and their relatives to give feedback about the care and support they had received.

## Innovation, improvement and sustainability

- Staff told us there were plans to increase the amount of day surgery performed at Ashford Hospital to improve the service provided.

# Outpatients and diagnostic imaging

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

## Information about the service

At Ashford Hospital each outpatient service was located within one of four divisions and managed through that department. At the Trust Board level, outpatient services came under the medical directorate. The Ashford and St Peter's Hospitals NHS Foundation Trust provided an outpatient service of around 405,870 first and follow-up appointments for 2013/14. About 187,000 of these were at the Ashford Hospital site

The majority of clinics were located in four main areas in the outpatient department and a separate suite for specific specialised clinics. Diagnostic imaging was located on the ground floor between the outpatients department and the hospital wards.

The diagnostic imaging department provided a range of diagnostic services on behalf of GPs and other medical units within the hospital. The facilities included general x-ray, computerised tomography (CT) scanning and mammography.

During our inspection we visited the outpatients clinics for physiotherapy, breast clinic, the bariatric (weight loss) clinic, cancer, maxio-facial, endoscopy and several orthopaedic clinics. We met with 40 patients and carers and spoke to 28 reception staff, booking staff, medical records staff, nurses, radiographers, healthcare assistants, therapists and consultants.

## Summary of findings

All staff we spoke with said they were encouraged to report incidents and learning was disseminated when required. In diagnostic imaging, World Health Organization (WHO) safety checklists were being used for interventional radiography and staff were clear of their responsibilities under the Ionising Radiation (Medical Exposure) Regulations 2000 and Ionising Radiations Regulations 1999.

However, there were issues surrounding the security and confidentiality of medical records, as notes were left in corridors with patients' names visible. We also found blood samples that were left unattended on a clinic reception desk.

There were concerns that some receptionist staff were unsure about their responsibilities if a patient deteriorated in a waiting area. Some could not locate where the crash trolley (for transporting emergency medication) was and didn't know the correct process for alerting the 'crash team' by telephoning 2222.

There was an issue around the management of medicines where saline 100ml intravenous fluid was being used and stored inappropriately. We also found that there was lack of clarity from staff about the process to alert the emergency 'crash team' to incidents.

The diagnostic imaging department had integrated diagnostic reference levels in to their practices as required by the Ionising Radiation (Medical Exposure) Regulations 2000, In physiotherapy, patient outcomes

# Outpatients and diagnostic imaging

were monitored using quality of life outcome measures, cost effectiveness analysis, and benchmarking these against best practice and National Institute for Health and Care Excellence (NICE) guidelines.

The outpatients and diagnostic imaging department were caring and considerate to patients, carers, and visitors. We observed that staff at all grades shared the same level of compassion and understanding of patients' needs and treated everyone with dignity and respect.

Although there were plans to improve the outpatients service, we were not provided with information about this until after the inspection. There was a positive working environment which was dedicated to putting the patient first, however, there was limited evidence of robust

## Are outpatient and diagnostic imaging services safe?

Requires improvement



Outpatients and diagnostic imaging services required improvement. There were issues surrounding the control of medical records, as notes were left in corridors with patients' names visible. We also found blood samples that were left unattended on a clinic reception desk. There was an issue around the management of medicines where saline 100ml intravenous fluid was being used and stored inappropriately.

Some receptionist staff were unsure about their responsibilities if a patient deteriorated in a waiting area. Some could not locate where the crash trolley (for transporting emergency equipment and medication) was and didn't know the correct process for alerting the 'crash team' by telephoning 2222.

All staff we spoke with said they were encouraged to report incidents and learning was disseminated when required. In diagnostic imaging, WHO safety checklists were being used for interventional radiography and staff were clear of their responsibilities under the Ionising Radiation (Medical Exposure) Regulations 2000 and Ionising Radiations Regulations 1999.

We saw that the main waiting areas were all clean and hygienic. The outpatients department had been renovated in 2013 and all outpatient areas were easily accessible, providing a comfortable area for patients.

### Incidents

- At the time of the inspection, there had been no reported serious incidents or Never Events (serious, largely preventable patient safety incidents which should not occur if the available preventative measures have been implemented) in the outpatients or diagnostic imaging services within the last year.
- All staff we spoke to said they were encouraged to report incidents through the intranet's Datix patient safety incidents healthcare system and said they could tick a box on this form if they wished to receive feedback. We were told that the most common incidents were concerns about patient transport delays, with some patients having to wait up to four hours.

