Fulwood Hall Hospital

Quality Report

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

Ratings

Overall rating for this location	**Good**
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Overall summary

Fulwood Hall Hospital is operated by Ramsay Health Care UK Operations Limited. The hospital/service has 29 inpatient and twelve day case beds. Facilities include three main operating theatres with laminar flow; an endoscopy/ minor operations unit; X-ray, outpatient and diagnostic facilities.

The hospital provides surgery, outpatients and diagnostic imaging services. We inspected surgery, outpatients and diagnostic imaging services.

We inspected this service using our next phase inspection methodology. We carried out the inspection with an unannounced visit to the hospital on 14 and 15 August 2018.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Summary of findings

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The main service provided by this hospital was surgery. Where our findings on surgery – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery service level.

Services we rate

Our rating of this hospital stayed the same. We rated it as good overall. We found practice was good in relation to care in surgery, outpatients and diagnostic imaging services:

- The provider managed staffing effectively and services always had enough staff with the appropriate skills, experience and training to keep patients safe and to meet their care needs.
- The hospital provided mandatory training for all staff and completion rates were high; this was up to date at the time of inspection.
- Staff were aware of hospital safeguarding procedures and followed these correctly.
- Staff were aware of the types of incident which could occur and reported these if they occurred. There was a good culture of incident reporting and learning was shared following this.
- Staff followed evidence-based care pathways for specific conditions; policies and procedures were developed on national guidance.
- Seven-day services were available in case of emergencies and for responding to concerns.
- Staff worked well together in multidisciplinary team approach to meet patients' needs.
- The service responded well to different patient needs and had well established systems for supporting patients living with dementia or a learning disability.
- Leaders were visible and there was an open and positive culture amongst staff. The hospital had developed a clear vision and strategy in engagement with staff.
- There was a clear governance system in place and this had been reviewed and strengthened since our last inspection.
- The hospital engaged well with patients, staff, the public and local organisations to plan and manage services appropriately, and collaborated with partner organisations effectively.

However

- Surgical safety and other theatre checklists were not always being carried out in accordance with recognised best practice guidelines. The service did not always control infection risk well and we saw equipment and environmental defects which could present an infection control risk.
- Managers did not always ensure staff received annual appraisals. Appraisal rates in outpatients were poor and had been low in surgery.
- Pain scoring tools were used routinely in the physiotherapy department but not used consistently in the outpatient departments to manage patients' pain levels.

We found areas of outstanding practice in surgery, outpatient and diagnostic care, including

- Development of a working group for supporting patients who had autism.
- A focus on safety culture, with implementation of a 'Speak up for Safety' initiative and provision of human factors training for all staff.
- Opportunities for staff development, and access to learning support funding for this, through Ramsay Healthcare.

We found areas of practice that require improvement in surgery and diagnostic imaging services, for

- Improving practice in World Health Organisation (WHO) checklists.
- Maintaining robust systems for cleaning radiology equipment used in theatres.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with two requirement notices that affected surgery and diagnostic imaging services. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North West)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as good because it was caring, effective, responsive and well-led, although it requires improvement for being safe
Outpatients	Good	Outpatient services were available for consultants with practising privileges to refer patients. We rated this service as good because it was safe, caring, responsive and well-led. We inspected but did not rate effective.
Diagnostic imaging	Good	Diagnostic imaging services were available to consultants with practising privileges who were authorised as referrers We rated this service as good because it was caring, responsive and well-led, although it requires improvement for being safe. We inspected but did not rate effective.

Summary of findings

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Services we looked at

Surgery; Outpatients; Diagnostic imaging;

Summary of this inspection

Background to Fulwood Hall Hospital

Fulwood Hall Hospital is operated by Ramsay Health Care UK Operations Limited. The hospital opened in 1986. It is a private hospital in Preston, Lancashire. The hospital primarily serves the communities of Preston and Lancashire. It also accepts patient referrals from outside this area.

The hospital has had a registered manager in post since 2016.

Fulwood Hall Hospital provided a range of surgical procedures and outpatient services for patients aged 18 and over, including orthopaedic surgery; neurosurgery; general surgery; ear, nose and throat; gastroenterology, gynaecology; neurology; ophthalmology; vascular surgery; colorectal surgery; and urology.

The hospital also offers a range of diagnostic imaging, including plain X-rays; dental X-rays; fluoroscopy imaging; arthrography; general ultrasound scanning and ultrasound guided injections; urodynamic testing and barium swallow investigations.

The hospital also offers cosmetic procedures such as dermal fillers and laser hair removal, ophthalmic treatments and cosmetic dentistry. We did not inspect and do not regulate these services.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, other CQC inspectors, and specialist advisors with expertise in surgery, diagnostic imaging and outpatient services. The inspection team was overseen by Nicholas Smith, Head of Hospital Inspection.

Information about Fulwood Hall Hospital

The hospital has one inpatient ward and is registered to provide the following regulated activities:

- Diagnostic and screening; family planning; treatment of disease, disorder or injury;
- There are 29 inpatient beds on the ward, four of which are double rooms and the remainder are single, ensuite rooms. There are 12-day case cubicles.
- The diagnostic imaging department has an X-ray and ultrasound room, with a mobile X-ray machine for the ward and an X-ray image intensifier available in theatres. Computerised tomography (CT) scanning and magnetic resonance imaging (MRI) scanning services were also available at a mobile unit at the hospital, from a different provision within Ramsay Healthcare UK. These services were not inspected as part of this inspection.
- The physiotherapy department has four individual treatment rooms and a small rehabilitation area with a gym. Physiotherapists support orthopaedic and spinal inpatients, also pre-operative assessments appointments.
- The outpatient department has nine consultation rooms (specialist ear, nose and throat, and eye rooms) and a treatment room for minor procedures. There are two rooms designated for pre-operative assessments.
- The theatre department comprises three main operating theatres (with laminar flow) and an endoscopy/ minor operations unit.

During the inspection, we visited the ward, surgical theatres, X-ray, ultrasound and outpatient areas. We spoke with 55 staff including; registered nurses, health care assistants, reception staff, medical staff, operating

Summary of this inspection

department practitioners, and senior managers. We spoke with 19 patients and two relatives. During our inspection, we reviewed 17 sets of patient records and five employment records

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected on two previous occasions, and the most recent inspection took place in November 2016, which found that the hospital was meeting all standards of quality and safety it was inspected against.

- In the reporting period June 2017 to May 2018 There were 8,252 inpatient and day case episodes of care recorded at the hospital; of these 89% were NHS-funded and 11% other funded.
- Twenty percent of all NHS-funded patients and 30% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 39,489 outpatient total attendances in the reporting period; of these 82% were NHS funded and 18% other funded.
- One hundred and twenty-three surgeons, anaesthetists, physicians and radiologists worked at the hospital under practising privileges. Two regular resident medical officers (RMO) worked on a one week on and one week off rota. Fulwood Hall Hospital employed 37 registered nurses, 23.3 health care assistants and operating department practitioners and 62.7 other hospital staff, as well as having its own bank staff. The accountable officer for controlled drugs was the matron.

Track record on safety

- One never event.
- Clinical incidents – 137 in total, of which 112 were no harm, 20 were low harm, 5 were moderate harm.
- One incident was categorised as a serious injury.
- 1 incidence of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),
- 0 incidences of hospital acquired Methicillin-sensitive Staphylococcus aureus (MSSA)
- 0 incidences of hospital acquired Clostridium difficile (c.diff)
- 0 incidences of hospital acquired E-Coli
- 44 complaints

Services accredited by a national body:

- Joint Advisory Group on GI endoscopy (JAG) accreditation

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Interpreting services
- Grounds Maintenance
- Laundry
- Maintenance of medical equipment
- Pathology and histology
- Resident Medical Officer provision

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as requires improvement because:

- Surgical safety checklists were not always being carried out in accordance with recognised best practice guidelines to ensure the safety of the patient during surgery.
- The service did not always control infection risk well. Staff did not always keep equipment clean and we saw some equipment in outpatient and theatre departments was dirty. We saw that there were some defects with the environment in theatres that could present an infection control risk.
- Intra-operative temperatures were not being routinely recorded and this was not in line with recognised guidelines
- Medicines used for certain diagnostic imaging procedures were not always securely stored.

However

- The hospital provided mandatory training for all staff and completion rates were high; this was up to date at the time of inspection.
- Safeguarding training was completed and staff were aware of hospital procedures and followed these correctly.
- Staff were aware of the types of incident which could occur and reported these if they occurred. Learning from incident investigations was shared with staff.
- The service used safety monitoring results well. The hospital screened for Methicillin Resistant Staphylococcus Aureus (MRSA) and staff followed procedures for dispensing and administration of medicines.
- There were high levels of compliance in cleanliness and hand hygiene audits; ward areas were visibly clean and storage rooms were well ordered.
- Staff in diagnostic imaging services completed radiation risk assessments and followed safety protocols, in accordance with Ionising Radiation Medical Exposure Regulations (IRMER). Local safety standards for invasive procedures (LocSSIPS)were in place for certain diagnostic imaging investigations.
- There were appropriate procedures and pathways in place to recognise and manage the deteriorating patient and to ensure they were transferred to the NHS hospital in a timely way, if required.
- The hospital had enough staff with the right qualifications, skills, training and experience to provide safe care for patients.

Summary of this inspection

- There was a strong focus on safety following recent incidents and staff were aware of emergency procedures at the hospital.
- The resident medical officer was available 24 hours a day, seven days a week, for response to any patient emergencies or concerns.

Are services effective?

Good

We rated effective as good because:

- Care was based on national guidance and staff followed a number of care pathways for specific conditions. Policies and procedures were developed using an evidence-based approach.
- Diagnostic imaging services routinely used diagnostic reference levels and completed observational audits as part of their practice. The service followed robust systems for checking patients' previous exposure to radiation.
- Pain management was good for surgical patients and patients were supported after discharge with follow-up calls within 48 hours.
- A multidisciplinary approach was evident across the different hospital departments and staff worked well together when providing care for patients
- Staff were aware of the needs of patients who lacked capacity and followed procedures appropriately in managing different patient needs.

However

- The service did not always make sure staff were competent for their roles. Completion of annual appraisals was low in outpatient areas and had been poor in surgery.
- Physiotherapy routinely used pain scoring tools but there was limited use of pain scoring tools in the outpatient department, despite these being available.

Are services caring?

Good

We rated caring as good because:

- Staff were kind and showed compassion when caring for patients, with good communication skills.
- Staff respected patients' dignity and took time to engage with and understand patients' individual circumstances.
- Services endeavoured to improve patient experience where they could and feedback indicated high satisfaction levels.
- Patients we spoke with were very appreciative about their care and treatment.

Summary of this inspection

- Patients felt involved in their treatment and were provided with emotional support where they felt anxious or upset.

Are services responsive?

Good

We rated responsive as good because:

- The service took account of patients' individual needs, and supported these appropriately where they had been identified.
- People could access the service in a timely way. Waiting times from assessment to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- X-ray and other diagnostic imaging services could provide same day appointments for patients attending outpatient clinics and additional clinics could be arranged in response to increased demand.
- The hospital received low numbers of complaints but investigated these when they occurred and learned lessons from the results.
- Chaperones were available for patients who wished to have a chaperone during their appointment.
- Patient feedback was consistently positive, with numerous thankyou letters and cards displayed in departments. Any negative responses were mostly concerned with parking facilities.

However

- Patients did not routinely receive copies of clinic letters and were unaware they needed to request these, although there was a sign in the reception area to inform patients on how to request clinic letters.
- The waiting area for diagnostic imaging services was limited and could become congested at times.

Are services well-led?

Good

We rated well-led as good because:

- Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff we spoke with were involved in development of services at the hospital.
- There was a clear governance system in place and this had been reviewed and strengthened since our last inspection.
- There was a systematic approach to continually improving the quality of services and safeguarding high standards of care.
- There were effective systems in place to identify risks, planning to eliminate or reduce them and coping with both he expected and unexpected.

Summary of this inspection

- The hospital collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. Managers had access to data to monitor performance and identify improvements.
- The hospital engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires improvement	Good	Good	Good	Good	Good
Outpatients	Good	N/A	Good	Good	Good	Good
Diagnostic imaging	Requires improvement	N/A	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Good

Surgery

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

Are surgery services safe?

Requires improvement

The main service provided by this hospital was Surgery. Where our findings on Surgery – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the Surgery section.

Our rating of safe went down. We rated it as **requires improvement.**

Mandatory training

- The hospital provided mandatory training in key skills to all staff and made sure that everyone completed it.
- Staff undertook mandatory training courses delivered through e-learning or face to face training. The hospital followed the Ramsay Healthcare UK policy for mandatory training, which staff completed annually. The provider had a learning management system for recording all training undertaken and this was monitored and audited by the hospital human resources department.
- The hospital had a mandatory training policy that identified the training that was considered mandatory and provided staff with information on how and when to access appropriate training. The policy was in date and was next due to be reviewed in May 2020.
- Staff undertook mandatory training courses in clinical basic life support; general data protection regulation; general induction; non-clinical basic life support; emergency management and fire safety; equality and diversity; health and safety; infection control; information security; manual handling, sharps and blood borne virus and safeguarding.
- The hospital did not have a fixed target for completion of mandatory training courses but managers told us that the expectation was for 90 to 95% of staff to have completed each course.
- Data supplied by the hospital for May 2018 showed that numbers of theatre staff who had completed mandatory training was below the 85% target in information security (71%) and sharps and blood borne virus (69%).Numbers of ward staff who had completed mandatory training was below 85% in May 2018 for general data protection regulation (79%); information security (76%) and sharps and blood borne virus (76%).
- At the time of our inspection the hospital was undertaking a training day when no surgery was scheduled. They supplied updated mandatory training figures, following the training day, that showed that overall, 74% of theatre staff and 91% of ward staff had completed all of their mandatory training courses. The remainder of theatre and ward staff still had one or more mandatory training courses to undertake.

Safeguarding

- Staff understood how to protect patients from abuse and the service worked with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The provider had a policy on safeguarding adults at risk of abuse or neglect and a policy on safeguarding of children and young people. Both policies were in date

and had been reviewed at regular intervals with details of any revisions clearly stated. The policies covered identification of a vulnerable adult or child, types of abuse, signs of abuse, disclosure and referral. The policies also covered the PREVENT government strategy, that was developed to assist in signposting organisations where there was a suspicion of an adult or child having been radicalised and female genital mutilation.

- Staff received mandatory training in the safeguarding of vulnerable adults and children as part of their induction, followed by annual safeguarding refresher training.
- Hospital data showed that, at the time of our inspection, 96% of theatre staff and 100% of ward staff had undertaken training in safeguarding adults level one and 82% of theatre staff and 97% of ward staff had undertaken training in safeguarding adults level two.
- At the time of our inspection 100% of theatre staff and 100% of ward staff had undertaken safeguarding children level one training. Safeguarding children level 2 training had been undertaken by 79% of theatre staff and 97% of ward staff.
- The provider safeguarding policy stated that all staff must complete their safeguarding training and competencies in line with the intercollegiate document "Safeguarding children and young people: roles and competencies for health care staff 2014".The policy gave a summary of training requirements and stated that all clinical and non-clinical staff who had any contact with patients, adults and children should be trained to level two in safeguarding children and young people, in line with the intercollegiate document. Although the hospital did not treat children under 16 years of age, staff encountered children who were accompanying or visiting adult patients.
- The matron was the named safeguarding and PREVENT lead for the hospital and there were four further safeguarding leads, including three permanent staff members and one consultant from the local acute NHS trust. They were responsible for ensuring that staff had undertaken safeguarding and PREVENT training to the required levels.
- The safeguarding leads sat on the county safeguarding adults' leadership group and the NHS Lancashire PREVENT leads group.
- Staff gave us an example of a safeguarding referral that had been made to the police where domestic violence was suspected. Safeguarding flowcharts were on display throughout the hospital and staff were aware of the process to follow to raise a safeguarding concern. Safeguarding referrals were generally made to the local authority safeguarding team.
- There were seven-minute safeguarding briefing notices on display on the hospital's safeguarding noticeboard and managers told us that any safeguarding concerns were discussed at team meetings.

