The Princess Grace 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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

The Princess Grace Hospital is a 126 bedded private hospital and part of HCA Healthcare UK, who also provide care at five other hospitals in London.

The hospital undertakes a range of surgical procedures and provides medical and critical care for adults. The hospital also provides services for private patients through the outpatients department and the Urgent Care Centre. The Princess Grace Hospital therefore provides five of the eight core services that are inspected by the Care Quality Commission as part of its new approach to hospital inspection.

We inspected the hospital as part of our planned inspection programme, visiting on 31 August, 1 and 2 September 2016, followed by an unannounced visit on 14 September 2016.

Overall, we have rated the Princess Grace Hospital as 'requires improvement'.

Our key findings were as follows:

Are services safe at this hospital?

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

Overall, we rated safe as 'required improvement'.

- Infection Prevention and Control (IPC) did not always reflect current evidence-based guidance, hospital policy and best practice. We observed that best practice guidelines were not always implemented in practice and observed that hospital policies were not always followed.
- We observed staff washed their hands between seeing patients but staff did not always adhere to the "bare below the elbows" requirement for the prevention and control of infection.
- We had concerns about the lack of a formal system to prioritise patients by acuity or severity of their condition during the triage process in the Urgent Care Centre. Staff did not follow the hospital's policy to use National Early Warning Score (NEWS) system to monitor and detect deterioration in patients.
- Throughout the surgery departments, basic life support training (BLS) was poorly attended when compared to other mandatory training topics. In theatres, only 50% of staff had attended this training.
- The UCC did not have sufficient numbers of nursing or medical staff trained to to level 3 in safeguarding children in line with the intercollegiate guidance for clinical staff working with children, young people (including people aged 16-18 years old) and/or their parents/ carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person.
- Incidents were discussed at monthly divisional governance meetings and information and lessons learnt were shared with staff and staff were encouraged to report incidents. Although learning from incidents was shared with all staff via learning grids, not all staff were able to give us an example of any changes due to an incident. This indicated that learning from incident was not widely spread. Incident reporting in some areas such as theatres was low.
- Records were not consistently kept up to date and we saw documentation that did not meet GMC standards. We saw and nurses told us that consultants did not always document in the patients notes when they reviewed patients. Nursing care plans did not always continue all the necessary information required to provide personalised care to patients.

Summary of findings

- The storage room on ITU where unit waste was collected before disposal was not kept locked and did not comply with the Department of Health 2011 Safe Management of Waste guidelines.
- Medicines were stored appropriately and were managed safely although medicine administration did not always follow best practice guidelines on the surgical wards. We saw drug omissions were not always recorded and we saw staff administrating medication without checking the patients name and date of birth.
- Flooring in most outpatient clinic rooms did not meet national standards, but we were shown an action plan to resolve the situation by March 2017.
- All equipment was safety tested and maintenance contracts were in place to make sure specialist equipment was serviced regularly.
- Staff were clear about their responsibilities to report adult safeguarding concerns.
- Staffing levels and skill mix was planned, implemented and reviewed to keep people safe at all times. Staff shortages were responded to quickly. This included the identification of risks at a service and individual patient level, and taking steps to limit the number of patients on the ward when challenges in achieving appropriate staffing levels occurred.
- The wards had clear systems to manage a deteriorating patient and patient risks were appropriately identified and acted upon.
- Plans and arrangements were in place to respond to emergency situations.

Are services effective at this hospital?

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

Overall, we rated effective as 'good'.

- Patients received coordinated care from a range of different teams. An experienced team of consultants and nurses delivered care and treatment in line with current evidence-based guidance, standards, best practice and legislation.
- Staff were supported by managers, mentors and practice development nurses to deliver effective care and treatment, through meaningful and timely supervision and appraisal. Medical staff received regular training as well as support from consultants.
- The hospital had a process for checking competency and granting and reviewing practicing privileges for consultants. The medical advisory committee (MAC) reviewed patient outcomes and the renewal of practicing privileges of individual consultants. It also reviewed policies and guidance and advised on effective care and treatments.
- There was participation in relevant local and national audits where appropriate. Accurate and up-to-date information about outcomes was shared internally amongst staff. Although in the medical departments, audits to assess clinical outcomes and benchmark them with other services were not well developed.
- Patients had good access to seven-day services and the unit had input from a multidisciplinary team.
- Staff at all levels had a good understanding of the need for consent.
- The urgent care centre (UCC) offered access to on-site diagnostics and imaging services.

Summary of findings

- Intensive Care National Audit Research Centre (ICNARC) data for the period, April 2015 to March 2016 showed no cases of unit-acquired infections in the blood. This was better than similar units. The unit did not meet all the standards of Intensive Care Society related to screening patients for delirium. There was no regular joint multidisciplinary team (MDT) meeting. The unit had put plans in place to improve both issues.
- We had concerns about the combined use of electronic and paper based records which resulted in difficulties in obtaining a full contemporaneous picture of the patients' health care information. Documentation such as fluid charts were not consistently completed.
- Pain was assessed using different scoring systems. Patient feedback and audits demonstrated post-operative pain was not always effectively managed. Pain relief scores were not always documented in patient notes in the UCC. On the medical ward, systems to monitor and manage patients' pain were not always effective.
- The dietitian told us that they only visit when critical care staff referred patients. Although this was in line with the hospital policy but there were plans to start daily visits to the unit in line with the HCA (provider) standards.
- There was poor compliance with Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) policy in critical care, but an action plan was in place to improve compliance.
- The requirements of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards were not well understood and applied. No doctors in the UCC received mental capacity act training.
- An End of Life care plan had only recently been introduced and was not fully embedded in practice.

Are services caring at this hospital?

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

Overall, we rated caring as 'good'.

- During the inspection, we saw that staff were caring, sensitive to the needs of patients, and compassionate. Staff maintained patients' dignity and respect at all times.
- Patients commented positively about the care provided by all staff and said they were treated courteously and respectfully.
- Patients told us they had sufficient information about their treatment and were involved in making decisions about their care.
- Staff supported patients emotionally with their care and treatment as needed. In addition, a psychologist attended the oncology ward regularly and offered support.
- We found an absence of documentation of discussions with patients about their prognosis and discussions about their options in relation to their care and treatment when they had a poor prognosis.
- There was no formal feedback recorded for patients attending the Urgent Care Centre.

Are services responsive at this hospital/service?

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

Overall, we rated responsive as 'good'.

Summary of findings

- Services were planned and delivered in way that met the needs of the local population. Patients were able to access care and treatment in a timely way and action was taken to minimise the time patients had to wait for investigations. We observed that there was good access to appointments and there were minimal waiting times for outpatient clinics and diagnostic imaging. Patients we spoke with confirmed this. Diagnostic appointment slots were available on the same day.
- Facilities and premises were appropriate for the services being delivered. Waiting areas were furnished to a high standard, provided free refreshments and were well stocked in the latest newspapers and magazines.
- Patients had access to services that met their individual needs including interpreting services for patients that did not speak English.
- There was an effective complaints process, with evidence of appropriate investigations and there was culture of learning from complaints across all areas. Formal complaints were rare and issues arising from formal and informal complaints led to changes in working practice. Although patient information leaflets regarding complaints procedure were not readily available on the critical care unit.
- There were no formalised patient pathways in the Urgent Care Centre which had been officially approved by the medical advisory committee (MAC).
- The Urgent Care Centre had no processes in place to assist patients with complex needs or learning disabilities.
- The coordination and delivery of medical services did not take account of the needs of people living with dementia and those with a learning disability.
- There was a large number of hospital cancelled operations and not all patients were rescheduled within 28 days.
- There was no multi faith room to meet the spiritual needs of patients and their relatives.

Are services well led at this hospital?

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

Overall, we rated well led as 'requires improvement'.