# Outpatients and diagnostic imaging

- There was a monthly incident review meeting within the specialties where incidents were shared and learning disseminated.
- In diagnostic imaging, appropriate WHO safety checklists were being used for interventional radiography and staff were clear of their responsibilities to provide safe care. Staff were informed on a weekly basis of any incidents and learning via a newsletter.
- Staff in diagnostic imaging were clear of their responsibilities when reporting radiation incidents and could identify who their radiation protection supervisor and radiation protection adviser was.
- We saw that equipment was regularly cleaned and a green sticker was placed on it, stating when it was last cleaned.
- Some equipment, such as a hoist in an outpatients treatment area, was overdue for an annual service.
- In diagnostic imaging, we were told about the Philips Medical Equipment Scheme which was going to replace the equipment in the department. Currently all plain film machines had been replaced with digital machines, with a CT scanner due to be replaced in 2015.
- Staff told us that sometimes the signage in the rest of the hospital was vague and patients could find it difficult to find the x-ray or haematology departments.

## Cleanliness, infection control and hygiene

- In the outpatients department, results from hand-hygiene audits were clearly displayed and visible to patients and visitors. At the time of inspection, they displayed 98% compliance.
- All of the waiting areas in the main outpatients department appeared clean and hygienic. When we asked, we were provided with cleaning charts, all of which were up to date. However, one room in diagnostic imaging had not been cleaned the day before our inspection.
- Patients we spoke with told us they thought the hospital was always clean and expressed no concerns about the risk of infection.
- All staff we spoke with had completed infection control training and complied with the trust's 'bare below the elbow' policy for best hygiene practice.
- Toilet facilities were located throughout the outpatients and diagnostic imaging departments and these were clearly signposted. We saw records showing these were regularly cleaned.
- We saw that clinicians had easy access to protective clothing, with gloves, gowns and alcohol gel available in all assessment, treatment and scanning rooms.

## Environment and equipment

- The outpatients department had been renovated in the last year. All outpatient areas were easily accessible, providing a comfortable area for patients. There was sufficient seating.
- Resuscitation equipment was available in all outpatients and diagnostic imaging areas. We looked at a sample of these and saw that weekly and daily checks were carried out.

## Medicines

- Medications were stored securely in a non-clinical area. In diagnostic imaging, contrast media (medicines used as part of imaging procedures) was also stored securely. There were appropriate records to monitor medicines in the outpatient and diagnostic imaging departments.
- In one clinic, saline 100ml intravenous bags, used for breast implant patients, were being used for more than one patient without appropriate labelling. Bags were being left for several days before they were used again. We were told by a nurse that this was done to avoid waste. They also said they considered the bags were still sterile because of the protective rubber top. We informed the outpatients sister and this practice was stopped immediately. We went back the following day and found that all staff were aware of why this was not best practice for medication control. However, new processes were yet to be put into place.

## Records

- We observed that notes were left in corridors on trolleys. This was a breach in patient confidentiality as the trollies were not all in sight of the nurses' station and patients' names were clearly visible. We also observed that blood samples were left on an unoccupied reception desk which was also a breach in patient confidentiality. The blood samples were removed during the inspection and made secure.
- We observed in the outpatients department that a medical notes cupboard was left open and was unattended. This compromised patient confidentiality. We also observed that computers in waiting areas were left unlocked and unattended which compromised patient confidentiality.

# Outpatients and diagnostic imaging

- We were told by staff that there were issues with the tracking of notes as staff were not doing this properly. We were shown data which suggested that more than 360 sets of notes were currently missing. This meant that some notes were not available for clinics as they could not be found.
- Notes for both hospitals were stored on the Ashford Hospital site. We were told that notes were not in chronological order or maintained well, making them difficult to follow. We were told about examples where it was difficult to see if patients had had surgery. Staff told us they had been reassured by their managers that a digital notes system, due to be operational in 2015, would overcome this issue.
- A documentation audit assessing the completeness of notes found that they were compliant only 70% of the time.

## Safeguarding

- All the staff we spoke with told us they had completed safeguarding training which was part of the required mandatory training for the trust. We were told that staff in areas which saw a high number of paediatric patients attended level 3 safeguarding training, such as the maxillo facial clinic.
- Staff in this clinic could give us examples of when they used their safeguarding training in practice and could tell us how to escalate any concerns.
- Staff in diagnostic imaging understood the processes involved in safeguarding of adults and children and had received the appropriate training. Staff could describe how to raise a safeguarding alert and escalating an alert for non-accidental injury.
- Telephone numbers were displayed in the outpatients department for adult and children safeguarding contacts, as well as a telephone number for a learning disability nurse.
- Staff in diagnostic imaging knew who the hospital's safeguarding leads were. We were told of examples where social workers had been contacted when a member of staff raised a concern.