Cleanliness, infection control and hygiene

- There had been no cases of no cases of clostridium difficile or escherichia coli infections at the hospital from June 2017 to May 2018.
- There had been one case of methicillin-resistant staphylococcus aureus or methicillin-sensitive staphylococcus during the period June 2017 to May 2018. Admitted patients underwent screening for methicillin-resistant staphylococcus aureus before surgery.
- Patients with a positive methicillin-resistant Staphylococcus aureus virus were deferred until the screening was negative.
- The ward area was visibly clean and free from clutter. Housekeeping staff carried out daily cleaning tasks and completed daily checklists. Patient rooms were visibly clean and dust free.
- We saw that, in patient rooms, there was hand gel and hand wash available and a hand wash sink with paper towels. There were appropriate bins for the disposal of clinical and non-clinical waste in patient rooms.
- Appropriate waste bags were in use in theatres and were labelled with the location and date, in accordance with the Association of Perioperative Practice guidelines.
- The clean utility room in the ward area contained appropriate segregated bins for recycling and clinical waste disposal.There was a hand wash sink and disposable aprons and other personal protective equipment.
- We saw that sharps waste bins were labelled appropriately, were partially closed and were not overfilled.

- Staff were observed wearing personal protective equipment, such as gloves and aprons, whilst delivering care. However, an anaesthetist was observed to insert a cannula without wearing surgical gloves.
- Surgical instruments were reprocessed and decontaminated locally, off-site. There was a 24-hour turnaround time for trays of surgical instruments to be returned to the hospital. There was a healthcare assistant lead for decontamination who liaised with the off-site facility to minimise turnaround times and discrepancies on trays.
- We looked at the log book for the flexible naso endoscope and cleaning was compliant with Management and decontamination of flexible endoscopes guidance, Health Technical Memorandum 01-06. However, there was no documentation of leak testing being carried out on the endoscopes between patient use. To conform with the guidance this needs to be undertaken between all patients following Tristel 3 wipe system.
- Surgical site infections surveillance service were carried out on all orthopaedic implants. Hospital records showed that there were six surgical site infections following hip replacement surgery between April 2017 and March 2018 and five surgical site infections following knee replacement surgery in the same period. From June 2017 to May 2018, there were a total of 14 surgical site infections for all surgical procedures. Any patient presenting signs of an infection was reviewed by the infection control link nurse and a root cause analysis was completed to determine any possible trends. Results and lessons learned were presented at health and safety meetings, governance meetings and quarterly infection control committee.
- Hand hygiene audits were carried out monthly. The audit for May 2018, showed hand hygiene compliance of 86% with seven staff observed and one missed hand hygiene opportunity by a doctor. Planned actions from the audit were to feed back the results to theatre staff and to raise hand hygiene actions at mandatory training. The hand hygiene audit for June 2018 showed 100% compliance when observations were carried out on five staff.
- Cleanliness audits were carried out monthly. The cleanliness audit for June 2018 showed an average overall score of 96% compliance. There were 22 areas of measurement in the audit with 17 out of the 22 areas scoring 100% compliance. Observations made for the areas that scored less than 100% were that in theatres, there was quite a lot of equipment on floor space which hindered cleaning and equipment was not always labelled with an “I am clean” sticker when cleaned.
- The recently published patient-led assessments of the care environment assessment 2018 showed that the overall cleanliness score for the hospital was 100% positive compared to a national England average of 98.5%.
- The provider told us that a ward nurse was currently completing an infection control post-graduate course. This would serve to strengthen knowledge and training around infection control within the hospital.
- However, we noted that, in the theatre areas lead aprons were visibly dirty and the C-arm X-ray machine was dusty and this was a potential infection control risk.

Environment and equipment

- Ward areas were visibly clean and corridors were free from congestion and clutter. However, we observed that, in theatre areas, there were defects to door coverings, the skirting was coming away from the walls in places and there was a hole in the floor covering that exposed the concrete underneath. This meant that these areas could not be cleaned correctly. Following inspection, the provider made repairs to these areas.
- Equipment storage rooms were well ordered and tidy. A sample check of single use equipment showed that they were all within their expiry date.
- Pressure relieving mattresses could be ordered for those patients at risk of developing pressure ulcers and load bearing trolleys and wheelchairs were available for patients with a high body mass index.
- The hospital had an equipment inventory maintenance schedule in place that showed that equipment servicing was carried out regularly both internally and by external contractors.
- A log book of equipment, such as drug fridges and syringe drivers was kept on the ward and contained maintenance and servicing records of the equipment.

- Emergency resuscitation trolleys were available across all areas and were checked daily.
- Suction oxygen was available in-patient rooms and was observed to be tested regularly and working.
- We observed that, before surgery, implant identifiable stickers were placed in the implant register with the patient details so that individual implants could be traced back to a patient if necessary.
- The hospital had previously achieved joint advisory group for gastrointestinal endoscopy (JAG) accreditation. The week before our inspection the joint advisory group accreditors had inspected the endoscopy theatre again. Managers told us that re-accreditation had been deferred until the hospital resolved an identified issue relating to privacy and dignity and the need to put a door across a corridor so that the day case waiting room was sufficiently separated from an area where gowned patients were entering the endoscopy theatre. We did not inspect the endoscopy area during this inspection although managers told us that they did have new decontamination equipment. There were no patients for endoscopy procedures during our inspection.
- The recently published patient-led assessments of the care environment assessment 2018 showed that the overall positivity score for the condition, appearance and maintenance of the environment was 97.7% which was higher than the overall England average score for hospitals of 94.1%.
- During our last inspection, we saw that pre-operative assessments were taking place in a room with two patient bays, divided by a curtain. During this inspection, we saw that the hospital now had another pre-operative assessment room and patients were no longer seen in a room with another patient.

Assessing and responding to patient risk

- The hospital admitted patients for surgery that were considered low risk. The hospital followed a set of exclusion criteria to exclude patients at risk of requiring high dependency care post-surgery, or at higher risk of deterioration.
- An emergency telephone line was available for staff to use in the case of an emergency or deteriorating patient. There was a resident medical officer on site 24 hours a day. As part of their practicing privileges (the right to practice in the hospital), consultants were responsible for the care and treatment of their patients at all times and were accessible by telephone 24 hours a day, seven days a week for advice and guidance when required. If they were unavailable, alternative cover was arranged and communicated to the hospital.
- The hospital had a policy on the recognition and management of the deteriorating patient that included a number of pathways when deterioration in a patient was noted, such as a sepsis tool and pathway; anaphylaxis pathway; asthma pathway; hypoglycaemia pathway and acute kidney injury assessment and pathway. In the event of a patient needing to be transferred to the local acute NHS trust where there was a critical care unit available, the policy advised that an emergency ambulance should be called to facilitate the transfer.
- The hospital was involved with a Ramsay Healthcare UK safety programme and staff had undertaken the relevant programme training. The programme encouraged all staff to challenge and speak up if they saw something that was unsafe or potentially unsafe, regardless of who the person was that they were challenging. Staff spoke positively about the course and said that it made them feel more empowered to challenge safety issue more confidently.
- During our inspection we observed theatre teams use the World Health Organisation five steps to safer surgery checklist.From the five steps, we observed one briefing, which takes place before the patient is brought into theatre; three “sign-in” steps which take place before the patient is given anaesthesia and includes ensuring the patient identity is correct, the right site for surgery incision is marked, allergies are recorded and the risk of blood loss is discussed. We observed two “time-out” (or surgical pause) steps which take place before an incision is made when the team double check the patient identification and incision site and any likely surgical risks are discussed and the nurse confirms the sterility of instruments. We observed three “Sign-out” steps. This is supposed to take place before any members of the team have left the theatre and includes recording the name of the procedure, counting the

instruments, swabs and sharps used during the procedure to ensure all are present and nothing has been left inside the patient and any specimens have been properly labelled.

- We observed that the checklists were not always carried out in accordance with the guidelines to ensure the safety of the patient during surgery. For example, we saw that in the "sign-in" process not all elements of the checklist were verbalised, during the "sign-in" for two checklists, the anaesthetist was not present during some or all of the checklist; during the three "sign-out" steps the operating department practitioner had left the room before the checklist was read so did not have an input. During "time-out" and "sign-out" steps we saw that there was a radio playing loudly and we could not be assured that everything that was said had been heard by all team members, especially during the equipment count.
- We fed back to the theatre manager who arranged for the staff training day that was taking place at the time of our inspection to cover the checklist. Following the inspection, the provider told us they had implemented other actions, including an immediate daily observational audit of the World Health Organisation's checklist.
- The hospital provided two surgical safety checklist audits, for May and June 2018 that showed that, in both instances, nine out of ten surgical procedures, safety checklists were completed appropriately and according to policy.
- We saw that in the records of seven out of eight post-operative patients, that intra-operative (during the operation) temperatures had not been recorded. This went against National Institute for Care Excellence guidelines for the prevention and management of hypothermia in adults having surgery (CG65). The guidelines recommend that patient temperature should be taken before surgery so that they could be actively warmed to an optimum temperature for surgery and temperatures should be taken every 30 minutes until the end of surgery and temperature maintained to prevent hypothermia. The provider told us that intra-operative temperature checks were being taken but had not been recorded on observation charts (though had been on one record checked). We have no evidence that this was the case.
- Ward nursing staff had undertaken a training exercise in major haemorrhage the week before our inspection that involved a real-life scenario run through.
- Staff carried out risk assessments to identify patients at risk of falls and acquiring pressure ulcers and venous thromboembolism (when a blood clot breaks loose and travels in the blood) as part of the assessment carried out before patients were admitted for surgery. The hospital had consistently achieved its target for the assessments to be completed for at least 95% of NHS funded patients and had achieved an average of 98.9% during the reporting period.

Nursing and support staffing

- The ward had sufficient trained nursing and support staff, with an appropriate skill mix to ensure that patients were safe and received the right level of care.
- At the time of our inspection, the hospital had no nursing vacancies and had been over-recruiting to ensure that adequate staffing was maintained in the event of nurses leaving the hospital. A registered nurse and two assistant practitioners had recently been recruited. This was a better picture than in May 2018 when there had been vacancies for 8.4 whole time equivalent staff in theatres and the ward but the vacancies had been filled by August 2018.
- Staffing levels were planned and reviewed using an electronic rostering system. The system enabled heads of departments to manage rotas, shift allocations, annual leave, sickness absence, skill mix and senior cover.
- Managers told us that staffing establishments were set in advance, based on planned procedures and patient acuity. Staffing levels could be increased if a patient requiring additional support was identified during their pre-operative assessment.
- Shift times could also be altered to meet the needs of the service and staff worked flexibly.
- Nursing handovers were held at lunchtime and incorporated a recorded handover and a written handover sheet. Patient details, including their condition and mobility, medications, allergies and treatment plans were discussed during the handover.

- Nursing staff were allocated to theatre lists based on their skills and competencies. Bank staff were used in theatres when the need arose but there were low levels of bank staff usage. The hospital did not use agency staff.
- The rate of use of bank registered nurses in theatres and inpatient areas was 13% for March, April and May 2018 and had remained fairly consistent from June 2017 to May 2018.The rate of use of operating department practitioners and healthcare assistants was 14% in March 2018; 22% in April 2018 and 13% in May 2018.This figure had reduced since June 2017 when the rate of use was 38%.An increase in permanent staff to fill vacancies had reduced the need to use bank staff though they were still being used to cover sickness and other absences
- The staffing establishment on the ward was 22 whole time equivalent registered nurses and 5.2 whole time equivalent healthcare assistants at 1 May 2018.
- The staffing establishment in theatres at 1 May 2018 was 10.7 whole time equivalent registered nurses and 14.4 whole time equivalent operating department practitioners and healthcare assistants. All theatre nurses who had been in post for more than six months had their registrations validated between June 2017 and May 2018.
- The staff turnover rate from June 2017 to May 2018 on the ward was 13% for registered nurses and 21% for other staff. The rate for healthcare assistants was 0%.
- The staff turnover rate from June 2017 to May 2018 in theatres was 33% for registered nurses and 41% for operating department practitioners and healthcare assistants.
- The staff sickness rate in the ward was below 1% for nursing staff from February to May 2018.The sickness rate for healthcare assistants was below 3% from June 2017 to May 2018
- The staff sickness rate in theatres was below 10% for all staff from June 2017 to May 2018.

Medical staffing

- Medical cover on the wards was provided by two resident medical officers that worked alternate shifts of one week on and one week off. They were employed by a resident medical officer agency. During their shift the resident medical officer was based at the hospital 24 hours per day. They were expected to work on the ward floor for eight or nine hours per 24 hours a day and were on call overnight.
- The duties of the resident medical officer included the monitoring of patients on the ward and prescribing medicines. They were responsible for taking blood samples and inserting or removing patient cannulas and catheters.
- The resident medical officer cover was sufficient to meet patient needs because the majority of patients were deemed to be low risk and did not have complex needs.
- The resident medical officers were trained in advance life support and safer prescribing.
- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists who were mainly employed by other organisations (usually in the NHS) in substantive posts and had practicing privileges with Fulwood Hospital.
- The consultants and anaesthetists were responsible for their individual patients during their stay in hospital. Patient records showed that consultant reviews were carried out daily.
- As of 1 May 2018, there were 123 doctors practicing at the hospital under privileges. From October 2015 to September 2016, 30 consultants carried out more than 100 procedures and 54 consultants carried out between 10 and 99 procedures. Sixteen consultants carried out no procedures during this period. There were provisions in place to review the scope of practice and competencies of consultants who did not work regularly in the hospital.

Records

- The hospital had a medical records management policy that set out the responsibilities of all staff members in the creation, handling, storage and destruction of records. It also detailed standards for confidentiality and access rights to records.
- The hospital used paper based records which were securely stored in each area we inspected.
- We looked at the records for nine patients. Records were well structured and legible.

- Patient records included appropriate risk assessments for falls, venous thromboembolism, pressure care and nutrition.
- The hospital carried out quarterly medical records audits where 10 sets of patient records were examined in detail.
- A theatre medical records audit, carried out in May 2018, showed an average overall compliance of 92% (an amber rating).Fifty-seven of the 69 areas examined in the audit scored a compliance rate of 100%.Two areas received a compliance rating of 80-99% and ten areas received a compliance rating of less than 80%.
- Examples of the medical record audit that had received a low compliance rating, requiring improvement were: a signed copy of the consent had been given to the patient; evidence that the intended benefits of the procedure had been discussed with the patient; evidence of information that had been provided to the patient; evidence of risks being discussed with the patient; the anaesthetic record containing date, time and signature, the name of the surgeon, anaesthetist, operation and urgency and the consultant's signature.