- We were shown patient feedback survey forms for the UCC, however there was no evidence that results were collected, analysed or acted upon.
- The hospital was in the process of implementing a care in the last days of life strategy, aligned to NICE guidance in collaboration with a local NHS trust. Although training had been commenced, limited progress had been made at the time of the inspection.
- A hospital-wide risk register incorporated risks, which could affect staff, patients and visitors. The management team had oversight of the risks within the services. There were no local risk registers and some staff were unaware of the risks in their local areas. Risks and issues identified during inspection had not been identified or dealt with in a timely way. The risks described did not correspond to those reported to and understood by leaders.
- Staff who had identified issues such as consultant documentation did not speak up about these concerns.
- Staff in all areas knew and understood the vision, values and strategic goals for the hospital and corporate provider. There were quarterly staff forums where senior management and all staff could engage regarding the goals and strategy of the hospital.

Summary of findings

- The CEO and other executive team members had an open door policy encouraging staff to engage with them. All staff we spoke with confirmed that the executive team was approachable.
- Leadership was visible and supportive at all levels and staff told us they felt valued by the senior leadership team. They were able to contribute their views and felt encouraged and supported to innovate and implement new ideas.
- The arrangements for governance and performance management operated effectively. Hospital wide information was cascaded effectively though the organisation and staff were aware of some quality improvement initiatives.
- The data from a staff feedback audit showed 97% of staff was 'committed to doing their best for HCA'.
- Medical care services had been progressively developed and steps taken to ensure the safety and quality of services when challenges occurred. The consultant team for oncology brought significant expertise and were actively engaged in research and development.

We saw areas of outstanding practice, including:

- The London Breast Institute offered a complete and state of the art service for patients, including consultation and diagnostics during one appointment in one clinical area.

However, there were areas of where the hospital needs to make improvements.

The hospital must:

- The Urgent Care Centre must have a formal system to prioritise patients by acuity or severity of their condition during the triage process.
- Staff in the Urgent Care Centre must follow the hospital's policy to use National Early Warning Score (NEWS) system to monitor and detect deterioration in patients.
- The theatre department must implement an infection control policy which reflects best practice guidelines to ensure infection prevention control procedures are fully embedded in practice to protect patients from the risk of infections.
- The hospital must ensure clinical staff have level 3 in safeguarding children in line with the intercollegiate guidance for clinical staff working with children, young people (including people aged 16-18 years old) and/or their parents/ carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person.
- The hospital must ensure patient records are fit for purpose in that there is a full contemporaneous record of patient care and treatment. In addition, ensure the person making an entry is identified, they are legible, include an accurate record of all decisions and make reference to discussions with people who use the service and their wishes.

The hospital should:

- The hospital should ensure all staff are "bare below the elbows" when in wards and clinical areas.
- The ward areas should ensure all medicines are administered in line with the corporate policy.
- The service should ensure all staff are up to date with mandatory and statutory training. Including safeguarding training for staff and mental capacity act training for doctors working in the Urgent Care Centre.
- The hospital should update policies in the Urgent Care Centre to include author and date.
- The Urgent Care Centre should have a formalised way to review and manage the opinions of patients.

Summary of findings

- The hospital should take a consistent approach to the identification and management of patients with pain to ensure the timeliness and effectiveness of interventions. The Urgent Care Centre should improve documentation of pain scores in patient notes.
- The theatre department should ensure all equipment is easy to access and clearly labelled to ensure agency, bank or new staff would know where to find essential equipment.
- The surgical services should ensure all staff have access to professional development and career progression.
- The critical care unit should introduce stringent processes in place to ensure full compliance with all applicable standards of the Intensive Care Society.
- The critical care unit should as a priority review the storage room where unit waste was collected before disposal and to be kept locked at all times with provision for staff to access it when required, in line with the Department of Health 2011 Safe Management of Waste guidelines.
- The critical care unit should ensure there is wider learning from incidents across all staff level.
- The critical care unit should ensure more systematic process are in place for MDT jointly with pharmacy, dietitian, physiotherapy and any other relevant professionals.
- The hospital should review the provision for daily visits to critical care unit by a dietitian to assess all relevant patients.
- The critical care unit should improve compliance with DNACPR policy.
- The critical care unit should ensure patient information leaflets about complaints process are available in the unit. Steps to be taken to raise awareness among patients and relatives.
- The hospital should ensure there is full compliance with the Deprivation of Liberty Safeguards (DoLS) and ensure records provide documentary evidence of mental capacity assessments and best interest decision making when patients are not able to make specific decisions about their care and treatment.
- The hospital should improve the coordination and delivery of services for people living with dementia and those with a learning disability.
- The hospital should review its provision facilities for patients and relative regarding quiet or prayer room within the hospital.
- The hospital should develop and implement a strategy for End of Life Care to reflect current guidance and should develop a governance framework for End of Life Care to monitor implementation of the strategy and best practice guidance.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Urgent and emergency services	Requires improvement 	There was no formal system to prioritise patients by acuity or severity of their condition during the triage process. Staff did not follow the hospital's policy to use National Early Warning Score (NEWS) system to monitor and detect deterioration in patients. There was an over reliance on the individual judgement of clinical staff rather than the use of a standardised tool to monitor patients. There were low rates of safeguarding training among UCC staff. Pain relief scores were not always documented in patient notes. No doctors received mental capacity act training. There was no formal patient feedback recorded for the UCC. There were no formalised patient pathways with agreement from the medical advisory committee (MAC). There were no processes in place to assist patients with complex needs or learning disabilities. The vision and values of the centre were non-existent and staff were not aware of a department wide strategy. There was no formalised way to review and manage the opinions of patients. Medicines were managed safely. There were sufficient GP and nursing staff on duty to meet the needs of patients. Staff had appropriate A&E experience. The UCC offered access to on-site diagnostics and imaging services. Patients we spoke with spoke very highly of the care they received. Patients were supported, treated with dignity and respect and were involved in their care. People's needs were met through the way the centre was organised and services were delivered. There was adequate seating and space in the reception and waiting areas and during our inspection we observed that all patients waiting were catered for with a seat.

Summary of findings

The registration system was easy to use and supported patients in understanding the pricing structure.
Complaints were responded to in a timely way.
The leadership and culture of the centre supported the delivery of high quality person-centred care.
All staff we spoke with felt actively engaged by the senior leadership team.
There was an effective and comprehensive process in place to manage risk.

Medical care

Good

The infrastructure for medical services had been progressively developed to enable the delivery of safe and effective for patients. This included the identification of risks at a service and individual patient level, and taking steps to limit the number of patients on the ward when challenges in achieving appropriate staffing levels occurred.
There was access to specialist services when patients deteriorated. Sufficient staff, with the appropriate level of knowledge and skills for their job role, were available and they had access to appraisal and support.
Staff were kind and compassionate and patients felt involved in their care and treatment.
Psychological support was available for patients to help them cope emotionally with their diagnosis and treatment.
Patients had timely access to care and treatment and investigative and diagnostic services were available seven days a week when required.
There was good access to interpreting and translation services for patients for whom English was not their first language.
There was effective leadership at all levels of medical care services and staff felt supported, valued and engaged. Medical care services had been progressively developed and steps taken to ensure the safety and quality of services when challenges occurred. The consultant team for oncology brought significant expertise and were actively engaged in research and development.
The requirements of vulnerable patient groups were not always fully recognised and met. For example, the requirements of the Mental Capacity

Summary of findings

Act (2005) and the Deprivation of Liberty Safeguards were inconsistently applied and the needs of people living with dementia were not fully explored and addressed.
Audits to assess the outcomes of care and treatment and benchmark them with other services needed further development.
Care records did not always meet professional standards for documentation and some lacked the detail necessary to provide personalised and effective care for patients.
End of Life Care (EoLC) services required further development and documentation of discussions with patients and decision making in relation to palliative care required improvement.