## Mandatory training

- The senior nurses managed training. We were shown that a training tracker prompted staff when their mandatory training was due for deprivation of liberty safeguards, medicines management and conflict resolution which could be accessed online.

- We were shown information showing that 98.46% of staff had completed all their mandatory training.
- Educational half-days were held when fewer clinics were running. This enabled mandatory training to be delivered.

## Assessing and responding to patient risk

- In some clinics the quality standards from the resuscitation council were not being followed. Some receptionist staff were unsure about their responsibilities if a patient deteriorated in a waiting area. Some could not locate where the crash trolley (for transporting emergency medication) was and didn't know the correct process for alerting the 'crash team' by telephoning 2222. Some reception staff relied on the fact that a nurse or healthcare assistant would notice a deteriorating patient before they did.
- We were told that communication exercises were carried out to ensure that acute deteriorating patients were transferred quickly to St Peter's Hospital accident and emergency department. We were told of examples in diagnostic imaging where a patient deteriorated in the x-ray room and were admitted to accident and emergency within 20 minutes of leaving Ashford Hospital.

## Staffing

- The clinical nurse leader told us that there was a waiting list for nurses wanting to work at Ashford Hospital. This meant that bank (overtime) staff were not needed and there was an optimum skills mix in each clinic. The clinical nurse leader showed us the staffing establishment for each clinic and all areas were staffed correctly.
- We were told that diagnostic imaging was fully staffed but were stretched if a member of staff was off sick.
- In diagnostics staff reported that repetitive strain injury was common but that they were well-supported to cope with this, and workloads had been adjusted to meet the changing abilities of staff.
- Radiology had recently employed three new staff to manage a backlog in reporting within the diagnostic imaging department.

## Major incident awareness and training

- An outpatient's sister stated that there was training in managing major incidents but this had not been

# Outpatients and diagnostic imaging

disseminated to other staffing levels. The sister was not aware of policies or processes involved in escalation of incidents. They said they would seek advice from the estates team.

- Senior staff were clear about fire evacuation processes and policies.

## Are outpatient and diagnostic imaging services effective?

Outpatients and diagnostic imaging services required improvement. However, there were issues surrounding the control of medical records, as notes were left in corridors with patients' names visible. We also found blood samples that were left unattended on a clinic reception desk. There was an issue around the management of medicines where saline 100ml intravenous fluid was being used and stored inappropriately.

Some receptionist staff were unsure about their responsibilities if a patient deteriorated in a waiting area. Some could not locate where the crash trolley (for transporting emergency equipment and medication) was and didn't know the correct process for alerting the 'crash team' by telephoning 2222.

All staff we spoke with said they were encouraged to report incidents and learning was disseminated when required. In diagnostic imaging, WHO safety checklists were being used for interventional radiography and staff were clear of their responsibilities under the Ionising Radiation (Medical Exposure) Regulations 2000 and Ionising Radiations Regulations 1999.

We saw that the main waiting areas were all clean and hygienic. The outpatients department had been renovated in 2013 and all outpatient areas were easily accessible, providing a comfortable area for patients.

### Incidents

- At the time of the inspection, there had been no reported serious incidents or Never Events (serious, largely preventable patient safety incidents which should not occur if the available preventative measures have been implemented) in the outpatients or diagnostic imaging services within the last year.
- All staff we spoke to said they were encouraged to report incidents through the intranet's Datix patient safety incidents healthcare system and said they could tick a

box on this form if they wished to receive feedback. We were told that the most common incidents were concerns about patient transport delays, with some patients having to wait up to four hours.

- There was a monthly incident review meeting within the specialties where incidents were shared and learning disseminated.
- In diagnostic imaging, appropriate WHO safety checklists were being used for interventional radiography and staff were clear of their responsibilities to provide safe care. Staff were informed on a weekly basis of any incidents and learning via a newsletter.
- Staff in diagnostic imaging were clear of their responsibilities when reporting radiation incidents and could identify who their radiation protection supervisor and radiation protection adviser was.

### Cleanliness, infection control and hygiene

- In the outpatients department, results from hand-hygiene audits were clearly displayed and visible to patients and visitors. At the time of inspection, they displayed 98% compliance.
- All of the waiting areas in the main outpatients department appeared clean and hygienic. When we asked, we were provided with cleaning charts, all of which were up to date. However, one room in diagnostic imaging had not been cleaned the day before our inspection.
- Patients we spoke with told us they thought the hospital was always clean and expressed no concerns about the risk of infection.
- All staff we spoke with had completed infection control training and complied with the trust's 'bare below the elbow' policy for best hygiene practice.
- Toilet facilities were located throughout the outpatients and diagnostic imaging departments and these were clearly signposted. We saw records showing these were regularly cleaned.
- We saw that clinicians had easy access to protective clothing, with gloves, gowns and alcohol gel available in all assessment, treatment and scanning rooms.