Medicines

- The hospital had a service level agreement in place with the local NHS acute trust to provide pharmacy services. The hospital had access to a pharmacist and pharmacy technician on weekdays.
- The pharmacy technician topped up stored medicines to designated levels once a week.
- There was a medicines management policy in place which provided guidance for prescribing and administration of antibiotics and other medicines.
- We saw that medicines required for patients were readily available. They were stored in a secure room in secure cabinets.Medicines had been stored tidily and in separate cupboards according to use. The emergency drugs drawer was clearly labelled.
- In one of the cupboards, six unboxed blister packed trimethoprim 200mg were being stored behind two boxes of metronidazole 400mg rather than with the boxed trimethoprim. There was a risk that a clinician could have picked them up and administered them to a patient thinking they were a different drug. The concern was raised with the ward sister and the tablets were immediately removed from the cupboard and discarded.
- All the medicines that we saw were within the manufacturers' expiry dates.
- Staff carried out daily checks on controlled drugs which were checked by two registered nurses. We checked the stored controlled drugs and found that they had all been correctly reconciled.
- Medicines that required storage at temperatures below eight degrees centigrade were appropriately stored in medicine grade fridges. We saw that fridge and room temperatures were checked daily to ensure that they were stored at the correct temperatures. We saw no instances where the temperature had been out of range.
- There was a separate blood fridge where there was always a stock of two units of O negative blood. These were changed around every three weeks if they had not been used. Stocks of blood were obtained from the local acute NHS trust.
- There was an anaphylaxis shock kit and a hypoglycaemic crisis box stored in the clean utility room. We saw that both were in date and the contents were regularly checked.
- There was also a medical oxygen cylinder in the room stored in a bespoke wall unit. This was within the supplier's expiry date and contained sufficient levels of oxygen for use in an emergency.

Incidents

- Incidents were reported by staff using an electronic incident reporting system. Staff we spoke with understood their responsibility to report incidents and could give examples of when they had done this.
- The hospital reported a total of 163 incidents from April 2017 to March 2018 of which 137 were clinical incident and 26 were non-clinical incidents. One hundred and thirty-two clinical incidents were classed as causing no or low harm with five incidents classed as causing moderate harm.
- We reviewed six clinical incidents for the period January to March 2018 all had a root cause analysis and action plan in place.

- We saw that, following an incident that occurred in 2017 the hospital now had a stamp that they used in the patients notes if they were at risk of developing an acute kidney injury (AKI).
- All the staff we spoke to were aware of the incident reporting system and understood their responsibility to report incidents. Incidents were reported through an electronic system.
- Lessons learnt were shared with staff in team meetings, team briefings and discussed in their daily safety huddles.
- All staff we spoke with were aware of the duty of candour and the principles of being open and honest.
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- From June 2017 to May 2018, the hospital reported one incident classified as a never event. This related to a patient who had wrong site surgery. We saw that the incident had been reported appropriately and a root cause analysis investigation had been undertaken. Duty of candour had been carried out with the patient where the hospital apologised and explained what had gone wrong. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- The duty of candour arrangements was explained in the hospital complaints procedure. Staff were aware of duty of candour and about being open and transparent when things went wrong.
- The hospital had submitted five serious incident reports from June 2017 to May 2018.These reports were reviewed by the Greater Preston CCG Serious Incident Review Panel. They were all closed and there were no serious incidents outstanding for review. The serious incidents reported included a patient death with 30 days of receiving surgery; a post-operative bleed that resulted in the patient being admitted to the NHS trust for further surgery; a respiratory difficulty in recovery; wrong-site surgery and a post-operative infection. We saw evidence that lessons had been learned from these incidents and the hospital was reporting serious incidents appropriately.

Safety Thermometer (or equivalent)

- The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harms and “harm free” care. It looks at risks such as falls, pressure ulcers, blood clots and catheter acquired urinary tract infections.
- Information relating to the safety thermometer was displayed in the hospital.
- There had been one case of hospital acquired venous thromboembolism from June 2017 to May 2018.We saw that the hospital was using anti-embolism stockings to reduce the risk of blood clots.

Are surgery services effective?

Good

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

Evidence-based care and treatment

- The hospital’s policies and protocols were standardised by Ramsay Healthcare UK. They incorporated up to date recommendations and guidelines from the National Institute for Health and Care Excellence and other professional bodies, including the relevant Royal Colleges. Guidelines from the Association of Anaesthetists of Great Britain and Ireland were utilised in theatres for checking anaesthetic equipment.
- Any updated clinical guidance was reviewed by Ramsay Healthcare UK and fed into the hospital’s clinical governance and medical advisory committees. A process was in place to ensure that new guidance was applicable to the services that the hospital provided.
- Clinical policies and procedures which reflected national guidance were in place for staff to access on the hospital intranet. Care pathways for enhanced care and recovery were based on national guidance,

including from the National Institute for Care Excellence and the Royal College of Surgeons. Staff used integrated care pathways for surgical procedures such as for hip and knee replacements.

- Decisions to change processes were communicated to staff through emails, staff meetings and newsletters.
- The hospital participated in national benchmarking clinical audits within the Ramsay Hospital Group and had participated in a theatre review audit in May 2018 that included observational, operational and environmental aspects. The audit was used to benchmark all the hospitals against each other and promote best practice.
- The theatre audit carried out in May 2018 showed that there was an average score of 87% compliance (an amber rating) for the theatre observational audit and an average score of 78% compliance (a red rating) for the theatre operational audit.
- The hospital participated in the "react to red" campaign leading on pressure ulcer prevention and had two trainers at the hospital that also worked in collaboration with local hospitals.The trainers educated staff and the public on early recognition of pressure ulcers.

Nutrition and hydration

- The hospital had a nutrition and hydration corporate competency and participated in a nutrition and hydration audit within the patient journey audit. A theatre audit, carried out in May 2018 showed that all records examined contained a completed fluid balance chart with records of fluids administered, blood loss and urine output.
- Patients were assessed pre-operatively and as inpatients using the malnutrition universal screening tool. This is a five-step screening tool, used to identify adults who are malnourished, at risk of malnutrition or obese and can be used to develop an appropriate care plan.
- Patients had their nutritional needs assessed during pre-operative assessments. The hospital admitted patients with minimal waiting times to surgery to minimise the length of time that patients were "nil by mouth".
- The hospital catering department provided meals to inpatients and the chef catered for patients' individual needs by providing meals in accordance with their preferences, food allergies, medical or religious needs.
- The hospital had been given a five-star rating for food hygiene from the local authority environmental health department the day before our inspection.
- Patients tolerance to food and fluids was assessed in a follow-up call to the patient 48 hours post-discharge and further assessments and advice were made available if required.
- We saw that patients were regularly offered drinks and food, as required and patients we spoke to gave very positive feedback about the food they had whilst in the hospital.
- The recently published Patient-led Assessments of the Care Environment assessment 2018 showed that the overall ward food score given by patients was 96. 9% positive, compared to a national average for England hospitals of 89.9%.
- The hospital was committed to health promotion about nutrition and hydration and had previously held a nutrition and hydration week and sugar and salt awareness week.
- The hospital was running a hydration campaign at the time of our inspection. This involved ensuring that patients completed their own fluid record. There were hydration records in each patient bathroom and toilet throughout the hospital, alerting them to the colour of their urine to encourage hydration. Tray mats on patient trays gave information to educate patients about nutrition and hydration. There was a patient kidney education board in the day case waiting area.

Pain relief

- Patients were assessed pre-operatively for their preferred post-operative pain relief and this was reflected in care plans.
- The hospital had a post-operative pain management policy and this included a pain score tool from one to ten to assess the patients' level of pain. The assessment considered current analgesia levels, non-verbal indicators and levels of discomfort.

- Patient records showed that patients received the required pain relief and they were treated in a way that met their needs and reduced discomfort.
- Patients were given take home pain relief medicines and information on how to manage pain symptoms following discharge from hospital.
- Patients we spoke to told us that they received good support from staff and pain relief was given to them as and when required.
- Surgical patients were routinely contacted 48 hours after discharge and asked if their pain was at an acceptable level.Advice could be given by a qualified nurse.
- The hospital had held a pain management study day in March 2018 and a further study day had been arranged for September 2018.

Patient outcomes

- The hospital participated in national audits to measure patient outcomes. These were the National Joint Registry; Breast Implant Register; British Spinal Register (which had commenced on 1 July 2018); patient reported outcome measures for hip and knee replacements and the International Consortium for Health Outcomes Measurement. The hospital had recently also started to supply data for cataract patient reported outcome measures and were working with stakeholders to ensure that post-operative data was collected to ensure that they collected qualitative and quantitative data going forward.
- The National Joint Registry collects information on hip, knee, ankle, elbow and shoulder joint replacement surgery to provide an early warning of issues relating to patient safety. National Joint Registry data showed that, in 2017, the hospital completed 741 completed operations for hips, knees and shoulders with 100% National Joint Registry consent rate.In 2018, the year to date figures at September 2018 showed that the hospital had completed 440 completed operations for hips, knees and shoulders, with a 97% National Joint Registry consent rate.
- Patient reported outcome measures are published by NHS England for providers on a quarterly basis. Patients undergoing elective inpatient surgery for hip and knee replacements, funded by the NHS, are asked to complete questionnaires before and after their operations, to assess improvement in health as perceived by the patients themselves.
- Patient reported outcomes measures data showed that, from April 2017 to March 2018 there were 663 eligible hospital episodes and 377 pre-operative questionnaires returned. This was a participation rate of 56.9% against an England average of 84.2%.Of the 303 post-operative questionnaires sent out, 238 were returned. This was a response rate of 78.5% and was higher than the England average of 66.4%.
- Data showed that the percentage of patients with improved outcomes following hip or knee replacements in this period were in line with, or better than the England average except for the EuroQol-visual analogue scales index for knee replacements that measured the current state of the patient's self-reported general health pre and post-operatively. The hospital had recognised this and results were discussed at the monthly orthopaedic multidisciplinary team meeting.
- From April 2017 to March 2018 there were 14 unplanned inpatient transfers to another hospital. The assessed rate of unplanned transfers (per 100 patient attendances) was 0.1%.
- From April 2017 to March 2018 there were 18 cases of unplanned readmissions to the hospital within 28 days of discharge. In the same period, there were 11 cases of unplanned returns to the operating theatre.

Competent staff

- The hospital had an induction and training policy that included inductions for bank and agency staff. The policy set out the responsibilities of all staff members, including new employees.
- The hospital had a continuing professional development policy and staff were expected to maintain an up-to-date continuing professional development file.
- Staff had opportunities to undertake additional formal learning activities through the Ramsay Healthcare UK Academy and through the Ramsay Healthcare UK Scholarship Fund.
- Staff had not all had annual appraisals. The appraisal year ran from January to December. Records showed

that from January to May 2018, in inpatient departments, 41% of nursing staff; 25% of health care assistants and 6% of other staff had so far received an annual appraisal. In the previous year, a total of 34% of nursing staff; 85% of health care assistants and 15% of other staff had received an appraisal. In theatres 33% of nursing staff and 40% of operating department practitioners and health care assistants had received an appraisal from January to May 2018.This was already an improvement on the previous full year when only 33% of nursing staff and 21% of operating department practitioners and health care assistants had received an appraisal.

- The hospital provided updated appraisal figures following our inspection that showed that, at November 2018, in inpatient departments, 79% of nursing staff and 87% of health care assistants had received an annual appraisal. In theatres 83% of nursing staff and 93% of operating department practitioners and health care assistants had received an appraisal.
- There were procedures in place to review the suitability to practice of the resident medical officer. The matron had responsibility for reviewing the training and experience of the resident medical officer, prior to this being approved by the medical advisory committee.
- The resident medical officer undertook a period of supervised induction upon appointment and was required to undertake mandatory training courses through their agency on an annual basis. They were required to renew their certificate to practice every four years. They also undertook an annual appraisal and reviewed development objectives.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the ward and theatres. Nursing staff told us that they had a good relationship with consultants and the resident medical officer.
- Patient records showed that there was routine input from nursing and medical staff and allied health professionals, such as physiotherapists.
- Theatre staff carried out daily "safety huddles" to ensure that all staff had up-to-date information about risks and concerns.
- There was daily communication between the pre-operative assessment staff and ward and theatre staff so patient care could be coordinated and delivered effectively.
- There was a bi-weekly orthopaedic multidisciplinary meeting attended by consultants, theatre and therapy staff.
- There was good communication between the hospital and the local NHS trust. We were told that 80% of the consultants working in the hospital also worked at the local NHS trust. On occasions, where patients needed to be transferred to the local acute hospital for urgent care, nursing staff would continue liaison with the patient and medical staff for any further follow-up required.
- The hospital had private patient manager who communicated with patients' GPs.
- Discharge planning within the hospital commenced at the outpatient appointment, with the patient being given an information pack about admission and discharge. Most hip and knee replacement patients followed the 48-hour pathway rather than the five-day pathway from admission to discharge. Nurses liaised with district nurses and social care services to ensure that patients had the support they needed when discharged.

Seven-day services

- Routine surgery was performed in the theatres during weekdays and on Saturday. The ward accommodated patients seven days a week and staffing levels were suitably maintained during out-of-hours and weekends.
- The resident medical officer provided out-of-hours medical cover at the hospital 24 hours a day, seven days a week and had full access to consultant surgeon and anaesthetist contact details.
- Patients were seen daily by their consultant, including on weekends.
- The hospital practicing privileges policy required consultants to provide 24 hour on-call cover for patients post-operatively and to be within a 30-minute drive of the hospital. When a surgeon was not going to be available they were required to have "buddy cover" from another surgeon with the same speciality. Consultant

anaesthetists were also required to be within a 30-minute drive of the hospital and remained responsible for the patient for a period of not less than 24 hours post-surgery.

Health promotion

- Patients were encouraged to eat healthily whilst an inpatient at the hospital. The chef could advise on healthy dietary options and diet options for those with additional medical needs.
- Three staff members had been carrying out basic life support training in local schools and promoting health and basic first aid.
- Health promotion for staff was also in place with a healthy eating campaign in place, access to Pilates classes offered by the on-site physiotherapists and smoking cessation advice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a consent policy and this set out that consent to care and treatment was on a decision-specific basis.Staff needed to consider a person's capacity to understand the information being given, the ability to retain the information in order to consider this and make and communicate their decision about consenting to treatment.
- The consent policy was in date, was in line with current national guidance and was next due to be reviewed in 2019.
- The hospital carried out quarterly medical records audits where 10 sets of patient records were examined in detail. The last audit, carried out in June 2018 showed 100% in compliance with all areas around the consent process for eight of the records. One case did not have all procedures on the consent form written in terminology without abbreviation or jargon. In another case, a signed copy of the consent form had not been given to the patient.
- Staff had the appropriate skills and knowledge to seek consent from patients. Staff were clear on how they sought verbal informed consent and written consent before providing care or treatment.
- There was a two-stage process in obtaining written consent. This ensured that informed consent was given throughout the consent process. Stage one of the consent process was carried out by the consultant during the consultation and then stage two was carried out on the day of treatment. During both stages, risks and benefits were discussed and all patients were asked if they understood the plan of care. Additionally, we observed during the consultations that all patients were given time to absorb and ask questions about their treatment.
- The consent policy contained specific statements about patients receiving cosmetic surgery in line with General Medical Council and Royal College of Surgeons guidance and included a two-stage consent process so that patients had a two-week cooling off period between the stages to allow the patient to reflect on the decision. Where this period was not available, reasons were recorded in the patient's medical record.
- The hospital had a Mental Capacity Act and Deprivation of Liberty Safeguards policy which staff were aware of.
- Training in the Mental Capacity Act and Deprivation of Liberty Safeguards was available to all staff. A training course for staff had been held on 8 August 2018 and a further course was due to be held in September 2018.
- Patients that lacked capacity were identified during their pre-operative assessment and staff could seek advice from other professionals in order to complete capacity assessments. Staff told us that the majority of admitted patients had the capacity to make their own decisions. Staff were aware of best interest decisions and involving the patient's representatives and other healthcare professionals where the patient lacked the capacity to give informed consent.