Surgery

Requires improvement 

Infection Prevention and Control (IPC) did not always reflect current evidence-based guidance, hospital policies and best practice. We observed that best practice guidelines and hospital policieswere not alwaysimplemented in practice. For example we saw that theatre floors were not cleaned in between patients and observed during inspection thatthey were dirty, staff in clinical areas did not adhere to the bare below the elbows policy.
Information sharing did not inform nursing staff of incidents and learning that had occurred within their own ward areas. Staff were unable to recall recent incidents or learning from their areas and told us they had not reported any incidents within the previous 12 months. Incident reporting in surgery areas of the hospital was low when compared with other services.
Basic life support training (BLS) was poorly attended when compared to other mandatory training topics. In theatres only 50% of staff had attended this training. The staff that had not completed BLS traininghad not completed other forms of life support training.
Records were not consistently kept up to date when doctors visited their patients and we saw documentation that did not meet the General Medical Council (GMC) standards.
Medicine administration and medicine record keeping did not follow best practice guidance.

Summary of findings

We saw that staffing in theatres did not always comply with The Association of Perioperative Practice (AfPP) guidelines.
Risks and issues identified during inspection had not been identified or dealt with in a timely way.
The risks described did not correspond to those reported to and understood by leaders.
Staff who had identified issues such as consultant documentation did not always speak up about these concerns.
Care and treatment was planned and delivered in line with current evidence-based guidance, standards and best practice. This was monitored through audits to ensure high standards and consistency.
The World Health Organisation (WHO) safer surgery checklist was clearly defined and we observed that the three mandatory steps; sign in, time out and sign out were fully embedded in practice.
We saw staff responding to patients and their families compassionately. Patients' privacy and dignity was respected at all times. Feedback attained from patients and their families during our inspection was positive.
Services were flexible, individual patient needs and preferences were prioritised and patients were able to access services in a way and at a time that suited them.
The surgical services were using outstanding cutting edge technology including robotic surgery for orthopaedic and prostate surgery with outcomes monitored appropriately.
Leadership was visible and supportive at all levels in the surgical services and staff we spoke with felt valued by the senior leadership team. Staff told us they were able to contribute their views and felt new ideas were welcomed.

Critical care

Good 

Staffing in the unit was compliant with Intensive Care Society (ICS) guidance, with appropriate numbers of suitably qualified and registered staff. Nurse to patient and doctor to patient ratios were consistently in line with this guidance.

Summary of findings

An experienced team of consultants and nurses delivered care and treatment based on a range of best practice guidance. Suitably qualified nursing staff cared for patients. Medical staff were supported by consultants.
There was good access to seven-day services and the unit had input from a multidisciplinary team
The unit had fewer readmissions within 48 hours of discharges, compared to other similar units.
The critical care unit provided a caring, kind, and compassionate service, which involved patients and their relatives in their care. All the feedback from patients and their relatives we spoke with was positive.
Observations of care showed staff maintained patients' privacy and dignity and patients and their families were involved in their care.
ICNARC (Intensive Care National Audit and Research Centre) data for April 2015 to March 2016 showed that the unit performed better than similar units in many quality indicators.
The complaints process was effective, with appropriate investigations and there was culture of learning from complaints across the board.
There were good governance structures within the hospital and linked with critical care unit.
We saw good local leadership within the unit and staff reflected this in their conversations with us. Staff said the culture on the unit was supportive and any member of staff could approach the leadership team with any issues or new ideas.
The management team had oversight of the risks within the services and mitigating plans were in place.
Although learning from incidents was shared with all staff via learning grids, not all staff were able to give us an example of any changes in the unit due to an incident. This indicated that learning from incidents could be improved among staff members.
The storage area where unit waste was collected before disposal was not kept locked and did not comply with the Department of Health 2011 Safe Management of Waste guidelines.
There were no regular joint MDTs within the unit. The unit had put a plan in place to introduce this initiative.

Summary of findings

The dietitian told us that they only visit when CCU staff referred patients. Although this was in line with the hospital policy but there were plans to start daily visits to the unit in line with the HCA (provider) standards.
There was poor compliance with DNACPR policy, but action plan was in place to improve compliance.
The unit did not meet all the standards of Intensive Care Society related to screening patients for delirium. Staff were developing a policy to meet this standard.
The relatives we spoke with were not aware of how to make a complaint but they said that they don't need any information leaflet regarding this as they were happy with the care received and staff were always there to resolve any concerns.
There was no quiet or prayer room facilities for relatives.

Outpatients and diagnostic imaging

Good

There were quarterly staff forums where senior management and all staff could engage regarding the goals and strategy of the hospital.
Staff felt encouraged and supported to innovate and implement new ideas.
The CEO and other executive team members had an open door policy encouraging staff to engage with them. All staff we spoke with confirmed that the executive team was approachable.
Outpatient and diagnostic services were delivered by caring, committed and compassionate staff and care was planned that took account of patients' needs and wishes.
An electronic patient record (EPR) was used to ensure constant availability of medical records.
All radiological reporting was conducted within 24 hours and all diagnostic results were available with minimal delay.
We observed minimal waiting times for appointments, all patients we spoke with confirmed that they were seen on time and were kept informed on the rare occasion where they had to wait.
We observed that staff were very accommodating to patients individual needs.

Summary of findings

Managers and clinical leads were visible and approachable and had a good knowledge of performance in their areas of responsibility.
There was an open and honest culture within the service, morale was good and we were provided with evidence of continuous improvement and development of staff.
Carpeted flooring in most outpatient clinic rooms did not meet national standards which require any clinical area where spillage of bodily fluids is likely to be non-carpeted, but we were shown an action plan to resolve the situation by quarter 1 of 2017.

Summary of findings

Contents

Requires improvement

The Princess Grace Hospital

Services we looked at

Urgent and emergency services; Medical care; Surgery; Critical care; Outpatients and diagnostic imaging

Summary of this inspection

Background to The Princess Grace Hospital

The Princess Grace Hospital is a private hospital, which is based in Central London and part of HCA Healthcare UK.

The hospital operates 126 beds, including 9 beds on the intensive care/high dependency unit (ITU/HDU). There is an Urgent Care Centre on the ground floor with three cubicles and two consultation rooms. The on-site facilities include two endoscopy suites and eight operating theatres (three with laminar airflow). The outpatient department is spread across three sites with a total of 38 consulting rooms. The diagnostic imaging department offers plain X-ray, ultrasound, mammography, tomosynthesis, bone density, MRI and CT scans as well as an interventional radiology suite.

The hospital provides a range of services to patients aged 18 years and over, who are self-pay or use private medical insurance. Services offered include general surgery, orthopaedics, urology, ear, nose and throat, gynaecology, general medicine, oncology, endoscopy and diagnostic imaging and urgent care services.

The hospital was working towards Joint Advisory Group Accreditation (JAG) for endoscopy.

The three main outpatient department specialities are orthopaedics, general medicine and breast. The three most commonly performed surgical procedures were urology, knee and hip procedures.

Out of 12,068 inpatient and day case episodes of care during the reporting period April 2015 to March 2016, the hospital was providing 1% NHS funded care.

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

The registered manager, Charlotte Tempest, registered on 18 December 2012.

The nominated individual from HCA Healthcare UK Michael Neeb, registered on 18 December 2012.

Our inspection team

Our inspection team was led by:

Inspection Lead: Michelle Gibney, Inspection Manager, Hospitals Directorate, London.

The team included CQC inspectors and a variety of specialists: consultants, nurses, governance lead and expert by experience.

Why we carried out this inspection

We undertook a comprehensive inspection of the hospital as part of our planned inspection programme of independent acute hospitals.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Summary of this inspection

• Is it well-led?

Before visiting, we reviewed a range of information we held about the hospital and each core service.