### Environment and equipment

- The outpatients department had been renovated in the last year. All outpatient areas were easily accessible, providing a comfortable area for patients. There was sufficient seating.



# Outpatients and diagnostic imaging

- Resuscitation equipment was available in all outpatients and diagnostic imaging areas. We looked at a sample of these and saw that weekly and daily checks were carried out.
- We saw that equipment was regularly cleaned and a green sticker was placed on it, stating when it was last cleaned.
- Some equipment, such as a hoist in an outpatients treatment area, was overdue for an annual service.
- In diagnostic imaging, we were told about the Philips Medical Equipment Scheme which was going to replace the equipment in the department. Currently all plain film machines had been replaced with digital machines, with a CT scanner due to be replaced in 2015.
- Staff told us that sometimes the signage in the rest of the hospital was vague and patients could find it difficult to find the x-ray or haematology departments.

## Medicines

- Medications were stored securely in a non-clinical area. In diagnostic imaging, contrast media (medicines used as part of imaging procedures) was also stored securely. There were appropriate records to monitor medicines in the outpatient and diagnostic imaging departments.
- In one clinic, saline 100ml intravenous bags, used for breast implant patients, were being used for more than one patient without appropriate labelling. Bags were being left for several days before they were used again. We were told by a nurse that this was done to avoid waste. They also said they considered the bags were still sterile because of the protective rubber top. We informed the outpatients sister and this practice was stopped immediately. We went back the following day and found that all staff were aware of why this was not best practice for medication control. However, new processes were yet to be put into place.

## Records

- We observed that notes were left in corridors on trolleys. This was a breach in patient confidentiality as the trollies were not all in sight of the nurses' station and patients' names were clearly visible. We also observed that blood samples were left on an unoccupied reception desk which was also a breach in patient confidentiality. The blood samples were removed during the inspection and made secure.
- We observed in the outpatients department that a medical notes cupboard was left open and was

unattended. This compromised patient confidentiality. We also observed that computers in waiting areas were left unlocked and unattended which compromised patient confidentiality.

- We were told by staff that there were issues with the tracking of notes as staff were not doing this properly. We were shown data which suggested that more than 360 sets of notes were currently missing. This meant that some notes were not available for clinics as they could not be found.
- Notes for both hospitals were stored on the Ashford Hospital site. We were told that notes were not in chronological order or maintained well, making them difficult to follow. We were told about examples where it was difficult to see if patients had had surgery. Staff told us they had been reassured by their managers that a digital notes system, due to be operational in 2015, would overcome this issue.
- A documentation audit assessing the completeness of notes found that they were compliant only 70% of the time.

## Safeguarding

- All the staff we spoke with told us they had completed safeguarding training which was part of the required mandatory training for the trust. We were told that staff in areas which saw a high number of paediatric patients attended level 3 safeguarding training, such as the maxillo facial clinic.
- Staff in this clinic could give us examples of when they used their safeguarding training in practice and could tell us how to escalate any concerns.
- Staff in diagnostic imaging understood the processes involved in safeguarding of adults and children and had received the appropriate training. Staff could describe how to raise a safeguarding alert and escalating an alert for non-accidental injury.
- Telephone numbers were displayed in the outpatients department for adult and children safeguarding contacts, as well as a telephone number for a learning disability nurse.
- Staff in diagnostic imaging knew who the hospital's safeguarding leads were. We were told of examples where social workers had been contacted when a member of staff raised a concern.

## Mandatory training

# Outpatients and diagnostic imaging

- The senior nurses managed training. We were shown that a training tracker prompted staff when their mandatory training was due for deprivation of liberty safeguards, medicines management and conflict resolution which could be accessed online.
- We were shown information showing that 98.46% of staff had completed all their mandatory training.
- Educational half-days were held when fewer clinics were running. This enabled mandatory training to be delivered.

## Assessing and responding to patient risk

- In some clinics the quality standards from the resuscitation council were not being followed. Some receptionist staff were unsure about their responsibilities if a patient deteriorated in a waiting area. Some could not locate where the crash trolley (for transporting emergency medication) was and didn't know the correct process for alerting the 'crash team' by telephoning 2222. Some reception staff relied on the fact that a nurse or healthcare assistant would notice a deteriorating patient before they did.
- We were told that communication exercises were carried out to ensure that acute deteriorating patients were transferred quickly to St Peter's Hospital accident and emergency department. We were told of examples in diagnostic imaging where a patient deteriorated in the x-ray room and were admitted to accident and emergency within 20 minutes of leaving Ashford Hospital.