Are surgery services caring?

Good

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

Compassionate care

- Patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner. Staff spoke with patients in private to maintain confidentiality.

Good

Surgery

- We spoke with three patients and one previous patient. All of them said staff were kind and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained.
- Comments received included: "I thought the service was fantastic." "staff always introduce themselves" "staff are kind and treat me with dignity and respect". "the anaesthetist was absolutely brilliant. "I have no negatives about the service".
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The test data for all patients from December 2017 to May 2018 showed an overall score of 99.8% of patients who would recommend the hospital to friends and family. In all but one month the score was 100%. Response rates were between 39% and 100%.
- The Private Healthcare Information Network collects information from private healthcare providers about hospital information and patient feedback. Data on the website indicates that 98% of patients felt they were given enough privacy when discussing their condition or treatment and 98% of patients felt they were treated with respect and dignity.
- Patients attending appointments booked in at the hospital's main reception desk. Although the area was open and public staff communicated sensitively and appropriately. The seating in the reception area was far enough away from the reception desk to minimise the risk of conversations being overheard.
- Chaperones were available where patients requested this. Notices were displayed in clinic and reception areas regarding chaperones.

Emotional support

- Patients told us that their treatment and any procedures were thoroughly explained to them and they felt reassured and supported throughout their stay in the hospital.
- Patients had an allocated nurse who could support their understanding of care and treatment and ensure that they were able to voice any concerns or anxieties. Every patient received a daily visit from the ward manager or matron and could voice any concerns or give feedback to them.
- Patients were supported on discharge with information on how to manage their specific conditions. Patients received a post-discharge follow-up call to offer advice and check on pain levels.
- The hospital had a number of policies to address the emotional care needs of patients, including a bereavement policy and palliative care policy.
- Data from the Private Healthcare Information Network indicated that 85% of patients felt able to talk to staff about their worries or fears and 76% of patients felt that they were told who to contact if they were worried about their condition or treatment.

Understanding and involvement of patients and those close to them

- Patient records included pre-admission and pre-operative assessments that considered individual patient preferences.
- Patients told us that they were kept informed about their treatment and staff were clear at explaining their treatment to them in a way they could understand. They also spoke positively about written information, such as leaflets specific to their treatment.
- Data from the Private Healthcare Information indicated that 93% of patients felt involved in decisions about their care and treatment and 79% of patients felt they were told about medication side effects to watch for.

Are surgery services responsive?

Good

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

Service delivery to meet the needs of local people

- The hospital worked with other providers and stakeholders to plan and deliver its services to meet the needs of local people. A quality improvement manager met with the local clinical commissioning group to review the hospital's contract, the services offered and identification of local health trends. Meetings included discussion of progress towards meeting the hospital's agreed Commissioning for Quality and Innovation programme.

- A private patient manager was a link between the local primary care services and the clinical commissioning group.
- The hospital had plans to expand at the time of our last inspection with the addition of an extra theatre. These had since been reviewed and revised and the business plans were now for an expansion of the car parking space and additional waiting areas by utilising a courtyard area.
- Some patients and relatives told us that car parking could be an issue with the car park being very full at certain times of the day. However, parking was free for patients and visitors to the hospital.
- Patients had an initial consultation to determine whether they needed surgery and this was followed up with a pre-operative assessment. Where a patient was identified as needing surgery, staff could plan for the patient in advance so they did not experience delays in their treatment when admitted to the hospital. Pre-operative assessment appointments were available in the evenings and at weekends.
- As part of the pre-operative assessment process, patients with certain medical conditions were excluded from receiving treatment at the hospital. The hospital had an exclusion criteria document. This listed medical conditions that would exclude patients from receiving surgery at the hospital.
- Patients with a body mass index of greater than 40 were reviewed by the anaesthetic service to ensure that they were appropriate for surgery and their medical questionnaires were reviewed by a senior nurse, matron and pre-operative lead to ensure that they were appropriate for surgery. Patients may have been rejected at this point due to other co-morbidities.

Meeting people's individual needs

- The service took account of patients' individual needs.
- The entrance to the hospital was accessible to people with limited mobility. There was ramp access and automatic doors.
- The hospital reception desk was staffed by two members of the reception staff to ensure that patients arriving at the hospital were directed to the appropriate department in a timely manner. A hearing loop was in place in the reception area for those people with a sensory impairment.
- Accessible toilets for patients living with a disability were located within the main reception area.
- All services for patients were located on the ground floor of the building.
- The Accessible Information Standard requires healthcare providers to make information available to patients who have information or communication needs relating to a disability, impairment or sensory loss in a way that they can read, receive or understand. The hospital had a number of measures in place to make information available to patients with information or communication needs.
- Patients' individual needs were attached to their patient record on a communications slip. All staff were therefore aware of the patient's needs as they progressed through the treatment pathway.
- The service had a ward diary in which any individual patient needs could be recorded in preparation for patients who were due to be admitted. For example, the requirement for a diabetic diet, the need for a pressure mattress or hoist
- Patient information leaflets were available within departments and included "easy read" leaflets for patients with learning disabilities. Patient information leaflets about specific procedures were available to patients and given to patients during consultations and pre-operative assessments.
- Language line interpreter services were available to use for patients whose first language was not English. Healthcare leaflets about informed consent could be downloaded in different languages.
- Hospitals patient-led assessments of the care environment assessments provide a framework for assessing quality against common guidelines. Part of the assessment is whether the premises are equipped to meet the needs of people living with dementia or with a disability. The hospitals patient-led assessments of the care environment (PLACE) score for the period 21 March

2018 to 4 June 2018 for dementia was 85.2% and was better than the national average for this period of 77.6%.This was also much better than the score at the time of our last inspection in 2016 which was 71%.

- The hospitals patient-led assessments of the care environment (PLACE) score for the period 21 March 2018 to 4 June 2018 for disability was 91.8%. This was better than the national average for the same period which was 83.2% and was much improved from the score at the time of our last inspection which was 83%.
- The service had a dementia package in place to meet the needs of patients living with dementia. Patients were offered longer pre-operative assessment appointments, were introduced to a named nurse and were offered pre-admission visits to familiarise themselves with the ward area. The same was offered to patients with learning disabilities.
- A dementia box was available for staff to decorate a room in which a patient would be admitted. This was a positive initiative as the environment limited space to have a designated dementia area.
- The hospital had a "This is me" booklet for relatives and carers to provide details of patients' personal preferences and needs.
- Staff were supported in caring for patients who were living with dementia by way of an e-learning package for this purpose.
- Mandatory training for staff included training on equality and diversity. Records showed that, at end of May 2018, 91% of theatre staff and 100% of wards staff had undertaken this training.

Access and flow

- From June 2017 to May 2018 there were 1759 inpatient discharges from the hospital. This was a total of 4% of all patients treated by the hospital. In the same period there were 6,493-day case discharges. This was a total of 16% of all patients treated by the hospital in this period.
- Approximately 89% of inpatients and day case patients treated at the hospital were NHS funded patients. The remaining 11% were self-funded and privately insured patients. The proportion of patients that stayed overnight by patient group was 20% of NHS funded patients and 30% of non-NHS funded patients.
- The hospital had a waiting list and management of patients accessing NHS treatment policy. The principles of the policy incorporated the NHS 18-week referral to consultant-led treatment pathway. The hospital submitted data to NHS England about referral to treatment times monthly.
- The referral to treatment time figures, published by NHS England for June 2018, show that the hospital was around or above the standard for England of at least 92% of patients to be admitted and treated within 18 weeks of referral for six out of eight surgical specialities. These were urology (93.3%); trauma and orthopaedics (94.9%); ear, nose and throat (100%); gastroenterology (93%); gynaecology (100%) and other surgery (91.3%).
- General surgery (79%) and ophthalmology (14.7%) were below the England average for referral to treatment within 18 weeks. Only 11 out of 75 ophthalmology patients who were admitted for surgery were treated within 18 weeks in June 2018. However, ophthalmology procedures were the most common surgical procedure carried out at the hospital with double the number of procedures as the next most common procedure over a year. Many patients were received from the local acute trust who had a backlog of patients for ophthalmology procedures.
- The average waiting time for patients for all procedures to admittance was 11.4 weeks.
- Referral to treatment time data for June 2018 for non-admitted patients showed that 99.6% of patients were treated within 18 weeks of referral and the average waiting time was 3.3. weeks from referral. This was above the standard for England that was 92%.
- During June 2018, the hospital added 896 new referrals to be treated within 18 weeks of the date they were referred.
- Staff monitored the electronic referral system daily to ensure referrals were dealt with in a timely manner. The hospital's operations manager told us about the 'Fulwood cancellations project', which had also helped to reduce admission cancellation rates.
- Senior managers told us that the provider head office sent a weekly elective wait monitoring report so that wait times could be monitored to prevent 18-week referral to treatment breaches. We were told that the

data would be cleansed to remove any patients who no longer required treatment and any patients approaching the 18-week breach would have their admission dates expedited where possible.

- Patients we spoke with said they were happy with the waiting period before their admission for surgery and they all told us that they had been offered their admission date much sooner than expected.
- There was daily communication between the pre-operative assessment staff and ward and theatre staff to manage patient flow.
- Discharge planning was covered during pre-assessment to determine how many days the patient would need to be on the ward as well as ascertaining whether patients were likely to require additional support at home when they were discharged.
- Discharge arrangements were covered in detail in the patient journey policy. The responsible nurse went through discharge arrangements with patients and ensured the patient understood prescribed medications; dates of follow-up appointments; arrangements for any community nurse follow-up; transport arrangements; social care requirements and equipment requirements. Consultants had overall responsibility for discharging the patient when they were fit for discharge.
- Discharge summary letters were sent to GPs within 24 hours of the patient discharge.
- Day case patients that were assessed as not being fit for discharge following surgery were kept on the ward for overnight care if required.
- There were 8252 visits to the operating theatre from June 2017 to May 2018.Hospital data showed that there had been 416 cancelled operations during this period. This was 5% of all procedures. Of the cancelled procedures, 100% of patients had been offered another appointment within 28 days of the cancelled appointment.
- We asked for a breakdown of the reasons for the cancellations. Many of the cancellations were due to consultants being on annual leave, sick or on call at the acute trust. The highest number of cancellations was in January 2018 when 110 procedures were cancelled. Ninety-six of these cancellations were due to the absence of the consultant due to sickness, being on call or on leave. From October 2017 to January 2018 47 procedures were cancelled due to equipment failure in the endoscopy suite. From June 2017 to May 2018 only 19 procedures were due to the patient being unwell on the day of the elected surgery. No procedures were cancelled due to the patient not attending.

Learning from complaints and concerns

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff.
- Information on how to give feedback and raise complaints was visibly displayed in the areas we inspected. Patient feedback leaflets were available in all patient areas to encourage immediate feedback.
- The hospital had a management of patient complaints policy. This was in date and was next due to be reviewed in November 2019.The policy covered the complaints management process; dealing with formal and informal complaints; compensation and legal action; and the management of vexatious complainants.
- The policy stated that complaints would be acknowledged within two working days and investigated and responded to within 20 working days. Where the complaint investigation had not been completed with 20 working days, staff were required to send a holding letter explaining why a response had not been sent, followed by further holding letters every 20 days until the complaint was resolved.
- When patients or relatives were not satisfied with the response to their complaint, they were given information on how to escalate their concerns to the independent healthcare sector complaints adjudication service for non-NHS patients or to the parliamentary and health service ombudsman for NHS patients. From June 2017 to May 2018 no complaints were referred to the independent sector complaints adjudication service or parliamentary and health service ombudsman.
- The general manager was responsible for monitoring and oversight of the complaints process.
- The provider had an electronic system which was used to record complaints, investigations, further actions and outcomes.

- The service made efforts to resolve complaints informally at the earliest opportunity, escalating matters to more senior staff where the complaint could not be resolved immediately. Staff had received customer service training to better enable them to confidently resolve complaints as they occurred.
- From June 2017 to May 2018, the hospital received 44 complaints. This included complaints for outpatients, diagnostics and surgical services. This was a slight increase on the number received in the previous year. The assessed rate of complaints equated to 0.5 per 100 inpatient and day case attendances.
- The senior management team was informed about all complaints received. They were discussed at heads of department meetings and any themes emerging were identified. Complaints were reviewed at monthly senior management and head of department meetings and at the medical advisory committee and clinical governance committee meetings.
- We reviewed minutes from these meetings and saw that complaints and concerns were a standard agenda item.
- Lessons learnt and actions taken or required were disseminated by departmental managers to staff at team meetings

Are surgery services well-led?

Good

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

Leadership

- The hospital was led by a general manager, who was supported by a senior management team, consisting of the matron, finance manager and the operations manager. The general manager had been at the hospital for several years but had recently been managing another hospital in addition to Fulwood Hall as another general manager had left.
- There was now an operations manager at each hospital site. They had previously been reduced in number to work across two sites but, following consultation with clinical commissioning groups, the decision had been made to have an operations manager at each site again.
- The surgical ward was led by a ward manager. The theatre manager was responsible for the day to day management of theatres and had been in post for a short time. Theatre staff spoke positively about the theatre manager and their deputy.
- The senior management team understood the challenges to the hospital and the local healthcare economy and were ensuring that the hospital was an integral part of the local healthcare economy. For example, the matron was the lead on a local quality group. The private patient manager had arranged for consultants to give lectures in local GP practices, for example, on arthritis. We were told that this was often the first time that the GP had met the consultant and helped to build bonds with the local GP network.
- Managers were encouraged to attend national conferences to ensure that they could share best practice and keep up to date with changes to procedures across Ramsay Healthcare UK.
- The last staff survey for the hospital (taken between January and March of 2017-2018) was positive about the leadership in the hospital, at senior management and local leadership level. For example, staff said that hospital managers “know how things really are” (a score of 3.23 out of 5); “there is strong leadership at the hospital” (3.55 out of 5); “the senior management team role model the Ramsay way” (3.62 out of 5) and “the senior management team take the views and opinions of staff seriously” (3.36 out of 5).
- We observed that the senior management team took an active interest in all staff activity at the hospital and regularly rewarded staff who had gone above and beyond.
- Staff in focus groups were consistently positive and appreciative of the leadership, within Ramsay Healthcare UK and at Fulwood Hall Hospital Senior staff we spoke to told us they had good support from Ramsay Healthcare UK leaders also. There was a new chief executive officer and chief operating officer in place within the organisation and managers told us that their focus was on quality, culture and safety. They reported that they were heavily investing in management training, a leadership programme and looking after people training.

- Staff told us that the hospital leadership team was approachable and visible. The matron had an "open door" policy and was accessible to nursing staff and other staff on a day to day basis.
- Staff who said that their manager provided support when they needed it scored 3.84 out of 5 in the staff survey.