We carried out an announced inspection visit on 31 August and 1, 2 September 2016 and an unannounced inspection on 14 September 2016.

We held focus groups for staff in the hospital. We also spoke with staff and managers individually. We talked with patients and staff from the ward, operating department, outpatients and imaging departments, endoscopy unit and the Urgent Care Centre. We observed care and treatment, talked with patients, and reviewed patients' records of care and treatment.

We received 29 comment cards from patients, relatives and members of staff before and during the inspection. All comments were positive about the service and the hospital as a whole.

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

Information about The Princess Grace Hospital

Key facts and figures

The hospital has 117 inpatient rooms with en-suite facilities and nine ITU/HDU beds. The hospital operates two endoscopy suites and eight operating theatres, three with laminar flow. There are 38 consultation rooms across three sites with five consulting rooms at the London Breast Institute, 10 rooms at 47 Nottingham Place and 23 consulting rooms at 30 Devonshire Street. In addition, there is radiology service with MRI and CT scanners and an interventional radiology suite.

The Princess Grace Hospital offers consultation and treatment through an Urgent Care Centre and provides outpatient service for various specialties. This includes, but is not limited to, orthopaedics, urology, gynaecology, general surgery and general medicine. There were 7,371 surgical procedures and 1,980 endoscopy cases carried out between April 2015 and March 2016. In the same period, there were 5,322 inpatient attendances and 6,746 day cases.

The most common surgical procedures were:

- 734 urology,
- 715 knee procedures,
- 434 hip procedures,
- 415 other orthopaedic procedures,
- 322 breast surgeries.

The most common medical procedures were:

- 935 colonoscopies,
- 522 orthopaedic injections,
- 502 spinal injections,
- 349 urology biopsies,
- 305 urology endoscopies.

Between April 2015 and March 2016, 42,807 people were seen in outpatients and 6,266 patients were seen in the Urgent Care Centre.

There are 683 doctors with practicing privileges and their individual activity is monitored.

All patients were admitted and treated under the direct care of a consultant and medical care is supported 24/7 by an onsite resident medical officer (RMO.) Patients are cared for and supported by registered nurses, care assistants and allied health professionals such as physiotherapists.

The accountable officer for controlled drugs is Sara Morgan, registered on 1 February 2016.

The Princess Grace Hospital has been inspected once by the Care Quality Commission, in January 2014, with focus on oncology services. All standards assessed were found to be compliant.

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?

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

Requires improvement 

- Infection Prevention and Control (IPC) did not always reflect current evidence-based guidance, hospital policy and best practice. We observed that best practice guidelines were not always implemented in practice and observed that hospital policies were not always followed.
- We observed staff washed their hands between seeing patients but staff did not always adhere to the “bare below the elbows” requirement for the prevention and control of infection.
- We had concerns about the lack of a formal system to prioritise patients by acuity or severity of their condition during the triage process in the Urgent Care Centre. Staff did not follow the hospital’s policy to use National Early Warning Score (NEWS) system to monitor and detect deterioration in patients.
- Throughout the surgery departments, basic life support training (BLS) was poorly attended when compared to other mandatory training topics. In theatres, only 50% of staff had attended this training.
- The UCC did not have sufficient numbers of nursing or medical staff trained to to level 3 in safeguarding children in line with the intercollegiate guidance for clinical staff working with children, young people (including people aged 16-18 years old) and/or their parents/ carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person.
- Incidents were discussed at monthly divisional governance meetings and information and lessons learnt were shared with staff and staff were encouraged to report incidents. Although learning from incidents was shared with all staff via learning grids, not all staff were able to give us an example of any changes dueto an incident. This indicated that learning from incident was not widely spread. Incident reporting in some areas such as theatres was low.
- Records were not consistently kept up to date and we saw documentation that did not meet GMC standards. We saw and nurses told us that consultants did not always document in the patients notes when they reviewed patients.Nursing care plans did not always continue all the necessary information required to provide personalised care to patients.

Summary of this inspection

- The storage room on ITU where unit waste was collected before disposal was not kept locked and did not comply with the Department of Health 2011 Safe Management of Waste guidelines.
- Medicines were stored appropriately and were managed safely although medicine administration did not always follow best practice guidelineson thesurgicalwards. We saw drug omissions were not always recorded and we saw staff administrating medication without checking the patients name and date of birth.
- Flooring in most outpatient clinic rooms did not meet national standards, but we were shown an action plan to resolve the situation byMarch 2017.
- All equipment was safety tested and maintenance contracts were in place to make sure specialist equipment was serviced regularly.
- Staff were clear about their responsibilities to report adult safeguarding concerns.
- Staffing levels and skill mix was planned, implemented and reviewed to keep people safe at all times. Staff shortages were responded to quickly. This included the identification of risks at a service and individual patient level, and taking steps to limit the number of patients on the ward when challenges in achieving appropriate staffing levels occurred.
- The wards had clear systems to manage a deteriorating patient and patient risks were appropriately identified and acted upon.
- Plans and arrangements were in place to respond to emergency situations.

Are services effective?

Good

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

- Patients received coordinated care from a range of different teams. An experienced team of consultants and nurses delivered care and treatment in line with current evidence-based guidance, standards, best practice and legislation.
- Staff were supported by managers, mentors and practice development nurses to deliver effective care and treatment, through meaningful and timely supervision and appraisal. Medical staff received regular training as well as support from consultants.
- The hospital had a process for checking competency and granting and reviewing practicing privileges for consultants. The

medical advisory committee (MAC) reviewed patient outcomes and the renewal of practicing privileges of individual consultants. It also reviewed policies and guidance and advised on effective care and treatments.

- There was participation in relevant local and national audits where appropriate. Accurate and up-to-date information about outcomes was shared internally amongst staff. Although in the medical departments, audits to assess clinical outcomes and benchmark them with other services were not well developed.
- Patients had good access to seven-day services and the unit had input from a multidisciplinary team.
- Staff at all levels had a good understanding of the need for consent.
- The urgent care centre (UCC) offered access to on-site diagnostics and imaging services.
- Intensive Care National Audit Research Centre (ICNARC) data for the period, April 2015 to March 2016 showed no cases of unit-acquired infections in the blood. This was better than similar units. The unit did not meet all the standards of Intensive Care Society related to screening patients for delirium. There was no regular joint multidisciplinary team (MDT) meeting. The unit had put plans in place to improve both issues.
- We had concerns about the combined use of electronic and paper based records which resulted in difficulties in obtaining a full contemporaneous picture of the patients' health care information. Documentation such as fluid charts were not consistently completed.
- Pain was assessed using different scoring systems. Patient feedback and audits demonstrated post-operative pain was not always effectively managed. Pain relief scores were not always documented in patient notes in the UCC. On the medical ward, systems to monitor and manage patients' pain were not always effective.
- The dietitian told us that they only visit when critical care staff referred patients. Although this was in line with the hospital policy but there were plans to start daily visits to the unit in line with the HCA (provider) standards.
- There was poor compliance with Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) policy in critical care, but an action plan was in place to improve compliance.
- The requirements of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards were not well understood and applied. No doctors in the UCC received mental capacity act training.

Summary of this inspection

- An End of Life care plan had only recently been introduced and was not fully embedded in practice.

Are services caring?

Good

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

- During the inspection, we saw that staff were caring, sensitive to the needs of patients, and compassionate. Staff maintained patients' dignity and respect at all times.
- Patients commented positively about the care provided by all staff and said they were treated courteously and respectfully.
- Patients told us they had sufficient information about their treatment and were involved in making decisions about their care.
- Staff supported patients emotionally with their care and treatment as needed. In addition, a psychologist attended the oncology ward regularly and offered support.
- We found an absence of documentation of discussions with patients about their prognosis and discussions about their options in relation to their care and treatment when they had a poor prognosis.
- There was no formal feedback recorded for patients attending the Urgent Care Centre.