## Staffing

- The clinical nurse leader told us that there was a waiting list for nurses wanting to work at Ashford Hospital. This meant that bank (overtime) staff were not needed and there was an optimum skills mix in each clinic. The clinical nurse leader showed us the staffing establishment for each clinic and all areas were staffed correctly.
- We were told that diagnostic imaging was fully staffed but were stretched if a member of staff was off sick.
- In diagnostics staff reported that repetitive strain injury was common but that they were well-supported to cope with this, and workloads had been adjusted to meet the changing abilities of staff.
- Radiology had recently employed three new staff to manage a backlog in reporting within the diagnostic imaging department.

## Major incident awareness and training

- An outpatient's sister stated that there was training in managing major incidents but this had not been disseminated to other staffing levels. The sister was not aware of policies or processes involved in escalation of incidents. They said they would seek advice from the estates team.
- Senior staff were clear about fire evacuation processes and policies.

## Are outpatient and diagnostic imaging services caring?

Good



The outpatients and diagnostic imaging department were caring and considerate to patients, carers and visitors. We observed that staff at all grades shared the same level of compassion and understanding of patients' needs and treated everyone with dignity and respect.

## Compassionate care

- The outpatient department had adopted the NHS Friends and Family Test to assess feedback on people's experience of using the service. Results showed that patients were positive about their experiences and said that they always received good care and attention.
- We spoke to staff who acted as chaperones during clinics. These staff had received appropriate training for this and knew the processes involved.
- In diagnostic imaging, the NHS Friends and Family Test showed that patients had all of their questions answered and their results explained well.
- In diagnostic imaging patients said that staff were respectful and kind and showed compassion.
- Several patients said that reception staff were friendly and efficient. Some patients commented how bright the reception areas were and felt happy to wait for their clinics in these areas.
- A patient told us that all staff were caring and had been "brilliant throughout" their care.
- Patient confidentiality was respected. There were a large number of private rooms available in the clinic areas. Patients we spoke with told us that conversations with clinical staff were conducted in private.



# Outpatients and diagnostic imaging

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

- Patients in diagnostic imaging said that they were involved in their care and had results explained to them.
- Patients told us that the information they received was clear and concise.
- Patients felt well-informed during procedures and said that “they always explain what they are going to do and what these medications are for”. Another patient said that staff were always “honest, practical and sensitive with information and ongoing care”.

## Emotional support

- Reception staff were confident to manage difficult situations themselves, if necessary. They emphasised the importance of listening to problems, and gave examples to us of this in practice.
- We observed that staff supported patients through difficult situations in a sensitive and respectful way.
- There were designated quiet rooms in the outpatients department where bad news could be delivered. When bad news needed to be given, a doctor would be supported by a nurse, even in healthcare assistant-led clinics. There were processes to have a senior nurse attend if required to manage these situations. There was a multi-faith area provided which was clearly signposted for patients and visitors.

## Are outpatient and diagnostic imaging services responsive?

Good



Ashford Hospital had about 187,000 outpatient appointments in the year 2013/14: 22% of these were first appointments and 48% of these were follow-up appointments; 13% were cancelled by the hospital; and 12% were cancelled by patients. This is double the average for England. Data also showed that 5% of patients did not attend their appointments, which is 2% lower than the national average.

Analysis done by the trust showed that, of outpatient appointments cancelled by the hospital, 8% were cancelled with less than six weeks' notice.

The booking team for both hospitals was on the Ashford site and was responsible for booking appointments, cancelling patient appointments and received about 600 calls a day. We were told that capacity was an ongoing issue on both hospital sites and extra clinics had been created at weekends.

Staff gave us examples where complaints had been managed locally by individual teams. If a complaint or concern was escalated to the clinical nurse leader, we were told they personally managed them and talked to each person involved.

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

- The environment was appropriate for patients, with adequate comfortable seating and magazines. There was a café in the outpatients department which served a variety of food and drinks.
- There was a separate waiting area for children in the main outpatients waiting area, with a selection of games and books available. There was no specific waiting area for children in diagnostic imaging.
- All patients entering the outpatients department were required to check-in using a touch-screen computer. A variety of languages were available for this process, although we observed that the screen could clearly be seen from other parts of the waiting area, compromising patient confidentiality.
- Staff and patients told us that public transport to the hospital was good and that it was useful having a supermarket next door to the hospital.
- Staff and patients said that access to car parking was an issue on the site. Patients told us this was the most stressful aspect of their visit to the hospital.
- If a patient lived closer to one site than the other, there was a shuttle-bus service available between Ashford and St Peter's hospitals.