Vision and strategy

- The hospital followed the Ramsay Healthcare UK vision at a local level. That was "to establish strategic partnerships with local, national and global stakeholders to be the trusted provider of choice to deliver excellent, affordable care to all patients with the best team in the sector".
- The hospital had a five-year strategy, aligned to the Ramsay Healthcare UK five-year strategy. The five-year strategy was called "The Heart of our Plan". The projected achievement was to "become the number one healthcare provider in the UK and exceed £1 billion revenues by 2023, establishing the brand and quality reputation as the number one provider for payers, clinical excellence and for the consumers."
- The strategy was launched at the end of June 2018 and general managers were expected to communicate any details of the strategy to staff.
- We saw that the Ramsay Healthcare UK strategy was not yet fully embedded within the organisation and was difficult for staff members to tell us what the mnemonic stood for.
- We saw during inspection the vision and strategy was communicated to staff through staff newsletters and staff forums and through departmental meetings, and in visual displays in the hospital's public areas.
- The local and national strategy was called "The Heart of our Plan", Heart being a pneumonic and standing for: Hospital expanding into out of hospital care; Enhancing the core operating model; Accelerating projects and new partnerships; Reaching beyond traditional models; and Thinking big and getting to scale. Managers reflected that previously the hospital strategy had been somewhat vague and staff felt disconnected from this. The new strategy had recently been introduced and staff we spoke with were not yet fa-miliar with the full context of the strategy, with some staff describing this as "early days".

Culture

- We observed that there was a culture of openness and honesty at the hospital with a strong focus on patient-centred care. Staff had a positive and enthusiastic attitude towards the hospital and reported positive experience of working there.
- The staff survey showed positive results in staff saying that they felt that their concerns were listened to; that they felt safe, secure and supported to do their job; and there was a willingness to try and change new initiatives.
- Managers reported that there had been a shift to a more positive culture within the last two years as staff had previously been unsettled following a redundancy programme.

Governance

- The hospital had reviewed its governance arrangements since the last inspection and this was now clearly established. The hospital was led by the senior management team who met monthly. The senior management team was supported by the medical advisory committee, made up of consultant representatives from each surgical speciality. The medical advisory committee received reports from the clinical governance; infection prevention and control and health and safety committees and the heads of departments.
- There was also a blood transfusion committee though this rarely convened as the hospital only carried our two or three blood transfusions in any one year.
- Minutes from the last three medical advisory committee meeting minutes demonstrated that key governance areas were discussed including incidents, complaints and practising privileges.
- Heads of departments met monthly and discussed incidents, complaints and new initiatives. We reviewed minutes form these meetings and saw that there were standard agenda items and action plans arising.

- Staff at all levels were clear about their roles and reporting lines.
- The hospital had an established practicing privileges process for consultants working within the service. These are an authority granted to a physician by a hospital governing board to provide patient care in the hospital. The medical advisory committee had oversight of the process. The hospital received a monthly report on any parts of a consultant's practicing privileges that were due to expire. Consultants were asked to immediately supply up to date paperwork or their practising privileges were suspended. Practicing privileges and scope of practice were reviewed on an annual basis.
- Checks were made on the scope of practice of consultants and the number of procedures of a certain type carried out by that consultant. If the numbers of certain procedures carried out within the hospital was low, the consultant would be asked to provide evidence that they had carried out that procedure on a regular basis elsewhere to ensure that they had maintained the competencies to continue to carry it out. The hospital considered suspending procedures by certain consultants who could not demonstrate that they carried out those procedures regularly.
- The practicing privileges process was thorough. Consultants applied to practice at the hospital and where there was a demand, they were interviewed by the general manager and matron to review their curriculum vitae, work history and to ensure that the services they were applying to provide were within their current scope of practice. Checks were undertaken for disclosure and barring, identity and a review of their curriculum vitae and qualifications and registrations. Consultants had to submit a practicing privileges application along with copies of training certificates, references and evidence of indemnity insurance. Practicing privileges were signed off by the medical advisory committee and then by the group medical director. Practising privileges and scope of practice were reviewed annually.
- The hospital also monitored the medical indemnity insurance for consultants and they were required to provide evidence of renewed insurance upon expiry of their policy. Consultants were suspended from working if they did not produce this.
- On review of the medical staff indemnity insurance documentation, four staff had been suspended from carrying out any activities until they could supply the provider with their insurance details. A further nine staff were currently out of date but within the four-week grace that the provider gives for them to supply their documentation.
- Managers told us that they had worked with staff on recognising and challenging the scope of practice of consultants and their operating assistants. They gave an example of an assistant to a consultant who was not recognised. This was challenged and, as they had no practicing privileges within the hospital, they were turned away.

Managing risks, issues and performance

- Hospital and departmental risks were identified in the hospital's risk register, which was reviewed at clinical governance committee meetings. The highest rated risk was of unanticipated events, following a recent incident of aggression and abusive behaviour to staff. This had occurred at Fulwood hospital and another Ramsay hospital, with learning from this shared across Ramsay organisations UK wide.
- We saw that the management of risk had significantly improved since our last inspection and that manager had a good oversight of risks and there were actions in place to mitigate risks.
- The risk register was on a useable spreadsheet which had been designed by the Ramsay Corporate Group.
- Any risk with a residual risk of nine or above, after actions had been taken to mitigate the risk was added to the corporate spreadsheet.
- Senior managers talked through the risks and had a good oversight of them. Departmental managers "owned" the risks associated with their own department.
- Managers told us that the highest risk at the time of our inspection was unanticipated events.
- Staff were aware how to escalate key risks that could impact on patient safety, such as staffing and bed capacity issues.There was daily involvement by the ward and theatre managers to address these risks.

Good

Surgery

- We observed the major incident folder which was located in the reception area. All staff we spoke to were aware of the folder and their roles if it needed to be actioned. There have been no major incidents at the provider in the last twelve months.
- The hospital investigated serious Incidents, incidents and complaints with root cause analysis and team approach. Lessons learned were shared following incidents both internally and externally.
- Communications were in place for sharing central alerting system alerts via the governance committee and MAC meetings.
- The service had a clinical audit system to ensure that clinical audits were carried out at regular intervals and results were monitored, analysed and action plans were produced to address any failures in compliance.

Managing information

- A range of performance reports were available to the senior management team and heads of departments that were generated from various systems to provide assurance on performance.
- The service used an electronic system to report and allocate staffing levels and appropriate skill mix. This system also produced reports on sickness rates.
- The risk management system produced data on incidents, complaints and compensation claims. It could highlight performance issues and areas for improvement.
- Managers also had access to reports on practicing privileges, performance review data and staff completion of mandatory training.
- There were effective arrangements in place for the submission of data and notifications to external bodies, as required.

Engagement

- The hospital gathered feedback from patients in a number of ways, the “we value your opinion” leaflet, the NHS friends and family test leaflet and patient satisfaction tests that were fed into national data groups. The hospital had used an internet based response form to gather patient satisfaction feedback, however this was not proving to be accessible for patients and had been replaced by “We value your opinion” leaflets.
- There was a staff engagement group where staff were encouraged to put forward ideas for improvements.
- Nursing staff had been working with local schools offering basic life support training
- The hospital participated in the Ramsay Healthcare UK customer service excellence programme. Patients and staff could nominate individuals for recognition through this scheme.

Learning, continuous improvement and innovation

- The hospital was proactive in integrating with the local healthcare economy and had been working with GPs by offering consultant-led lectures on common conditions requiring surgical intervention.

Good

Outpatients

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients services safe?

Good

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

Mandatory training

- See information under this sub-heading in the surgery section.
- Mandatory training for all outpatient staff was 100%. The hospital did not supply departmental figures, however we reviewed a management spreadsheet in outpatients which demonstrated 100% compliance.
- We spoke to staff regarding time given to complete training and were informed that they were given time to undertake e-learning and face to face learning.

Safeguarding

- See information under this sub-heading in the surgery section.
- There were two named registered general nurses in outpatients that were the safeguarding leads and four for the overall hospital .
- All staff in outpatients were trained to level two. Figures provided by the provider were a combined total, however we observed the training log in outpatients and compliance was 100%.
- We were informed of a safeguarding incident that had occurred in the previous 2 months and all policies and procedures were followed. The incident was reported promptly to the appropriate services to ensure the patient was kept safe. Staff informed us that having safeguarding leads at the hospital was an extremely positive step in keeping patients, their families and staff safe.
- We looked at five staff competency files and there was documented evidence that safeguarding training had been completed following NHS England guidance (Safeguarding Adults 2017).

Cleanliness, infection control and hygiene

- There was an infection control policy in place and the staff we spoke with were aware of their roles and responsibilities within this area.
- We looked at five staff competency files and there was documented evidence that they had all attended training in infection prevention and control
- All outpatients areas we visited were visibly clean and tidy. The outpatient reception area and all clinical rooms were cleaned first thing in the morning by the housekeeping staff and then the clinical rooms were cleaned again when the clinic finished by staff. We saw completed cleaning schedules to indicate when areas had been cleaned. The underneath of the sink within the female toilet was dirty, this was reported to management at the time and the area was cleaned immediately.
- In one of the clinic rooms there was a crack in the top of the sink and it also had an overflow hole. In addition, the examination couch although clean was ripped in a number of places which would make cleaning it effectively very difficult. We were informed post inspection that the panels on the couch had now been replaced.

Good

Outpatients

- Equipment throughout the department appeared to be clean and tidy. 'I am clean' green stickers were utilised to show what equipment had been cleaned. We observed in patient consultations that monitoring equipment was cleaned after each patient use.
- The provider carried out monthly spot check cleanliness audits and in June 2018 scored 100% in all criteria.
- Uniforms appeared clean and tidy on all staff within the department. All staff were arms bare below the elbow.
- There were hand sanitiser gel dispensers outside the entrance to outpatients and next to the reception desk. We observed both patients and staff using the gel upon entry to the department.
- Within the housekeepers' office there was information displayed on the wall and in files to determine which cleaning agents were to be used dependent on need.
- Clinical areas had flooring which was washable and compliant with Department of Health (DoH) HBN 00-10. The reception area was carpeted although there was no cleaning schedule for the carpeted area. Staff informed us that it was vacuum cleaned every day. If a patient was to vomit on the carpet, we were informed that they would absorb as much as possible with a continence pad and then clean with a cleaning and disinfectant fluid. This was not in line with the housekeeping policy which said that the carpet would be steam cleaned. Furthermore, the product used was only designed for light cleaning. This meant that the was an increased infection risk if a patient vomited. We were informed post inspection that carpets throughout the hospital are cleaned every six months using professional steam cleaning equipment.
- Staff informed us that for patients with suspected methicillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile (C. diff) or carbapenemase producing Enterobacteriaceae (CPE) a deep clean would be carried out.There were no incidents of either of these bacteria reported at the present time.
- We observed a surgical orthopaedic pathway which entailed a fully compliant screening process for methicillin-resistant Staphylococcus (MRSA) and carbapenemase producing Enterobacteriaceae (CPE).We also observed the CPE flowchart and toolkit which was fully compliant with national guidelines, gateway number 2013314.
- For patients with communicable diseases such as tuberculosis (TB) the toilets would have bleach poured into them and left for ten minutes before flushing so that it reduced the risk of the bacteria entering the sewage system. The room would also receive a deep clean.
- All chairs within the outpatient reception area were found to be wipeable, clean and fully compliant with Department of Health (DoH) HBN 00-09.
- There were good waste and sharps management in place. We observed sharps bins correctly labelled and assembled with the temporary closure in place which were fully compliant with Department of Health (DoH) HTM 07-01. Waste was appropriately separated and disposed of. In the sluice area a poster was displayed which demonstrated colour coded waste.
- We observed a good selection of nitrile gloves in all areas. Personal protective equipment (PPE) was available in the clinical rooms inspected. We observed staff using PPE appropriately. Curtains in all the clinical rooms and physiotherapy department were clean and in date.

Environment and equipment

- Fire exits were clearly signposted. Fire break glass points were observed at each exit that complied with BS EN 54-11 and review of all fire extinguishers within the outpatient department were in date with their annual service.
- Resuscitation trolleys were located in the corridor outside the sisters' office and clinic rooms. All contents including automated external defibrillator, suction and oxygen were in date and checked daily.
- Within the physiotherapy department, we observed that the ultra-sound machine had a comprehensive standard operating procedure for use and the equipment had been electrically tested within the year.

- Environmental checks were not carried out in the consultation rooms as drugs were not stored in them. However, we observed thermometers in the rooms and were informed that fans were available in warm weather.
- Emergency call bells and alarms were evident in the clinical rooms. All were checked on a weekly basis.
- We observed the use of safety needle devices and they were fully compliant with the directive 2010/32/EU, the prevention from sharp injuries in the hospital and healthcare sector.

Assessing and responding to patient risk

- Staff we spoke to were aware of the deteriorating patient and sepsis guidelines. There was no sepsis lead in outpatients but we were informed there was a sepsis lead for the hospital. Staff compliancy for sepsis training was 100%.A sepsis box was located in the store room located near the sisters' office.
- The resuscitation trolley was located outside the sisters' office. Daily checks were undertaken and recorded. We checked a sample of equipment within the trolley and all were within the manufacturers'' expiry dates and itemised on the equipment checklist.
- National safety standards for invasive procedures were in place and we observed an action plan that staff had signed to acknowledge that they have read and understood them.

Nurse staffing

- There were enough registered nurses and health care assistants employed within the department with the right skill mix, qualifications and experience to keep people safe and provide the right care and treatment.
- We were informed that bank staff were used but not agency staff. The bank staff used were all experienced within the department.
- On review of the nursing off duty there were no shifts that had gone below agreed staffing numbers.
- There were no vacancies at the time of inspection. The use of bank nursing staff as an average percentage in April 2017 to March 2018 was 29% and the average percentage for healthcare assistants for the same period was 43%.Although figures demonstrated a high use of bank staff, we were informed that this was due to clinic demand and there were no job vacancies as occasionally clinics were low on capacity.

Medical staffing

- There were 123 consultants with practising privileges at the hospital who could refer patients to outpatient services.
- Staff in the outpatient and physiotherapy departments were able to request the resident medical officer to attend any patient that became ill in the department.
- A resident medical officer (RMO) was available twenty-four hours a day, seven days per week to support the clinical team in the event of emergencies or to help with patients requiring additional support.

Records

- Patient records were managed in line with the medical records policy.
- We were informed that on occasions when a patient's medical notes were not available a temporary medical record was created.The department used offsite storage to archive documents which could take more than 6 weeks to retrieve, however, they informed us that they could get notes back in 24 hours if they have just been sent. If this failed then they used the last patient letter for the consultation and all hospital correspondence was printed off and placed in the temporary record. Clinic appointments were never cancelled.
- The medical records department organised patient notes for the clinics. We observed patients' medical records within the clinical rooms before clinic commenced and the rooms were locked when the rooms were unattended.

Medicines

- The hospital had a service level agreement in place with the local NHS acute trust to provide pharmacy services. The hospital had access to a pharmacist and pharmacy technician on weekdays.

Good

Outpatients

- Medicines (excluding controlled drugs) were stored in a locked cupboard. We reviewed a sample of these medicines which were all within the manufacturers'' expiry dates and kept in chronological order.
- We were informed that there was a monthly safe and secure audit carried out and it was highlighted to senior staff that room temperatures should be added to the criteria.
- Drugs that needed to be stored at lower temperatures were stored in a fridge. Fridge temperatures were checked daily and were always in range. Any deviation of this range was reported straight away to the pharmacy department at the local NHS trust.
- Prescription pads (FP10s) were stored in sisters' office in a locked cupboard and the key kept in a key safe cabinet.
- We observed private prescriptions that could be dispensed at the pharmacy. We observed safe processes in place. For example, one copy to patient, one copy inserted in the patient's medical notes and one copy in the prescription box.
- There was oxygen available in the treatment room if required.