Are services responsive?

Good

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

- Services were planned and delivered in way that met the needs of the local population. Patients were able to access care and treatment in a timely way and action was taken to minimise the time patients had to wait for investigations. We observed that there was good access to appointments and there were minimal waiting times for outpatient clinics and diagnostic imaging. Patients we spoke with confirmed this. Diagnostic appointment slots were available on the same day.
- Facilities and premises were appropriate for the services being delivered. Waiting areas were furnished to a high standard, provided free refreshments and were well stocked in the latest newspapers and magazines.
- Patients had access to services that met their individual needs including interpreting services for patients that did not speak English.
- There was an effective complaints process, with evidence of appropriate investigations and there was culture of learning from complaints across all areas. Formal complaints were rare

Summary of this inspection

and issues arising from formal and informal complaints led to changes in working practice. Although patient information leaflets regarding complaints procedure were not readily available on the critical care unit.
- There were no formalised patient pathways in the Urgent Care Centre, which had been officially approved by the medical advisory committee (MAC).
- The Urgent Care Centre had no processes in place to assist patients with complex needs or learning disabilities.
- The coordination and delivery of medical services did not take account of the needs of people living with dementia and those with a learning disability.
- There was a large number of hospital cancelled operations and not all patients were rescheduled within 28 days.
- There was no multi faith room to meet the spiritual needs of patients and their relatives.

Are services well-led?

Requires improvement

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

- We were shown patient feedback survey forms for the UCC, however there was no evidence that results were collected, analysed or acted upon.
- The hospital was in the process of implementing a care in the last days of life strategy, aligned to NICE guidance in collaboration with a local NHS trust. Although training had been commenced, limited progress had been made at the time of the inspection.
- A hospital-wide risk register incorporated risks, which could affect staff, patients and visitors. The management team had oversight of the risks within the services. There were no local risk registers and some staff were unaware of the risks in their local areas. Risks and issues identified during inspection had not been identified or dealt with in a timely way. The risks described did not correspond to those reported to and understood by leaders.
- Staff who had identified issues such as consultant documentation did not speak up about these concerns.
- Staff in all areas knew and understood the vision, values and strategic goals for the hospital and corporate provider. There were quarterly staff forums where senior management and all staff could engage regarding the goals and strategy of the hospital.

Summary of this inspection

- The CEO and other executive team members had an open door policy encouraging staff to engage with them. All staff we spoke with confirmed that the executive team was approachable.
- Leadership was visible and supportive at all levels and staff told us they felt valued by the senior leadership team. They were able to contribute their views and felt encouraged and supported to innovate and implement new ideas.
- The arrangements for governance and performance management operated effectively. Hospital wide information was cascaded effectively though the organisation and staff were aware of some quality improvement initiatives.
- The data from a staff feedback audit showed 97% of staff was 'committed to doing their best for HCA'.
- Medical care services had been progressively developed and steps taken to ensure the safety and quality of services when challenges occurred. The consultant team for oncology brought significant expertise and were actively engaged in research and development.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Urgent and emergency services

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

Information about the service

The Urgent Care Centre (UCC) at the Princess Grace Hospital provides urgent care with no prior appointment and is open daily from 8am to 10pm. The last patient is registered to the centre at 9.30pm. The centre is open 365 days a year and offers urgent care for medical illnesses, disease and minor injuries in adults over the age of 16. The service does not treat patients under 16 years old, London Ambulance Service (LAS) patients, patients presenting with obstetric related problems and patients presenting with mental health issues.

Between August 2015 and July 2016, 6284 patients visited the UCC. The UCC saw 285 patients admitted as inpatients to the Princess Grace between July 2015 and July 2016.

Patients present to the centre by walking to the reception where the receptionist on duty asked the patient to complete a registration and information form before being seen.

GPs and nurses with emergency department experience staffed the service. The centre offers access to on-site diagnostics and imaging services and a complete initial assessment with referral or admission to the hospital where necessary. There are three cubicles and two consultation rooms within the centre.

During our inspection, we visited the UCC on Wednesday 31 August, Thursday 1 and Friday 2 September and during an unannounced visit on Wednesday 14 September. We followed the patient journey from arrival through to discharge. During our inspection we spoke with two doctors, four nurses, one receptionist, two patients and their relatives. We undertook observations within all areas of the department and reviewed documentation, including ten patient records. We also used information provided by the organisation and information we requested.

Requires improvement

Urgent and emergency services

Summary of findings

Overall, we rated the Urgent Care Centre as 'Requires Improvement' because:

- There was no formal system to prioritise patients by acuity or severity of their condition during the triage process.
- Staff did not follow the hospital's policy to use National Early Warning Score (NEWS) system to monitor and detect deterioration in patients. There was an over reliance on the individual judgement of clinical staff rather than the use of a standardised tool to monitor patients.
- There were low rates of safeguarding training among UCC staff.
- GPs did not receive mental capacity act training.
- There was no formal patient feedback recorded for the UCC.
- There was limited data on patient waiting times.
- There were no processes in place to assist patients with complex needs or learning disabilities.
- The vision and values of the centre were non-existent and staff were not aware of a department wide strategy.
- There was no formalised way to review and manage the opinions of patients.

However:

- Patients we spoke with spoke very highly of the care they received.
- Patients were supported, treated with dignity and respect and were involved in their care.
- Medicines were managed safely.
- There were sufficient GP and nursing staff on duty to meet the needs of patients.
- Staff had appropriate Emergency Department (ED) experience.
- The UCC offered access to on-site diagnostics and imaging services.
- Patients' needs were met through the way the centre was organised and services were delivered.
- There was adequate seating and space in the reception and waiting areas and during our inspection we observed that all patients waiting were catered for with a seat.
- The registration system was easy to use and supported patients in understanding the pricing structure.
- Complaints were responded to in a timely way.
- The leadership and culture of the centre supported the delivery of high quality person-centred care.
- All staff we spoke with felt actively engaged by the senior leadership team.
- There was an effective and comprehensive process in place to manage risk.

Requires improvement

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

We rated safe as 'requires improvement' because:

- There was no formal system to prioritise patients by acuity or severity of their condition during the triage process.
- Staff did not follow the hospital's policy to use National Early Warning Score (NEWS) system to monitor and detect deterioration in patients. There was an over reliance on the individual judgement of clinical staff rather than the use of a standardised tool to monitor patients.
- There were low rates of safeguarding training among UCC staff.

However,

- Medicines were managed safely.
- There were sufficient GP and nursing staff on duty to meet the needs of patients.

Incidents

- All incidents were reported through a hospital wide electronic reporting system. This allowed for management overview of incident reporting and an ability to analyse any emerging themes or trends.
- We spoke with medical, nursing and administrative staff who told us they knew how to report incidents and 'near misses' using the electronic reporting system.
- All the staff we spoke with said they were supported and encouraged to raise any concerns with the clinical and nursing leads in the department.
- Information provided by the hospital showed 23 incidents were reported by staff in the UCC between 1 October 2015 and 31 March 2016. Incident themes related to: infrastructure or resources (staffing, facilities, environment) (5 incidents); abusive, violent, disruptive or self-harming behaviour (4 incidents); medication (3 incidents); access to services (appointment, admission, transfer, discharge) (3 incidents) and clinical assessment (investigations, images and lab tests) (3 incidents). There were five other incidents that did not fit into these themes.
- In the reporting timeframe, there were no reported serious incidents within UCC that met the provider's threshold for investigation as a serious incident under their corporate incident reporting, management and investigation policy. Staff showed a good awareness of what constituted a serious incident.
- Staff told us they received feedback and learning from incidents hospital wide through learning grids, via email and at nursing handovers.
- There were no never events in the UCC in the last 12 months. (A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined).
- It was hospital policy to review patient deaths. There were no episodes of mortality in the UCC.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- All staff we spoke with had good awareness of duty of candour requirements. Staff knew that patients should be informed an incident had occurred, given an apology and told that an investigation would take place. There were no incidents in the UCC that met the criteria of notifiable safety incidents duty of candour regulation in the last 12 months.