## Access and flow

- Ashford Hospital had about 187,000 outpatient appointments in the year 2013/14: 22% of these were first appointments; 48% were follow-up appointments; 13% were cancelled by the hospital; and 12% were cancelled by patients. This is double the average for England. Data also showed that 5% of patients did not attend their appointments, which is 2% lower than the national average.

# Outpatients and diagnostic imaging

- Analysis done by the trust showed that, of outpatient appointments cancelled by the hospital, 8% were cancelled with less than six weeks' notice. An action plan had been agreed as part of the outpatient plan to improve these figures. Work was being done with the divisional teams and a monthly report to the executive board was being completed to monitor progress. Each specialty had a monthly performance review and any short-notice cancellation of clinics was now reported and discussed in these reviews.
  - We saw data which showed that the hospital was meeting its 18-week referral-to-treatment time targets, with the average wait being 5.9 weeks. Targets for urgent referrals and cancer referral to treatment times were also being met.
  - The trust provided information which showed that 18% of clinics started more than 30 minutes late. Patients said they were well-informed by reception and nursing staff when clinics had run late. Staff said that clinics could be delayed due to medical staff having to change hospital sites during the day. They said issues with traffic and parking had made it difficult for medical staff to get to clinics on time.
  - Staff we spoke with said that time allocation for appointments was "reasonable" but said that overbooking was a major cause for delay. We were given information which showed that 15% of clinics were overbooked across both sites, with physiotherapy and the orthopaedic clinics being overbooked at the discretion of the clinical teams. During our inspection, five patients said they had experienced delays. A member of staff told us that a clinic of 15 patients had been booked with 22 patients, resulting in a 45-minute delay.
  - The booking team for both hospitals was on the Ashford site and was responsible for booking appointments, cancelling patient appointments and received about 600 phone calls a day. They said that capacity was an ongoing issue on both hospital sites and extra clinics had been created at weekends.
  - We were told that, due to the high demand for booking and re-organising clinics, limited staff could be used to answer phone calls. We were told that three staff were responsible for taking calls which created queues of 13 patients at any one time. The average time for waiting could not be calculated but we were told that each patient was on the phone for about three minutes.
  - We saw a pile of patient referrals pending without the capacity in the clinics to handle this throughput. The bookings department had discussed this with the service managers but felt that they had little feedback on this issue.
  - We were told that the equipment in the booking department was affecting productivity and that, with better scanning equipment, this could be improved. This would mean that patients could be informed quicker of their appointments.
  - In diagnostic imaging, we were told that the reception staff managed clinics for non-urgent GP referrals, with an average wait of three weeks. All urgent scanning appointments were made within the two-week target.
  - In the diagnostic and imaging department, there were targets for each modality that were set by the department; on the week we visited, nine of 16 modalities were not meeting their designated targets for reporting x-rays. A weekly meeting looked at a patient tracking list which listed the waiting times for image reporting for every patient. Reports could be reallocated between staff that had capacity.
- ## Meeting people's individual needs
- We were told by staff that patients with learning difficulties or dementia were managed on an individual basis based on their previous clinical information, and also by trying to ensure that they saw the same doctor or nurse for all of their appointments.
  - All patients were asked for allergy information when they first attended the outpatients department. This was recorded in their notes. Some staff said that it was not possible to see this if notes were not available for clinics.
  - Information leaflets were displayed in waiting areas of clinics and there was information on how to order these leaflets in different languages. There was also information to provide audio, large print or Braille versions.
  - Some patients said they were not given a choice as to which site they had their outpatient appointment. This was considered important as it could sometimes be time-consuming to get to the other site.
  - We observed that staff in diagnostic imaging were listening to patients' needs and requests and helped them where they could.
  - The trust's policy was not to use members of the family as translators, and so there was a dedicated

# Outpatients and diagnostic imaging

communications room in the outpatients department. This meant that appointments requiring translation services did not have to be rebooked. These facilities needed to be booked in advance but did not cause any delays.