Incidents

- There were nineteen clinical incidents and two non-clinical incidents from April 2017 to March 2018 within the outpatient department. There were no never events reported within the outpatient department.
- We reviewed six clinical incidents for the period January to March 2018 all had a root cause analysis and action plan in place. Information was cascaded to staff via email and staff meetings.
- Senior management informed us that following an incident that occurred in 2017 they now had a stamp that they used in the patients notes if they were at risk of developing an acute kidney injury.
- All the staff we spoke to were aware of the incident reporting system and understood their responsibility to report incidents. Incidents were reported through an electronic system.
- Lessons learnt were shared with staff in team meetings, team briefings and discussed in their daily safety huddles.
- All staff we spoke with were aware of the duty of candour and the principles of being open and honest.

Are outpatients services effective?

Inspected but not rated.

Evidence-based care and treatment

- There were a range of clinical patient care pathways and protocols for the management and care of various outpatient procedures which were developed in conjunction with healthcare professionals from a range of specialities, for example, outpatient care pathway injection into joints. We reviewed two pathways which were fully completed and easy to understand.
- Staff told us that they were able to access local and corporate guidelines through information folders held in the sisters' office and also via the hospital intranet.
- Physiotherapy patients receive three follow-up appointments following joint surgery which follows NHS England national tariff April 2017 to March 2019.
- The department carried out audits which were benchmarked to local and corporate policy, department of health (DoH) guidance and the national institute for health and care excellence (NICE) guidelines.
- A radiological review of took place of pre and post orthopaedic patients, ensuring that all hip and knee surgeries were appropriate. Additionally, within these meetings, national joint registry data was looked at to ensure best practice was always kept in line with up to date guidelines.

Nutrition and hydration

- Refreshments were available within the outpatient waiting area. The hospital had a food hygiene rating of five displayed in reception.

- We observed a patient waiting on NHS transport, the patient was looked after by the reception staff. Refreshments were offered and assistance was offered for their hygiene needs.
- A water fountain was present within the physiotherapy department for patients and staff.

Pain relief

- Staff used a visual analogue score (zero to ten) for orthopaedic patients only. Other outpatient specialities didn't use a pain management tool. However, there was a verbal numerical pain rating tool (zero to ten) available for staff to use but this was not evident that it was used in all ten patient records that we reviewed.
- Pain clinics were available with the pain consultant alternate Mondays and Fridays. We reviewed ten patient records and there was no evidence of a routine pain management tool or a full bio-psychosocial pain assessment. Conversations held with patients to assess their pain were usually completed verbally with no documented score.
- The physiotherapy staff informed us that this was an area that they were discussing with the pain consultant and senior management. They also informed us that they request the pain consultant to use the Keele StarT Back Screening Tool, however this was not documented.
- Staff informed us that they did not use a cognitive impairment assessment tool for those patients with cognitive impairment.However, the physiotherapy department stated that they would use the abbey pain scale if required. We did not review any patient records with cognitive impairment or delirium and therefore could not corroborate this at the time of inspection.
- The physiotherapy department offered acupuncture and shockwave therapy (mechanical pressure pulse treatment for tendon-related pain).Although acupuncture was no longer endorsed by the National Institute for Health and Care Excellence (NICE), the department told us that research provided by healthcare professionals and patient feedback collated by the physiotherapy department demonstrated the benefits of acupuncture. Acupuncture was therefore offered to both NHS and privately funded patients following referral from the pain consultant.
- A pain management study day was attended by staff on 21 March 2018 and a further study day has been scheduled for the 12 September 2018.

Patient outcomes

- The patient pain pathway and triage system and the Pilates classes offered to patients and staff have improved patient outcomes. This was confirmed by the positive feedback taken from the Pilates patients we spoke to.
- Senior management stated that ten patient record forms were audited each month and feedback given to staff to improve practice. For example, patient care pathways for a certain speciality was reviewed. We did not see evidence of the audit at this time.

Competent staff

- Staff appraisals and personal performance reviews were not in date due to the recent outpatient manager role becoming redundant. We were informed that it was agreed by the hospital management team that the role would be managed more efficiently and effectively by clinical staff. Two staff nurses had recently been promoted to sisters and were now both sharing the job role of outpatient manager.
- Data supplied for appraisal compliance demonstrated outpatient nurses at 67% and healthcare assistants at 100% in August 2018. Appraisals of remaining staff would be commencing shortly with the help and support of the clinical matron.Reception staff had their appraisals two weeks prior to inspection and we observed clear action plans for the coming year.
- We looked at five staff employment records and all had disclosure and barring service checks in date. Of the five reviewed, three had nursing and midwifery council registration in date, the remaining two were healthcare assistant records which did not require registration.
- We were informed that all staff received induction training with the aid of a corporate induction booklet. We reviewed five staff records which demonstrated

that staff had undertaken induction that incorporated moving and manual handling, fire safety, basic life support, information governance, equality and diversity, adult safeguarding and health and safety.

- We were informed that new starters received four weeks supernumerary status and following this received buddy support as well as support from a senior member of staff who observes them in their new role.
- We were informed that staff received clinical supervision but this was not recorded.
- The five employment records that we reviewed demonstrated 100% validation of professional registration for nurses working in outpatients. An annual check was made by the general manager's personal assistant.

Multidisciplinary working

- Multidisciplinary meetings were carried out alternate Tuesdays within the orthopaedic department. We were informed that other specialities did not carry out any multidisciplinary meetings.
- The physiotherapy department had good working relationships with all the orthopaedic and spinal consultants as well as the pain consultant.
- We were told by all staff that we spoke to that all departments support each other and worked well together.

Seven-day services

- The outpatient department offered a six-day service. Monday to Friday between 8am and 9pm and on a Saturday from 8am to 2pm.The department was closed on bank holidays.
- The physiotherapy department offered a six-day outpatient service from Monday to Friday. (Monday 7 am to 6.30 pm, Tuesday 7.30 am to 5.30 pm, Wednesday and Thursday 8 am to 6 pm, Friday 8 am to 7.30 pm and Saturday 8 am to 12 pm as demand dictates.The physiotherapy department also offered inpatients a seven day service from 8am to 8pm.Pilates classes were run each Tuesday and Thursday.
- Physiotherapy staff provided treatment to inpatients on bank holidays.
- A resident medical officer was available twenty-four hours a day, seven days per week.

Health promotion

- See information under this sub-heading in the surgery section.

Consent and Mental Capacity Act (Deprivation of Liberty Safeguards only apply to patients receiving care in a hospital or a care home)

- See information under this sub-heading in the surgery section.
- Staff were aware of the Mental Capacity Act (2005).A Mental Capacity Act flowchart was displayed in the sisters' office on the staff notice board and used when they need to access other services. Staff informed us that if a patient lacked capacity the consultation would stop in agreement with the patient and their family if present. An independent mental capacity advocate would be contacted and a new appointment would be made which would be in the best interests of the patient.
- We spoke to five members of staff who confirmed that they had attended training in the Mental Capacity Act and Deprivation of Liberty Safeguards.
- In the physiotherapy department, written consent was taken from patients undergoing acupuncture or shockwave therapy.
- Verbal consent was gained from patients undergoing physiotherapy. If staff had concerns about a patient's capacity to consent then the treatment was rescheduled and a mental capacity act assessment was requested of the patient.

Are outpatients services caring?

Good

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

Compassionate care

Good

Outpatients

- We observed a folder in the reception area containing numerous letters and cards thanking staff for their kindness.
- We spoke to seven patients and all stated that their respect and dignity was maintained and that confidentiality was maintained when booking in at reception.
- The seven patients that we spoke with all stated that they were not asked if they wanted to receive copies of their letters.Staff told us it was consultant preference to ask the question and usually it was left up to the patient to request copies.
- We were informed that all consultations were accompanied by a healthcare assistant. In consultations with nurses or healthcare assistants, patients were asked if they would like a chaperone present.
- We observed five consultations all of which introductions were made by staff to patients and their families.
- During the consultations we observed that the patient's dignity and respect was maintained while the consultant was examining the patients on the examination table. Full explanations were given and reassurances were given to the patient from the consultant and the nurse in the clinic room.
- We noted that during all consultations there was a good rapport between the staff and the patients and that all the patients appeared very satisfied with their appointments.
- Staff provided additional support to patients with physical disabilities. Staff gave us an example of meeting patient with a physical disability at his car and helping him into a wheelchair and into the hospital.
- We spoke to seven patients in the outpatient reception area, all were very positive about the provider and the staff. Of the seven we spoke to three stated that everything was great apart from the parking facilities. We spoke to two patients within the physiotherapy department who were waiting for a Pilates class. Pilates is endorsed by the National Institute for Health and Care Excellence (NICE) in the treatment of lower back pain. Both patients were very complimentary of the physiotherapy staff and the services that they provide.
- The hospital took part in the friends and family test, a survey that asks patients whether they would recommend the service they have received to family and friends who need similar treatment or care. Of the results 10% were related to the outpatient department and 100% were extremely likely to recommend the hospital service. Two examples we observed were: "The hospital was very clean, I was treated properly once again, which is how it should be. Thank you" and "All the staff have been wonderful, given me the best care. Thank you to all the staff. Hospitality has also been excellent, physios are brilliant".
- The physiotherapy department displayed comments from the friends and family test on their noticeboard in the patient waiting area, two comments observed: "So satisfied with the physiotherapist – I had great results" and "All the staff are very helpful and made me feel at ease."
- We also informed that we value your opinion cards were given to patients. The receptionists then input the data and any problems would be flagged to the general managers personal assistant who would then take action on this. Feedback would be discussed in the heads of department meetings and then information cascaded to staff on its completion via emails or team meetings. Two examples of feedback from these cards were: "Brilliant service" and "Everyone is so kind and friendly".

Emotional support

- We observed chaperone posters in the clinical rooms and patients were asked by staff if they wanted to bring a family member into their consultation with them. This was supported by the hospitals chaperone policy.
- We observed a patient quite distressed and in pain during a consultation. Reassurances were given from the consultant that their previous surgery was not the cause and a referral made to a general surgeon for further investigation. Reassurances and support also given from the nurse in the clinical room.

Good

Outpatients

- The outpatient department offered tours of the hospital and relevant areas of treatment for those patients living with dementia or learning disabilities which helped to alleviate any anxieties the patient may have.

Understanding and involvement of patients and those close to them

- We observed that during consultations time was given for the patient to ask questions. Treatment options were discussed and the patients were encouraged to be part of the decision-making process-rays were shown to patients and findings discussed at a level of understanding to the patient.
- When clinics are running late, the patients are kept informed regularly. On speaking to patients in the waiting room area they informed us that the reception staff were wonderful and always polite and helpful.

Are outpatients services responsive?

Good

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

Service delivery to meet the needs of local people

- See information under this sub-heading in the surgery section.
- There was a total of four reception staff and always two members of the team manning the reception desk to ensure patients were dealt with in a timely manner.
- The parking for patients was insufficient to the service needs. We spoke to ten patients who all stated they had struggled to find a parking space. We raised this with management and were informed that a business case was in progress for a car park extension.
- A television was situated in the reception area as well as a children's play area that had books and puzzles within it.
- There was sufficient seating in the waiting area for the number of patients waiting for appointments.
- Patient information leaflets were available in the outpatient and physiotherapy department. Examples of leaflets available were cosmetic surgery, hand hygiene, sport injury, bladder and bowel weakness, confidentiality and organ donation.
- Patient information leaflets were also available on specific procedures which were given to patients during their consultations.
- We were told by the physiotherapy manager that they do offer a sports injury service, however due to lack of equipment at the present time this service is limited.
- We were informed that patients referred by their GP could use the choose and book system. Choose and book is a national electronic referral service that gives patients a choice of treatment centre and at a time that is convenient for them.
- Patients informed us that they were not aware that they had to request a copy of their clinic letter if required. This was highlighted to management on the day of inspection.

Meeting people's individual needs

- A hearing loop was in place within the reception area for those with sensory impairment.
- Language line was available for patients who did not speak English. Healthcare leaflets could be printed off the intranet in different languages. We were informed that patients whose English was not their first language were flagged on referral.
- Reception staff informed us that patients with mental health ill health or learning disabilities were identified via their GP and referred directly to the consultant. However, for those patients that were not identified in this way they were put to the front of the clinic list to ensure that they were seen quickly.
- Established links for autism, dementia and mental health were displayed on the staff notice board within the sisters' office. Staff informed us that this was beneficial to them for when they needed advice on making referrals.

Good

Outpatients

- Staff we spoke to recognise the importance of supporting patients living with dementia, autism or learning disabilities. The hospital used the 'This is me' guide which assisted staff to understand the patient's personal preferences.
- A dementia box was available for staff to decorate a room in which a patient would be admitted. This was a positive initiative as the environment limited space to have a designated dementia area.
- A new working group for autism had recently commenced to improve the patients journey. We were informed that there was a representative from each department within the group.
- There were facilities for bariatric patients in the form of seating within the outpatient waiting area.
- There was an equal opportunities policy which provided guidance to prevent discrimination against patients and staff. We reviewed five staff files and all demonstrated that they had undertaken equality and diversity training.
- The entrance to the hospital was accessible to wheelchairs, with automatically opening doors. Accessible toilets for patients with a physical disability were located within the outpatient receptions area.
- All outpatient clinics were available on the ground floor of the building.

Access and flow

- The department had reported a high number of do not attend (DNAs) outpatient appointments. We were informed that they had a manual tracker system of up to ten DNAs per day which equated to approximately 55 DNAs per week. Patients were allowed two missed appointments and then they were discharged back to their GPs.
- We were informed that management team were looking at collating the DNA data to assess impact for patient outcomes and ascertain how much it was costing the hospital. A root cause analysis (RCA) would be completed to try and make things more efficient. Management also informed us that they were looking into a customer relationship management system which would ensure text messages were sent out to remind patients of their appointments. DNA rates were similar to other Ramsay hospitals.
- NHS referrals into the department were from GPs, consultants or through the NHS choose and book appointment system.
- Following inspection, the hospital informed us of different initiatives they had introduced to reduce cancellations and delays for patients. These included weekly anaesthetic reviews to assist in reducing cancellations on the day of surgery, also a service level agreement for provision of echocardiograms for patients who required this investigation prior to surgery.
- We were told by reception staff that one clinic persistently ran late due to the time management of one of their consultants. The management team were not aware of this but we were assured they would look into it. There had been no patient complaints following this.

Learning from complaints and concerns

- See information under this sub-heading in the surgery section.
- There were no complaints recorded in outpatients at the time of inspection.

Are outpatients services well-led?

Good

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

Leadership

- Two sisters that were new in post were managing the outpatients' department under the direct care of the clinical matron. On speaking to both nurses, they informed us that they were fully supported by the clinical matron and the management board.

Good

Outpatients

- The operations manager had been in post for five months and was working through policies and procedures and had a clear vision of the providers mission statement.
- Link nurses/Champions were evident for various specialities. This ensured that information was shared between specialist teams and the staff and patients in the clinical areas that they work. It was also evident from talking to staff that all the departments throughout the location worked together and shared evidence.

Vision and strategy

- See information under this sub-heading in the surgery section.

Culture

- Management informed us that they had an open culture where all staff could discuss ideas and concerns. On speaking to five members of staff they were all in agreement of this.
- Staff were empowered to speak up about safety issues within the outpatient department. A new initiative being carried out at the hospital, which is to be rolled out organisation wide, was a system known as the safety code. This ensured that communication was effectively given to prevent unintended patient harm. We observed a presentation being given on the code.Staff told us that there was a positive culture change since the code's implementation and they all felt more confident in challenging behaviour. We were also informed that there was now a better atmosphere within the hospital which had enhanced team working and created great positivity.
- Staff we spoke to commented that the clinical matron and management were approachable and very supportive. For example, a recent incident that involved the services of the police was promptly reviewed and acted upon. Lessons learnt were cascaded through emails and team meetings.
- Staff we spoke to were extremely positive about working at the hospital. They stated that there was an open and transparent culture and management were very supportive and approachable at all times.
- Freedom to speak up guardian details were displayed on a wall located in the dining room and staff were aware of the on-line referral system should they require it.
- Although all the staff we spoke to enjoyed working at Fulwood, three members of staff informed us that there was no clear pay structure in place and this had a negative effect on their morale.