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

- The hospital did not use the NHS Safety Thermometer. This is a tool which measures harm to patients which may be associated with their care. However, the hospital had developed a clinical dashboard which monitored pressure ulcers; falls and VTE. However, it was not used in the Urgent Care Centre because patients were in the department for a short time.

Cleanliness, infection control and hygiene

- A labelling system was in use to indicate that an item had been cleaned and was ready for use. The equipment we looked at was clean.
- The treatment areas had adequate hand-washing facilities. We observed staff washing their hands between seeing each patient and using hand sanitising gel.
- Monthly hand hygiene audits were undertaken in the UCC. Between January and July 2016 the average compliance was 95.2%. An action plan was developed to improve compliance.
- 100% UCC staff were compliant with infection prevention and control (IPC) training.
- We observed that staff complied with the hospital policies for infection prevention and control. This included wearing the correct personal protective equipment, such as gloves and aprons. The 'bare below the elbows' policy was observed by all staff working in clinical areas.
- Two consulting rooms were available to isolate patients presenting with a possible cross-infection risk.
- We saw monthly environmental audits in the UCC which showed good compliance with IPC standards.

Environment and equipment

- There was sufficient seating in the waiting room and reception staff had a direct line of sight of the area.
- The department was well-lit and spacious.
- Electronic 'swipe' locks maintained a secure environment.
- There were appropriate arrangements for managing waste and clinical specimens.
- Each cubicle had an adjustable height trolley with piped oxygen and suction equipment installed and ready to use. Cubicles were sufficiently spacious to deliver care to patients.
- A resuscitation trolley with appropriate equipment and defibrillator were available in the UCC and we found that equipment checklists for the resuscitation trolley were consistently checked and signed for daily.
- There was a 'grab bag' for paediatric resuscitation in the UCC. We asked why the grab bag was necessary as the service stopped providing a service to children on 31 August 2016; the provider told us they were in the process of reviewing resuscitation trolleys that contained both adult and paediatric equipment and planned to remove paediatric equipment.

Medicines

- Medicines were stored in a clinical room secured by a swipe card. Access was restricted to nursing and medical staff who had undertaken the hospital's medicine competency training.
- Cupboards and fridges in the clinical room containing medicines and intravenous fluids were locked and keys were held by nursing staff. The secure storage arrangements for controlled drugs (CD) complied with legislation.
- Fridge and room temperatures were recorded daily and were consistently within the recommended temperature limits.
- We saw records to show that controlled drugs (CD) were consistently checked twice daily by staff working in the department.
- We audited the contents of the CD cupboard against the CD registers and found they were correct.
- Patients' allergy status was recorded on all of the 10 patient records we looked at.
- Medicine administration records were completed accurately in the patient records we looked at.
- The hospital had its own pharmacy which provided medicines to the wards, theatres and 'take home' medicines for patients.
- Nursing staff confirmed they did not use Patient Group Directives (PGD) for the administration of medicine. Medicine was not administered to patients without a written prescription from a doctor.
- The hospital had a local microbiology protocol in place for the use of antibiotics.

Records

- A paper record was generated by reception staff registering the patient's arrival in the department to record the patient's personal details, initial assessment and treatment. All healthcare professionals recorded care and treatment using the same document.
- Electronic Patient Records (EPR) were in use when patients were registered in the UCC. This was facilitated by the reception team. Clinical staff used both paper based and electronic records to access information. An electronic patient system ran alongside paper records and allowed staff to track patients' movement through the department and to highlight any delays.
- Clinical notes were audited twice a year with the results and action plans being made available after the audit.
- The records we looked at were accurate, complete, legible and stored securely.
- Staff in surgery, medicine, OPD, ITU and 'other' were 90.9% compliant with information security training. There was no data broken down for UCC staff as they were included in 'other'.

Safeguarding

- Staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns.
- 75% Nursing staff and 66% medical staff working in the UCC had completed safeguarding adults training.
- All clinical staff working with children, young people (including people aged 16-18 years old) and/or their parents/ carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person should be trained to level 3 in safeguarding in line with the intercollegiate guidance: Safeguarding Children and Young People: Roles and competencies for Health Care Staff published in March 2014. Between five and ten 16-18 year old patients attended the UCC each month. The UCC did not have sufficient numbers of staff trained to meet the intercollegiate guidance.
- 100% of nurses in UCC had Level 1 and 2 safeguarding children training and 20% had level 3 with the remainder booked for Level 3 training.
- 16% medical staff working in the UCC had completed safeguarding children training level 1 and 2. At the time of our inspection the provider informed us they working with the providers of the GP service in UCC to set up additional safeguarding training sessions for their staff to increase compliance.
- All patients under 18 had Level 3 safeguarding children trained staff involved in delivery of their care pathway. 23% of all clinical staff in Princess Grace Hospital were trained to Level 3.
- 80% of Duty Nurse Managers (who cover the hospital 24/7) had level 3 training in safeguarding children. There was 24 hour, seven days a week access to the CNO (level 3 safeguarding children trained) and Deputy CNO (level 4 safeguarding children trained).There was also 24 hour, seven days a week access to other provider paediatric advisors. These are nearby hospitals in the same provider group, HCA International.
- There was a female genital mutilation policy accessible through the hospital intranet in the policy library.

Mandatory training

- The provider gave us information about mandatory training compliance for surgery, medicine, OPD, ITU and 'other'. The average mandatory training compliance was good across all these services. For example; equality and diversity was 88.9%, fire safety was 87.8%, health and safety was 86.2% and manual handling theory was 86.3%.
- The hospital mandatory training target was 80%.

Assessing and responding to patient risk

- On arrival at the UCC patients registered with the receptionist and completed a form including their personal details and their reason for attending the UCC. Patients were registered on the system and waited for assessment by a nurse.
- The hospital policy for assessment of patients in the UCC stated that patients were triaged. The policy stated clinical staff should triage the patient immediately after registration and when possible within 15 minutes of the patient arriving in the Urgent Care Centre. Where not possible in 15 minutes this should be done as soon as possible.

- Data collected by the provider showed that 42% to 67% of patients attending the UCC in the six months February to July 2016 were assessed by a health care professional within the target of 15 minutes. Data from the provider showed that 75% to 93% of patients attending the UCC in the six months February to July 2016 were seen by a doctor within 60 minutes.
- A formal triage tool was not used to identify the acuity of patients. The policy stated, "all triage of patients should follow the problem-orientated medical record framework (POMR)." Nursing staff told us they 'used their own judgment'. Patients were not formally prioritised using triage so were seen in the order of their arrival or if a clinician used their own judgement to treat earlier.
- The Standards for Unscheduled Care Facilities (2009) developed by The College of Emergency Medicine and Emergency Nurse Consultation Association recommends: All patients should be assessed in a timely manner. If there are delays in a health professional assessing the patient then some form of initial assessment will be required to detect those at risk of deterioration or potentially serious conditions. Physiological early warning or 'track and trigger' systems for patients are recommended in order to identify acute deterioration.
- It was hospital policy to use National Early Warning Score (NEWS) system to monitor and detect deterioration in patients. The policy stated that every patient in the UCC would have a NEWS score. However, we did not observe it used in practise. A NEWS score was not calculated or recorded in any of the ten patient records we reviewed, although observations of vital signs were recorded for each patient.
- Implementation of a clinical care bundle within an hour of recognition of sepsis is recommended as an approach to reduce mortality in patients with sepsis. The UCC did not use a clinical care bundle such as 'Sepsis Six' in the management of sepsis.
- Patients requiring admission were referred to a consultant with admitting rights in the hospital and transferred to the appropriate area.
- In the event that a patient presented with a condition requiring treatment outside of the scope of the specialties provided at Princess Grace, they were transferred by ambulance to NHS. There were no formal agreements in place between The Princess Grace Hospital and NHS hospitals for transferring patients. For example, we observed one patient in the UCC assessed by a GP as having symptoms of meningitis. The was transferred to a neighbouring NHS hospital via a 999 call to the ambulance service. When asked about this the hospital informed us that in the interests of patient safety and timeliness, the ambulance service makes the decision as to where to take the patient.
- UCC staff had access to The Princess Grace Hospital cardiac arrest team whose members were ALS trained. UCC staff told us the team responded in "minutes".
- Staff who were not members of the cardiac arrest team (including GP staff in UCC) had a minimum requirement to be trained in Basic Life Support (BLS). 100% nursing staff and medical staff in the UCC had Basic Life Support (BLS) training. 100% Nursing staff and 50% medical staff in the UCC had Advanced Life Support (ALS) training.
- A policy was available for admitting patients to the main hospital via the UCC. The exclusion criteria was included within this.