## Learning from complaints and concerns

- Patients told us there was little information visible to them to advise on how to make a complaint.
- The Patient Advice and Liaison Service leaflets were displayed in some of the clinic waiting areas and staff knew to direct patients to this service.
- Staff gave us examples where complaints had been managed locally by individual teams. If a complaint or concern was escalated to the clinical nurse leader, we were told that they personally managed them and talked to each person involved.
- Some staff told us that there was a poor system for managing complaints formally. They told us there was no pathway within the organisation to ensure that complaints were fully addressed and that learning from complaints was disseminated.
- We were told of examples when the duty of candour had been considered by the clinical nurse leader when dealing with complaints. No complaints were recorded for learning or evaluation unless managed through the Patient Advice and Liaison Service.
- In diagnostic imaging, we observed that complaints were managed by senior members of the team and information and learning from these was disseminated through a weekly newsletter sent to all clinical and non-clinical staff.

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

Requires improvement



Although there were plans to improve the outpatients service, we were not told about this until after the inspection. Audits taking place were not reported on effectively and did not impact on governance. There was a positive working environment which was dedicated to putting the patient first, however, there was limited evidence of robust governance systems.

## Vision and strategy for this service

- The trust had an improvement strategy for the outpatients service. A project had been established in 2013 that had targeted a number of areas for work to be undertaken. These included improving the external website, standardising contact methods for making appointments, reducing the number of cancelled appointments and providing some customer training for frontline staff. An action plan had been developed, detailing steps to be taken in each specialty and clinical area. However, senior staff we spoke to were not aware of this.
- In the physiotherapy department, we were told that staff had reviewed the trust's values to produce their own set of departmental objectives. This was going to be used to develop a strategy for the service and to drive improvement.
- The NHS Friends and Family Test had been introduced to the outpatients department. Results from this were displayed in public areas for patients and visitors to see.

## Governance, risk management and quality measurement

- Where audits were carried out, there was no evidence of when it was assessed, what actions were being put in place, or when the area was going to be reassessed. It was not clear who these audits were reported to. One senior member of staff told us that "we do too many audits".
- We were presented with general risk assessments for the outpatients department, however, there were few risks identified. We were told that these risks were assessed by "feeling" rather than through a methodology of consequence, likelihood and risk scoring as recommended by the National Patient Safety Agency.
- The control measures for the identified risks were not adequate – for example, a leaking roof in a clinic area was considered a 'medium' risk; this risk was reduced to 'low' risk once estates had been requested to repair it. A timeframe for the resolution of this risk had not been considered.
- We were told by the clinical nurse leader that there were no governance meetings in the outpatients department. We were told that that any issues that arose were handled in a reactive way rather than using a proactive approach.
- The risk assessments provided were from November 2014; we asked to see the previous risk assessments but these couldn't be provided.

# Outpatients and diagnostic imaging

- We were told that the outpatients department did not have a risk register but that issues were escalated to the St Peter's site. The clinical nurse leader did not know what was on the risk register nor did they have access to it.
- We were told in diagnostic imaging that audits were carried out. A radiographer told us that they were only done by certain members of staff and that there was no audit timetable. This was managed by relying on the members of staff involved to remember to undertake the audits.

## Leadership of service

- There was a dedicated clinical nurse leader and sister responsible for nursing, reception staff, physical space (such as rooms and waiting areas), and management of patient experience and complaints. The clinical nurse leader was the direct link to the specialty-specific service managers and the divisional leads.
- All senior staff in the outpatients department had the clinical nurse leader's personal telephone number to discuss any issues out of hours. The clinical nurse leader held a walk-around in the outpatients department three times a day.
- Staff said that they felt well-informed of service, divisional and trust-level decisions. Senior staff and the clinical nurse leader had a positive working relationship and held management meetings on a weekly basis. The senior nurses held specialty-specific meetings once a week to disseminate information from the operational management team.
- Staff in diagnostic imaging were positive about their direct line managers and service managers. Staff felt there was an 'open door' policy with managers and received information from them regularly. Each morning a team meeting was held to discuss the activities for that day and issues occurring, such as sickness cover.
- There was a lack of clarity from staff in the outpatients department about who was responsible for the risk register.

## Culture within the service

- Staff said they were well-supported by their managers and regularly saw the chief executive and chief nurse on site. During these times, they had been approachable and listened to concerns. Senior nurses felt the managers were part of the team and were very approachable.

- Most staff we spoke with complimented the hospital and said the team worked well with each other and that they enjoyed working for the trust. We were told that they worked "like a family" and that the teamwork at the hospital was "amazing". Some staff thought there could be a disconnect between the two hospital sites.
- Staff felt comfortable to challenge doctors if they were not working to best practice – for example, forgetting to wash their hands.
- The staff in physiotherapy were very happy with their management and had regular interaction with non-executive directors and their line managers. Although they said it was a good place to work, they were also concerned about services such as physiotherapy being tendered to external companies. We observed that this had driven the department to competing with external companies and encouraged their practices to progress.
- Staff in diagnostic imaging were satisfied with the management in the department and felt well-supported by them.
- Some staff in non-clinical areas told us that morale was low due to the pressures of additional clinics and cancellations. One member of staff told us that working under these conditions was "soul destroying".