Governance

- See information under this sub-heading in the surgery section.
- We spoke to five members of staff within the outpatient department who all confirmed clinical governance information and changes to policies, protocols and procedures were cascaded down from the clinical matron and governance via emails, team meetings and safety huddles.
- Team meetings were carried out regularly and we observed the minutes from outpatient staff and physiotherapy department meetings. All demonstrated clear actions plans, sharing best practice and learning from clinical incidents.
- Heads of department met monthly and discussed complaints, incidents and any new initiative's. Meetings from these minutes were reviewed and action plans noted.
- Staff we spoke to were clear about their roles and who they should report to.

Managing risks, issues and performance

- See information under this sub-heading in the surgery section.
- We spoke to the operations manager who was not aware of what was on the risk register. However, he was new in post and informed us that he would look at that during our inspection
- We reviewed a variety of risk assessments, for example, prescription pads FP10's, deteriorating patient/escalation, sepsis, deep cleaning, cleaning carpets following spillage, audits and pre-operative assessment screening.

Managing information

Good

Outpatients

- See information under this sub-heading in the surgery section.
- We reviewed regular three monthly operational/ medical audits related to controlled drugs, medicines management and prescribing; safety and security. are carried out by senior management to ensure compliance. All items within the audit demonstrated above target figures.
- A procedure audit of thirty medical records was carried out monthly. Senior management informed us that they are looking to get other departments to carry out the audits so there was no bias. At the present time each department was conducting their own audits.
- We were informed that the patient administration system was very slow. Management were looking into improving this system at the time of inspection and are looking to replace it with an electronic patient record system in early 2019.

Engagement

- See information under this sub-heading in the surgery section.
- The physiotherapy department was in the process of introducing a new electronic patient feedback form. Their aim was to complete ten forms per month which would then be sent to the clinical matron and governance team and results pinned to the staff notice board. We observed the first month's results and ten out of the ten forms collated stated that they would recommend the hospital and the physiotherapy department. Results for the second month were not yet available as it is still in its introductory phase. It is also in the process of being networked out to other hospitals and we observed it being added to the northern regional meeting agenda for the week following our inspection.

Learning, continuous improvement and innovation

- The hospital had a new working group for autism to improve the patient journey.
- Human factors discussion sessions were held for all staff. Consultants were emailed directly by the clinical matron to attend.

Good

Diagnostic imaging

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

Are diagnostic imaging services safe?

Requires improvement

Our rating of safe went down. We rated it as **requires improvement.**

Mandatory training

- See information under this sub-heading in the surgery section.
- The imaging manager kept a training record folder for the department to ensure staff were up to date with mandatory training. The manager also reviewed mandatory training records during annual appraisal meetings with individual staff. In addition, staff received email reminders when they were due to complete mandatory training.
- Staff also completed additional role-specific mandatory training for radiography. This included reviewing the local rules and signing to record when they had completed this, in accordance with IRMER. Qualified radiographers completed annual training in use of the different radiology equipment used in the department. Non-qualified staff also completed role-specific annual updates in relation to their role within the diagnostic imaging service. This included subjects such as moving and handling radiology equipment, fire risk, and chaperoning.
- During our inspection we reviewed local records of mandatory training and saw staff in the department were compliant with mandatory training.

Safeguarding

- See information under this sub-heading in the surgery section.
- Staff completed adult safeguarding training as part of the mandatory training programme and records we reviewed during inspection confirmed the imaging department staff were up to date with safeguarding training. The hospital confirmed all staff completed level 2 safeguarding training.
- The hospital followed the Ramsay Healthcare UK policy for Safeguarding Adults. The safeguarding policy held in the department file for staff's reference was dated 2015 and not the current version, although the current version was available via the staff intranet.
- Although the service did not treat children, all clinical staff were required to undertake level two children's safeguarding training every three years, completed via e-learning. At the time of inspection, the hospital's learning management system was being updated and specific compliance rates for level two children's safeguarding training were unavailable. However, the overall training compliance for safeguarding training was 85% in July 2018 In addition all Safeguarding leads attended multidisciplinary team training every three years. This training was face-to-face and compliance was 100%.
- Staff were aware of the types of issues which could present a safeguarding concern. Staff described how they would initially discuss a safeguarding concern with the imaging manager, who would escalate these through the hospital's safeguarding lead if this was needed.

Good

Diagnostic imaging

- Staff were aware of the hospital's safeguarding lead and said there were good links with the department. There had been no safeguarding cases raised within the service during the inspection reporting period
- Staff checked patients' identification prior to carrying out investigations, following the Society of Radiographers "pause and check" process. We saw during one procedure that the patient's identification and procedure details were read out to them for agreement, rather than the patient actively being asked to confirm their details and explain their understanding of the procedure they were having.

Cleanliness, infection control and hygiene

- The radiography and ultrasound areas we visited were visibly clean. The hospital had a housekeeping policy and completed a monthly cleanliness audit. Results of the June 2018 audit recorded 96%, noting that items were stored clean but not always green labelled in clinical areas.
- The hospital followed the Ramsay Healthcare UK policy for infection prevention and control. We observed staff following guidance for arms 'bare below the elbows' when providing treatment and care to patients. Handwashing facilities, hand gel and protective personal equipment, such as aprons and gloves, were available in the radiography and ultrasound areas we visited.
- We saw staff washing their hands and using hand gel between patient contacts. Audit results for handwashing practice demonstrated 100% compliance.
- Full personal protective equipment lead aprons were available for staff to wear as protection for exposure to radiation. Cleaning for lead aprons was completed and recorded monthly, with these records up-to-date.
- The hospital completed regular handwashing audits to monitor staff adherence with this policy.
- Staff used sterile techniques for administering injections during invasive procedures.
- Staff maintained cleanliness of equipment after each patient use in the department. Ultrasound probes were cleaned in accordance with the hospital's policy for decontamination of non-invasive devices.
- We found some of the radiology equipment used in theatres was not clean. The C-Arm mobile X-ray system kept in the surgery recovery area was dusty and the lead aprons for radiation protection were dirty, with visible fluid marks and stains apparent. We raised this concern at the time of inspection and the hospital took immediate action to correct this. Following inspection, the provider confirmed there was a schedule in place for routine cleaning of radiology equipment, also that this had been completed at the time of inspection. Although the schedule was ticked to indicate the equipment had been cleaned, we observed this remained dusty or dirty and systems were not robust.
- Results of the Patient-led Assessments of the Care Environment (PLACE) assessment 2018 showed that the overall positivity score for the condition, appearance and maintenance of the environment was 97.7% against and overall England average score for hospitals of 94.1%.

Environment and equipment

- The environment was appropriate for the diagnostic imaging services provided in the radiography and ultrasound areas we visited, with suitable equipment available. However, the X-ray room was visibly tired in appearance and staff told us there were plans for development of a new X-ray suite, for completion in November 2018. We saw the initial proposals for this work at the time of inspection.
- Staff in the department had access to the resuscitation trolley kept on the outpatient department corridor, in case of patient emergency. This was a short distance from the X-ray and ultrasound areas; however, staff advised us that in cases of cardiac arrest, the emergency bell would direct the response team to the immediate location of the department. There had been no incidents of patient emergency or cardiac arrest in the X-ray department reported.
- The imaging manager was identified as the radiation protection supervisor, in accordance with Ionising Radiation Medical Equipment Regulations. The manager completed radiation risk assessments for radiography equipment and procedures used in the

department. We saw risk assessments were complete and current for mobile radiography; fluoroscopy; X-ray room one; surgical theatres and for pan-oral radiography.

- Radiation risk assessments were reviewed annually by the radiation protection supervisor and the radiation protection advisor, with details of these reviews submitted to the radiation protection committee.
- X-ray radiation warning signs were clearly displayed outside the X-ray room, to indicate radiation exposure took place in the area. Patient information was displayed in the X-ray waiting area providing patients with advice about general X-ray procedures.
- Staff in the service completed a programme of equipment quality assurance. The imaging department manager kept a record of equipment servicing and maintenance for X-ray and ultrasound equipment. We reviewed these records during and following the inspection and saw the servicing and maintenance records were complete and up to date.
- Staff working in the service wore radiation dosimeters to monitor the levels of radiation they were exposed to in the course of their work. Full personal protective equipment, including lead gowns, was available for staff.
- The service used an electronic picture archiving and communication system (PACS) to store diagnostic imaging files. Emergency back-up systems were in place in the event of any breakdown.
- We saw there was an orthopantomagram (OPG) dental X-ray machine in the X-ray room, which was not in use. Staff told us this had been out of use for several months and was due to be removed as part of the development plans for the X-ray room. The OPG machine was a large piece of equipment and a risk assessment had been completed regarding this.
- Following inspection the provider confirmed all plugs had a current compliance sticker for PAT testing and safety testing.

Assessing and responding to patient risk

- The imaging manager was the designated radiation protection supervisor and the lead radiographer was identified as deputy radiation protection supervisor in the department. This ensured there was always access to an expert for providing radiation advice, during the department's hours of operation. Details of the radiation protection supervisor and the radiation protection advisor were clearly displayed in the X-ray room and X-ray department office. A current Health and Safety Executive registration certificate for the service was displayed in the X-ray room.
- Supervision from the radiation protection advisor was provided by an external provider. In accordance with IRMER, the imaging manager attended quarterly meetings of the radiation protection committee to receive any updates of clinical alerts, and to share information. This information was shared with the local service during team meetings.
- The service followed Ionising Radiation Medical Exposure Regulations (IRMER) guidelines and had Ionising Radiation Regulations "local rules and employers' procedures for protecting patients and staff from ionising radiation". We saw during inspection, these were displayed in the X-ray room, however the version on display was dated December 2017 and was not the latest version as this had been removed for a training session. After the inspection, the hospital provided information which confirmed the local rules were in date.
- The service kept a list in the IRMER file of those designated clinical staff who were entitled to complete referrals for patients requiring X-ray and ultrasound procedures. Entitled referrers included: the hospital's Resident Medical Officer (RMO); consultants with practising privileges; and those entitled by the diagnostic imaging manager. Administrative staff checked this with the initial referral details and would return these to the referrer if incomplete, not signed by the referrer, or unclear.
- Radiographers from the service provided training for staff during monthly mandatory training sessions about the diagnostic imaging services. This included information about radiation safety as well as radiation protection and legislation for referrers.
- Radiology referral forms identified patient details, including name, address and date of birth, what examination was required and the clinical question to be answered. Radiographers completed other details,

including justification for the procedure and details of radiation dose and exposure times. Where relevant, patients completed details of date of last menstrual period and signed declaration of no risk they may be pregnant.

- Staff assessed risks for patients attending the department on an individual basis, following their referral. Staff followed Radiological Local Safety Standards for Invasive Procedures (LocSSIPS) for patients undergoing different invasive procedures. This would include such procedures as injecting contrast medium during ultrasound and X-ray investigations.
- Staff had access to anaphylaxis kits, in the event of any patients having an allergic reaction to the contrast medium used for certain diagnostic imaging procedures.
- The Resident Medical Officer was based at the hospital seven days a week, 24 hours a day and was available in case of any patient emergency. Radiologists provided an on-call service, should an emergency arise requiring urgent diagnostic intervention.

Nurse staffing

- Permanent staffing for the imaging department consisted of the imaging manager, lead radiographer and radiographer, supported by two healthcare assistant staff.
- Eight occasional bank radiographers were available to work alongside permanent radiographers, when this was required. One regular bank healthcare assistant was also available to cover the ultrasound sessions, if this was needed. Overall use of nursing bank staff across outpatient and diagnostic imaging services was reported as 29% during March to May 2018, with healthcare assistant bank staff use at 40% for the same period. No agency staff were used by the service.
- Two full time administrative assistants were based in the department to support the service with referrals, appointment bookings, and other communications as needed.
- There were no vacant posts in the diagnostic imaging department at the time of inspection.

Medical staffing

- Consultants with practising privileges at the hospital could make referrals for diagnostic imaging investigations.
- Consultant radiologists in different specialisms worked on a sessional basis within the service. These included three musculoskeletal consultant radiologists covering four ultrasound sessions per week, plus extra reporting sessions when required; and three general radiologists covering three ultrasound sessions, plus reporting, per week. One chest radiologist was available to report on chest X-rays when needed.
- Consultants we spoke with working in the service felt well supported and involved as part of the team.

Records

- The service used electronic and paper systems for patient records. The picture archiving and communication system (PACS) was in use for storing images from different types of diagnostic imaging, including plain X-ray, ultrasound and fluoroscopy procedures.
- Referrals were made via the hospital's electronic systems and in paper format. Paper referral documents were scanned into the radiology information system by administrative staff prior to allocation to a radiographer.
- Results from diagnostic imaging investigations were available post procedure for clinicians to review, through the hospital's electronic system.

Medicines

- See information under this sub-heading in the surgery section.
- Medicines required for different X-ray imaging procedures were stored in a locked cabinet in a key safe in the X-ray room, following the hospital's clinical standard operating procedure for medicines management. Contrast medium medicines used for ultrasound investigations were stored in a locked cabinet in the ultrasound room.
- Medicines that were stored included contrast media including Baritop, easygas, and magnavist. All

medicines were within manufacturers expiry dates and a daily medicines sign in and out sheet was used. Stock levels were checked on a regular basis by one of the healthcare assistants in the service.

- On one morning during our inspection we saw two boxes of Carbex granules and liquid, a sealed carton of Barium sulphate and a sealed can of Baritop. had been left out in the X-ray room. A radiographer informed us this was in preparation for an investigation later in the afternoon and confirmed these should have been in the locked cupboard until required. Following the inspection, the provider informed us this had been an isolated incident due to circumstances on the day of inspection and steps had been taken to improve practice from this.

Incidents

- The hospital reported a total of 163 incidents from April 2017 to March 2018 of which 137 were clinical incident and 26 were non-clinical incidents. Six of these incidents were reported for outpatient and diagnostic imaging services.
- Out of six diagnostic imaging and outpatient incidents, two related to staff in theatres having worn lead aprons for an extended period of time, resulting in discomfort. Following this, a session was introduced at mandatory training on how to wear a personal protective equipment (PPE) lead apron; and risk assessment was introduced for staff who may be at risk of musculoskeletal pain. Another incident related to a late and incorrectly completed referral, received for a patient undergoing surgery the same afternoon. This identified the referrer was new in post and following this, the imaging manager introduced a radiology induction for all new resident medical officers.
- Staff were aware of the different types of incident which could arise within diagnostic imaging services and reported any incidents on the hospital's electronic incident reporting system. The most commonly reported incidents were referral errors. These would be returned to clinical referrers for correction or clarification.
- Incidents were reviewed and discussed during weekly team meetings, with learning shared from this.

Are diagnostic imaging services effective?