Nursing staffing

- There were sufficient numbers and skill mix of nurses on duty in the UCC during its opening hours to care for patients safely given the acuity of patients and the geographical layout of the department. Nurse staffing had been reviewed in the six months before our inspection and an additional nursing post was created in the UCC.
- There were four whole time equivalent (WTE) registered nurses in post in the UCC against a planned nurse staffing establishment of five WTE.
- There were two shifts per day in the UCC: one nurse worked from 8am to 8pm and one nurse worked from 10am to 10pm. This meant there were two nurses on duty between 10am and 8pm and one nurse on duty 8am-10am and 8pm-10pm. Nursing staff confirmed there was never an unfilled shift.
- The average nurse agency usage in the UCC between February and July 2016 was 11.6%. We looked at the duty rota for September 2016 and saw 13 out of the 56

nursing shifts were allocated to agency. Nursing staff told us all agency nurses had ED experience and it was usual to use the same few agency nurses which provided continuity.

- The sickness rate among nursing staff in the UCC was between 0.8% and 3.6% monthly between January and June 2016, except for March when the long term absence of one staff member meant the rate was 15%.

Medical staffing

- The UCC was staffed by GPs employed by a HCA primary care service.
- The planned establishment of 4.5 WTE GPs was achieved.
- GPs worked 3 shift patterns during UCC opening hours, which meant there was always one GP on duty and two GPs at 'peak times' (these were identified as after office hours)

Major incident awareness and training

- The hospital had an up to date major incident and business continuity plan in place. Staff we spoke with and staff showed us that they were familiar with how to access the guidance online.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated the effectiveness of the UCC as 'good' because:

- Care and treatment was delivered in line with evidence-based practice.
- Patients were offered timely pain relief.
- Nursing and medical staff in the UCC had appropriate emergency department experience.
- There was a wide range of multidisciplinary team members working in the hospital which could be contacted if needed to assess or treat patients.
- Patients had access to food and fluids in the UCC.
- The UCC offered access to on-site diagnostics and imaging services.
- Staff we spoke with were aware of the Mental Capacity Act 2005 and its implications for their practice.

However

- There was a lack of patient outcomes monitoring.
- Medical staff did not receive mental capacity act training.

Evidence-based care and treatment

- Care and treatment was delivered in line with evidence-based practice. Policies and procedures followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE).
- As the service was provided by an independent hospital it did not need to comply with the audit schedule recommended by the Royal College of Emergency Medicine (RCEM). However, the service did not develop any audit to monitor their efficacy for patient outcomes.
- We asked the provider for evidence of internal audits and were informed by staff that they took place in HCA wide audits. From evidence provided, we observed that the UCC took part in the controlled drugs audit from the HCA schedule. The service also took part in the following internal audits: hand hygiene, safe management of sharps, clinical waste/disposal, equipment audit and patient environment.

Pain relief

- Nursing staff told us that pain was assessed regularly as part of the patient's observation records and we saw there was a pain scoring tool available. We saw that patients had access to pain relief when they arrived. We observed a nurse asking a patient to identify the severity of their pain on a scale of one to ten and was then issued pain relief medication. However, there was no pain score recorded in the ten sets of patient records we examined.
- Analgesia had been prescribed for patients presenting with pain in the records we looked at.
- The two patients we spoke with informed us that they had been asked about their pain and offered pain relief when they had been assessed by the nurse.

- We did not see any patient displaying verbal or non-verbal signs of pain during our inspection that was not being addressed by the staff.

Nutrition and hydration

- The UCC did not use nutritional risk assessment tools as patients were not likely to spend over two hours in the centre.

Patient Outcomes

- As the service was provided by an independent hospital it did not need to comply with the audit schedule recommended by the Royal College of Emergency Medicine (RCEM). However, the service did not develop any audit to monitor their efficacy for patient outcomes.
- The provider informed us that there were no relevant national audits that the Princess Grace UCC were eligible to participate in and whilst on inspection we did not see any internal audits where practice was compared with national outcomes or other similar services.
- Between August 2015 and July 2016, 6284 patients visited the UCC. 285 patients were admitted to the Princess Grace from UCC between July 2015 and July 2016.
- In the year prior to inspection there were no mortalities within the UCC.

Competent staff

- Appraisals of staff performance were undertaken annually. 100% UCC staff including receptionists, nurses and doctors had received an appraisal in the 12 months prior to our visit.
- The UCC was staffed by GPs employed by a HCA primary care service. There was a nominated responsible officer in HCA for consultants who worked exclusively private practice who would ensure correct revalidation procedures were followed.
- Staff told us the appraisal process was useful to identify any gaps in knowledge and look at training and development available. Staff told us the hospital provided adequate funding for external courses relevant to their development. We saw evidence of development programmes for nurses at varying grades in the folders kept for all staff in the service. The folders contained certificates of competencies for example, basic life support.
- Nursing and medical staff in the UCC had appropriate emergency department experience.

Multidisciplinary working

- We were informed by doctors that a lot of the patients they saw were being treated for minor injuries. This was confirmed during our inspection when we observed a patient being treated for a mosquito bite. Other patients we observed were being treated for minor injuries. Due to this, there was rarely need for vast multidisciplinary input but doctors were confident that should they need assistance from a subspecialty they could get it.
- There was a wide range of multidisciplinary team members working in the hospital which could be contacted if needed to help assess patients.
- Doctors informed us that should they need to speak with a specialty consultant they were able to use the phone book on the intranet and call them. Doctors told us that this was a helpful resource open to them even in unsociable hours.

Seven-day services

- The UCC was open for adults from 8am to 10pm, seven days a week and 365 days a year.
- Support services were available seven days a week, which included x-ray (which was adjacent) and other diagnostics.
- There was a 24/7 on-call consultant rota for advice or if patients required admission.

Access to information

- The results of blood tests and other diagnostic results were available online and staff had access to these.
- All healthcare professionals recorded care and treatment using the same document.
- Upon discharge, patients were provided with a letter of exactly what had taken place and what treatment they had received. The doctor who treated the patient wrote up this letter. If the centre was busy, the letter would be posted out to the patient. The patient was then able to provide their local GP with the information.