## Public and staff engagement

- Leaflets were displayed about groups and organisations outside of the hospital, for example, the Ashford breast cancer support group.
- In the chemotherapy suite, appointments were booked so that patients could be grouped together. This promoted relationships between patients and the staff helping them through their treatment.
- Staff were aware that the trust was focused on a merger with the Royal Surrey County Hospital NHS Foundation Trust. Some staff said they received little information about this.
- There was a patient participation panel being rolled-out in January 2015 to discuss the views and opinions of the patients being used to improve the service.
- We observed that the intranet was regularly updated with information from the board of directors and a weekly note from the Staff said this was an accessible and informative way to get this information, as well as access policies and leaflets for patients.

# Outpatients and diagnostic imaging

- A display in the main reception of outpatients showed what changes had taken place as a result of patient feedback. For example, a patient requested delays to be shown on a screen and this was planned to be implemented in 2015.
- The physiotherapy department had conducted several service evaluations to identify areas to develop, they had then used best practice guidelines, journals and other evidence, including comparisons with peer groups, to improve their practice.

## **Innovation, improvement and sustainability**

# Outstanding practice and areas for improvement

## Areas for improvement

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

- Take action to ensure all staff understand their responsibilities in the event of a medical emergency and be able to summon assistance when required.
- Take action to ensure that medications are being used and stored appropriately and are safe for use.
- Take action to ensure that records are secured appropriately to protect patient confidentiality.

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

- Ensure that all relevant staff receive feedback and information from divisional governance meetings to be able to identify and address risks in their area of work.
- Ensure that outcome data enables identification of site-specific patient outcomes.
- Improve the storage facilities for equipment on the medical wards to reduce clutter and prevent the risk of patient falls.
- Ensure that all staff are up to date with mandatory training requirements including for the Mental Capacity Act 2005 and learning disability.

- Ensure that there is a robust process for the referral and handover when transferring patients from St Peter's to Ashford Hospital.
- Ensure, where the acuity (health needs) of patients increase, that there are sufficient staff to meet patients' needs.
- Ensure that all staff are aware of the process for alerting the emergency 'crash team' in the event of a patient becoming unwell.
- Ensure that the systems for risk assessments and governance in the outpatient department are appropriate to identify and manage risk.
- Ensure that pharmacy staff have sufficient time to check medication prescription charts for errors in prescribing.
- Ensure that the reasons for as required medication are clearly described on prescription charts.
- Ensure that all staff are supported to attend training courses.
- Ensure communication regarding the future strategy for Ashford hospital is well timed and clear for all staff.
- Consider the arrangements for clinical nurse leader overview and support for theatres.

## Compliance actions

### Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services</p> <p>The registered person had not taken proper steps to ensure that each service user is protected against the risks of receiving care that is inappropriate or unsafe by means of ensuring the welfare and safety of the service user. Some receptionist staff were unsure about their responsibilities if a patient deteriorated. Some could not locate where the crash trolley (for transporting emergency equipment and medication) was and didn't know the correct process for alerting the 'crash team' by telephoning 2222.</p> <p>Regulation 9 (1) (b) (ii)</p>
Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines</p> <p>The registered person had not ensured that medications were being used and stored appropriately and that they were safe for use.</p> <p>In one clinic, we found that saline 100ml intravenous bags used for breast implant patients were being used for more than one patient without appropriate labelling. Bags were being left for several days before they were used again.</p> <p>On Wordsworth Ward, we saw a poor response to the maximum fridge temperature being out of an acceptable range. We saw no action had been taken to remedy this since 15 November 2014 and staff did not know how to re-set the thermometer.</p>



This section is primarily information for the provider

## Compliance actions

Prescription charts had been accurately completed, however, we saw that, on some charts, the reason for 'as required' medication was not clearly described.

The medicine incidents database highlighted two occasions where the medicines ordered by 2pm on one day were not delivered to the ward until after 6pm the following day. This led to missed doses of medication and delayed patient discharges.

Regulation 13

### Regulated activity

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

The registered person had not ensured that records were kept securely.

Records were left in corridors in unlocked trolleys in outpatient and ward areas. There was a risk that notes could be accessed by unauthorised persons where areas were unattended.

Regulation 20 (2) (a)