The service was inspected but not rated

Evidence-based care and treatment

- The hospital's policies and protocols were standardised by Ramsay Healthcare UK. These incorporated up to date recommendations and guidelines from the National Institute for Health and Care Excellence and other professional bodies, including the Society of Radiographers.
- The service had a clinical audit programme to ensure that clinical audits were carried out at regular intervals. Results were monitored, analysed and action plans were produced to address any failures in compliance.
- Radiography staff provided care and treatment following evidence-based guidance and professional standards. The imaging service used diagnostic reference levels for X-ray and ultrasound procedures. Notices displayed diagnostic reference levels in the ultrasound and X-ray procedure rooms for staff reference.
- Staff followed the Ramsay Healthcare UK care pathway for outpatient radiological procedures.
- The service completed observational audits in accordance with the Ramsay Healthcare UK policy - employers IRMER procedures. Audit results at the time of inspection showed the service had not ensured the minutes from team meetings had been read by all staff, or that all notices and documents were dated and version controlled.
- The diagnostic imaging manager maintained records of radiographers' quality audits. Criteria used for audits included technical details of exposures; collimation used; operator name recorded; number of projections recorded and radiation dose levels. The manager monitored audit results in providing assurance of overall quality and safety of the service.
- Audits of referrals from other departments were monitored. Results at the time of inspection showed the lowest score of 70% for consent forms not dated

but signed; and 70% score for referrals from outpatient clinic not dated. The imaging manager used this information to raise awareness and promote learning about referral procedures by other clinicians.

Nutrition and hydration

- Patients were given advice for certain types of procedure which may require fasting. Following their appointments, patients had access to drinks and snacks in the hospital's main waiting areas.
- The hospital had received a five-star rating for food hygiene from the local authority just prior to our inspection.

Pain relief

- Staff did not administer pain relief to patients attending appointments for X-ray and ultrasound investigations. Staff monitored and checked patients' comfort levels during investigations and could call on medical staff for assessment of any pain management, if this was needed.

Patient outcomes

- The diagnostic imaging service participated in the Ramsay radiology audit programme
- At the time of inspection, the hospital's radiology report turnaround times were not included in the Ramsay radiology audit programme. However, this was being planned for, with the imminent upgrade of IT systems. This report data would also be fed back into the clinical governance meetings. It was anticipated that national benchmarks would be set for report turnaround times and this data could then be used to monitor the department's performance.

Competent staff

- Qualified radiographers were registered with the Health and Care Professionals Council and maintained records of their continuing professional development as part of their professional revalidation. The hospital ensured qualified radiographers were correctly registered as a condition of their employment; the imaging manager also kept a copy of staff HPCP registration records in the department.
- Staff completed Continuing Professional Development (CPD) in relation to their role. Although specific time was not allocated for CPD, staff were supported to attend radiology meetings for this purpose.
- Consultant radiologists worked under practising privileges within the service. These clinical staff completed their medical revalidation and CPD within the NHS trust where they were based and managers at Fulwood Hall checked these records as part of the practising privileges process.
- Healthcare assistants completed different competencies for working in the diagnostic imaging service. These related to ultrasound and imaging procedures, including subjects such as understanding radiation safety; reading local rules; understanding of controlled areas lead protection. Healthcare assistants and administrative staff also completed Ramsay competencies for chaperoning patients. Competency records we reviewed were completed and up-to-date.
- The imaging manager completed annual appraisals for staff in the department. During this, training needs were reviewed and any development opportunities were discussed. Staff appraisals were 100% completed at the time of inspection.

Multidisciplinary working

- Multidisciplinary team working was well established within the department and staff communicated well with various other services in the hospital to provide holistic care to patients. This communication particularly involved consultants, nursing and allied health professional staff in wards, outpatient clinics and theatres; but also related to the wider hospital services.
- The service also worked with external providers of services, including local NHS hospitals and GP services, as part of routine daily communications. We saw written records, and heard staff communicating, with other staff and services in a clear and professional manner.
- In the course of reviewing referrals, radiographers liaised with hospital imaging departments to check patients' previous exposure to radiation. This was

undertaken as part of the justification process to carry out exposure to radiation, and ensured patients were exposed to the minimum levels required during the course of investigations.

- Diagnostic imaging staff attended multidisciplinary team meetings weekly in the department. During these meetings staff discussed clinical matters including X-ray reports, image quality and quality of referral information reports.

Seven-day services

- The service's working hours were Monday to Friday, 8.30am to 5.00 pm. Radiographers provided an on-call cover rota for out of hours services. This rota was shared between the three permanent radiographers and provided a 24-hour service, seven days a week. Staff said this was mostly used for check X-ray requests at weekends, to support patients who were being discharged. Other requests for out of hours services were infrequent, but could arise if the resident medical officer had a concern about a patient's condition.

Health promotion

- See information under this sub-heading in the surgery section.

Consent and Mental Capacity Act

- Staff took time to explain and thoroughly check patients' understanding prior to procedures. Written consent was used for ultrasound and X-ray examinations. Staff completed training and were aware of the needs of patients who may lack capacity, and followed appropriate consent documentation for consent for such patients.

Are diagnostic imaging services caring?

Good

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

Compassionate care

- Staff were caring and showed kindness to patients when attending their appointment, respecting the dignity of patients and those who were close to them. They were aware of patients' care needs and communicated in an appropriate and professional manner.
- Patients attending appointments booked in at the hospital's main reception desk. Although this area was quite open and public, reception staff communicated sensitively and appropriately, lowering their voices for privacy and with consideration for patients' individual needs.
- Chaperones were available when patients asked for one. Notices were clearly displayed in waiting areas to inform patients if they would like a chaperone during their investigation.
- We observed staff interacting positively with patients, and those close to them, in different areas of the hospital.
- Patients we spoke with told us they were happy with the treatment and care they had received, saying staff were helpful.

Emotional support

- Staff informed patients about the procedure they were having and we saw different leaflets and notices were available to support patients with their understanding. Staff told us how they would reassure patients who may be anxious about their investigations.
- During an ultrasound clinic we observed there was good communication with patients and staff were aware of patient's comfort needs and frequently checked these.

Understanding and involvement of patients and those close to them

- We heard staff speaking with patients by telephone prior to their appointments. Staff spoke clearly and checked patient's details, taking time to ensure patients had understood correctly. Staff provided patients with contact details, in case of any follow up queries.
- Appointment letters provided clear instructions regarding any starving or fluid intake that may be required for a procedure.

Good

Diagnostic imaging

- Following their appointments, patients we spoke with confirmed they received information and copies of letters from the hospital about any further appointments, and details of test results. Patients confirmed that staff had provided them with sufficient information and advised what to do if they were worried or concerned.
- Where patients required additional support, their relatives or carers were able to attend appointments and were involved in discussions to clarify communication with patients and aid their understanding. The service took note of where patients had any additional need, such as dementia or a language communication need, in order to prepare for this appropriately.

Are diagnostic imaging services responsive?

Good

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

Service delivery to meet the needs of local people

- The diagnostic imaging service provided plain film X-ray and ultrasound, including fluoroscopy and X-ray guided injections. Services were provided for inpatients as needed, and on an outpatient appointment basis
- Information was sent to patients in appointment letters, providing details of their appointment, directions to the hospital and contact details for the department.
- Patients attending appointments booked in at the hospital's main reception area. Reception staff notified the X- ray department when patients had arrived, through the hospital's electronic appointment system.
- Radiologists provided an on-call service, should an emergency arise requiring urgent diagnostic intervention.
- The X-ray waiting area, also shared by patients waiting for magnetic resonance imaging (MRI) scan appointments (not provided by this service and not included in this inspection), had limited space, with seven seats and two changing cubicles separated by curtains. Each cubicle had a locker for storing patients' personal possessions whilst they were having their investigations. During our inspection we saw this area was quite congested at times, with some patients having to stand whilst dressed in a theatre gown. Staff said there could be limitations with this waiting room and if it was busy, they would inform main reception to direct patients to wait in the main waiting area.
- Car parking at the hospital could be an issue on certain days and at particular times of day, however we did not hear any significant concern from patients about this. There were no parking charges for patients, public or staff.

Meeting people's individual needs

- The hospital had a system for identifying patients who had an additional need. This included whether patients had certain conditions, such as Alzheimer's disease or dementia; or a physical or learning disability; or if the patient required language communication support.

Access and flow

- Ward patients who required any diagnostic imaging investigations were referred as needed. The service prioritised time at the start of each day to respond to any ward requests and attended these through the day. Sufficient staff were available to be able to respond to ward requests and manage booked appointments alongside these.
- Outpatients attended diagnostic imaging services on an appointment basis. The waiting times for appointments was two weeks for routine X-ray and ultrasound investigations. The service was also available to respond to same day requests for X-ray investigations, for patients attending outpatient appointments.
- The service had agreed a standard operating procedure for report turnaround times, in August 2018. This indicated the waiting times for routine plain film X-ray result reports as 14 days, and for urgent reports 48 hours. Ultrasound investigation reports, for both urgent and routine investigations, were indicated as available after 48 hours.

Good

Diagnostic imaging

- The report turnaround times procedure stated that management information about report times should be reviewed in weekly radiology meetings. At the time of inspection, due to an imminent upgrade in IT systems, this management information was not routinely available as an electronic report, but was monitored daily by the radiology manager. This information was discussed, shared and documented in weekly team meetings with all radiology staff. We saw from team meeting minutes that report turnaround times were an agenda item and discussed.
- Staff in the department told us they would run extra clinics in response to times of additional demand and when waiting lists started to increase. This could occur four to five times a year. This helped to maintain access for patients and support the continuing delivery of other clinical services in the hospital.
- Outpatients were offered a choice of appointment time and this could usually be accommodated within two weeks following referral. Many patients were also referred directly from outpatient clinics and could be seen on the same day.

Learning from complaints and concerns

- See information under this sub-heading in the surgery section.
- The diagnostic imaging service received a low number of complaints and during the 12 months prior to inspection there had not been any formal complaints raised. A concern about staff communication had been identified from a comment in friends and family test feedback, six weeks prior to inspection. We saw from departmental meeting minutes, this had been discussed with staff and reflected on during a team meeting.
- We saw information about how to raise any concerns was displayed in the public areas of the hospital. Leaflets and feedback forms were readily available for patients to provide any immediate comments.

Are diagnostic imaging services well-led?

Good

Leadership

- See information under this sub-heading in the surgery section.
- The diagnostic imaging manager had suitable qualifications and experience to lead the imaging service and was supported by the hospital's matron to do this. The diagnostic imaging manager met with the matron who provided support for the hospital manager's overall leadership of the hospital.
- Staff in the service were clear about their roles and responsibilities and said there was good leadership within the service on a day-to-day basis. The diagnostic imaging manager was accessible and responded to queries when these arose, and staff said they were well supported by managers.
- We observed that the senior management team took an active interest in all staff activity at the hospital and regularly rewarded staff who had gone above and beyond. A member of staff in the diagnostic imaging service commented "the hospital manager calls me by name and shows an interest"

Vision and strategy

- See information under this sub-heading in the surgery section.

Culture

- Staff we spoke with were positive about the diagnostic imaging service and described how they worked well together as a team. During the inspection, we saw evidence of good teamworking, with on-going communication and staff support for each other.
- The hospital management actively encouraged staff in being open and honest. Staff we spoke with felt there had been an improvement in communications since the last inspection, both between different staff and between staff and management levels. The hospital had promoted "human factors" training during the past 12-18 months, which staff felt had also contributed to the development of open communication. Some staff felt this had also helped improve standards at the hospital.

Good

Diagnostic imaging

- Staff were aware of the importance of informing patients when a mistake had occurred; whilst there were no examples of this from the diagnostic imaging service, staff understood the principles of the duty of candour.
- Staff were proud to work at Fulwood Hall Hospital and described the experience as "like working in a family". In a staff focus group during inspection, over half the group had been working at the hospital more than five years, and others over ten years.
- Staff said they felt confident and able to raise any issues of concern to the matron or hospital manager if needed.
- Patients we spoke with said they thought staff were positive, communicated well and appeared happy in their work

Governance

- See information under this sub-heading in the surgery section.
- Heads of departments met monthly and discussed incidents, complaints and new initiatives. We reviewed minutes from these meetings and saw that there were standard agenda items and action plans arising.
- The diagnostic imaging manager provided regular updates from the radiation protection committee meetings to the clinical governance committee.

Managing risks, issues and performance

- See information under this sub-heading in the surgery section.
- The imaging manager kept a local risk register, which identified risks in diagnostic imaging services. Managers were clear in describing the risk register and had good insight of the areas of concern. Monitoring systems for identifying and managing risks were effective and appropriate.

Managing information

- See information under this sub-heading in the surgery section.
- Managers had access to various types of report from different services in the hospital and used these to monitor performance and improve the quality and safety of the services that were delivered.
- The risk management system produced data on incidents, complaints and compensation claims. It could highlight performance issues and areas for improvement.
- Managers also had access to reports on practicing privileges, performance review data and staff completion of mandatory training.

Engagement

- See information under this sub-heading in the surgery section.

Learning, continuous improvement and innovation

- Radiographers supervised and supported student radiographers in their clinical education placements at Fulwood Hall Hospital.
- The diagnostic imaging manager had attended heads of department training and met on a six-monthly basis with the quality improvement manager within Ramsay Healthcare UK.
- Staff had opportunities for development through the Ramsay scholarship funding scheme. The Ramsay regional clinical educator confirmed two staff at Fulwood Hall Hospital had completed MSc qualification through this programme.

Outstanding practice and areas for improvement

Outstanding practice

- A 'perfect pain, triage and Pilates class' approach, provided by physiotherapists, was audited and showed improved outcomes for patients with different types of pain.
- Staff in outpatient departments had held a pain study day in March 2018, with plans for this to be repeated in October.
- In responding to patients' individual needs, the hospital had identified a working group for supporting patients with autism.
- The hospital had been awarded a food hygiene rating of five by the local authority.
- There was a strong focus on promoting a safety culture with implementation of a " Speak up for Safety" initiative and all staff had completed human factors training.
- The physiotherapy service had identified an electronic feedback form for patients; this initiative have been shared with other Ramsay hospitals.
- The hospital was proactive in integrating with the local healthcare economy and had been working with GPs by offering consultant-led lectures on common conditions requiring surgical intervention.
- Staff members had promoted health and basic first aid training in engagement with local schools.
- Staff had opportunities for development through the Ramsay scholarship funding scheme and two staff at Fulwood Hall Hospital had accessed this to completed MSc qualification.

Areas for improvement

Action the provider MUST take to improve

In surgery services

- The provider must ensure that World Health Organisation (WHO) checklists are undertaken fully and correctly, according to guidelines, before and after every surgical episode.

In diagnostic imaging services

- The provider must ensure that radiology equipment in theatres is cleaned after each patient use and robust systems are in place for routine cleaning of equipment.

Action the provider SHOULD take to improve

In surgery services,

- The provider should complete and record intra-operative temperature checks to ensure patients are kept at an optimum temperature for surgery and protected from hypothermia.

In the outpatient department,

- The provider should ensure staff complete their appraisals.
- The provider should implement consistent use of pain-scoring tools in the outpatient department.
- The provider should maintain all equipment, including treatment couches, in good condition.
- The provider should review systems for documenting staff clinical supervision.

In the Diagnostic Imaging department,

- The provider should ensure medicines are correctly stored at all times in accordance with the hospital's policy.
- The provider should arrange for removal of the out of service OPG equipment in the X-ray room.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3) – Safe care and treatment The provider did not always carry out surgical safety checklists in accordance with recognised best practice to ensure the safety of the patient during surgical episodes. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3) (as amended) parts 12 (1) and (2)(a)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3) – Premises and equipment. The provider did not ensure robust systems were in place for routine cleaning of radiology equipment used in theatre. This is a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3) (as amended), parts 15 (1) (a)