Requires improvement

Urgent and emergency services

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent forms were not in general use in the UCC, when asked about this staff said they did not carry out procedures that required formal, written consent. This was confirmed by our observations whilst on inspection. We observed staff giving explanations about procedures (such as taking blood pressure) and obtaining verbal consent for interventions.
- Nursing staff were clear about their responsibilities about how to gain consent from patients, including people who lacked capacity to consent to their care and treatment.
- Staff informed us that the majority of patients presenting at the centre had full capacity, however, there were times when relatives with dementia or delirium were brought to the centre.
- Although staff did not have much cause to utilise the Deprivation of Liberty Safeguards (DoLs) they had a demonstrable knowledge of the principles of consent and mental capacity, including the care and treatment of patients with a DoLs order. In the year before inspection no DoLs applications had been made within the UCC.
- Nursing staff within the UCC were 100% compliant with Mental Capacity Act training. No doctors had received mental capacity act training. When asked about this doctors informed us that the clinical directors for the UCC were in the process of producing a training schedule for them.
- The UCC treated patients from the age of 16. The hospital's policy 'Access and consent to treatment for patients under 18', dated July 2016 referred to the assessment and recording Gillick competency for these patients.

Are urgent and emergency services caring?

Good

We rated caring as 'good' because:

- Patients we spoke with spoke very highly of the care they received.
- Patients were supported, treated with dignity and respect and were involved in their care.

However

- Whilst patient feedback forms were available to patients there was no formal patient feedback recorded for the UCC.

Compassionate care

- Throughout our inspection of the UCC we saw that staff treated patients with compassion, dignity and respect. People's privacy was respected and curtains were drawn when personal care was given. Staff lowered their voices to prevent personal information being overheard by other patients.
- We saw staff were caring and demonstrated compassion towards patients and their relatives. We observed reception staff greeting all patients with a warm welcome.
- Patients we spoke with informed us that they were happy with the care provided. One patient told us that "the staff here are very friendly, they are the best".
- Whilst the Princess Grace Hospital participated in the HCA Healthcare patient feedback programme the UCC results were not recorded.
- There was a glass reception desk with an open space for patients to speak with reception staff but this opened up onto the waiting area so both reception staff and patients would have to speak quietly in order to not be heard by other patients.

Understanding and involvement of patients and those close to them

- Although we did not observe the doctors or nurses explaining treatment options, the patients and relatives we spoke with felt very included in their treatment plan.
- During the unannounced we spoke with a patient and their relative. The relative informed us that they felt very involved in the patients care. They told us that the doctor was very "clear and succinct" with the patients treatment plan.

Emotional support

Requires improvement

Urgent and emergency services

- We observed staff providing reassurance to patients and relatives. Patients we spoke with told us they felt supported by both the clinical and non-clinical staff throughout their pathway.
- Staff informed us of the importance of taking into account the patients religious and cultural needs. For example, patients were asked whether they wanted to be examined by a male or female medical professional. Doctors informed us that it was not always possible to adhere to these patient requests but they would attempt to in every instance.
- A corporate chaplaincy service providing spiritual, pastoral and religious care across all faiths and beliefs was available for patients, visitors and staff. Leaflets were available which informed patients of how to access this service.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Good

We rated responsive as 'good' because:

- People's needs were met through the way the centre was organised and services were delivered.
- There was adequate seating and space in the reception and waiting areas and during our inspection we observed that all patients waiting were catered for with a seat.
- The registration system was easy to use and supported patients in understanding the pricing structure.
- Complaints were responded to in a timely way.

However:

- Although reception staff logged patient waiting times, this was not formalised into raw data. There was no data on the patient length of stay in the centre.
- There were no processes in place to assist patients with complex needs or learning disabilities.

Service planning and delivery to meet the needs of local people

- The centre was open from 8am to 10pm. The late closing time accommodated people who were coming from work. The service had an agreement with several big companies in the city and was open late to meet the needs of those who worked in the city.
- The service had a large clean and tidy waiting area which was never overcrowded during our inspection. There was step free access throughout the waiting area and throughout the service as whole to cater for patients with wheelchairs.
- There was a water dispenser in the waiting area as well as copies of the UCC price list, newspapers and other information on the hospital.
- The facilities and premises were appropriate for the services that were planned and delivered. For example, if a patient required further diagnostics or imaging, the imaging department was through the exit towards the back of the unit.
- Telephone translation services were available for patients who did not have English as their first language and we observed several members of staff speaking more than one language to various patients.
- Patient leaflets were available in both English and Arabic.
- The pricing structure was available both in the waiting area and once the patient was registered onto the unit. The receptionist staff also spoke with each patient about prices of procedures and medication. If a patient required admission to the hospital they were informed of the financial implications of admission.

Meeting people's individual needs

- The service informed us that they did not see many patients with complex needs and there was no learning disability link nurse within the hospital. Doctors told us there were no specific tools available to care for patients with learning disabilities (LD). Staff told us they would be made aware of a patient with LD upon registration and provided us with examples of times when patients had come with a carer who could help support them.
- Dementia training was part of the mandatory training programme and nursing staff had 100% compliance rates.

Requires improvement

Urgent and emergency services

- One of the receptionists and a nurse spoke Spanish and we witnessed him communicating with a patient in Spanish.
- A number of patients were from overseas with English not being their first language. Interpreters were used where necessary and staff were aware of how to access an interpreter. Translation services over the phone were also available.
- There was step free access to the centre and within the washroom facilities. There was a designated accessible toilet for patients in wheelchairs in the patient waiting area on the ground floor. The toilet beyond the secure door in the UCC was not accessible for patients who used wheelchairs or who required assistance.
- Patients were provided with a discharge letter to take to their General practitioner (GP).
- Patients were provided with contact information for the centre in case they had further queries.
- There was adequate water dispensing facilities in the waiting area and in the centre itself. There was also a coffee machine in the centre that was serviced by facilities.
- If patients wanted something to eat, the catering team could provide food. We observed staff offering patients drinks.

Access and flow

- On presentation at the UCC, patients had to fill out an initial registration form detailing their name, date of birth, address, contact number, next of kin, GP details and account number of the patient.
- The reception staff had an online spread sheet that documented how long patients had been waiting and what treatment they had received.
- In the reporting period of August 2015 to July 2016 between 74% and 92% of patients were treated by a GP within an hour. In that same reporting period 15 patients left the UCC before being seen by a medical professional.
- Patients were able to be admitted to the hospital from the UCC and would need to be assigned a consultant who had admitting rights to the hospital.
- Staff told us that patients admission to the ward from the UCC was sometimes delayed as it took time to verify insurance details.
- We requested data on the length of time patients waited in the centre and the number of patients who waited 4 and 12 hours before discharge or admission. Data received from the hospital illustrated that the average time patients spent in the UCC from registration to discharge was one hour 22 minutes. The average waiting time to see a doctor was 32 minutes.
- The service did not treat patients under 16 years old, London Ambulance Service (LAS) patients, patients presenting with obstetric related problems and patients presenting with mental health issues.

Learning from complaints and concerns

- There were pamphlets in the centre on how to complain and patients we spoke with understood the complaints process.
- Any member of staff could receive a complaint. The most appropriate person dealt with these. Staff were aware that if they could not resolve an issue they should advise the patient/relative how to use the formal complaints policy.
- Between October 2015 and March 2016 there were nine complaints recorded by the UCC. Half of these complaints related to the clinical treatment provided. One complaint related to the admission/transfer and discharge process, two complaints related to communication between the patient and UCC staff. One complaint related to other outpatient clinics and one complaint related to staff attitude/behaviour.
- The service complied with the HCA complaint management timeframe. The service had to acknowledge complaints in writing within two working days or receiving the complaint and had 20 days to provide a full written response to the complainant. All nine of the complaints in the reporting period October 2015 to March 2016 were replied to within the HCA timeframe.
- Staff we spoke with were aware of how to escalate complaints and the processes for complaint handling and learning from complaints was discussed in staff huddles and monthly meetings.

Requires improvement

Urgent and emergency services

Are urgent and emergency services well-led?

Requires improvement

We rated well-led as 'requires improvement' because:

- Risks were not always identified and mitigated in the UCC and the risk register did not include the areas for improvement we identified during inspection.
- Staff were not aware of the hospital's vision and values and there was no local strategy for the development of the UCC.
- There was no formalised way to review and manage the opinions of patients in the UCC.

However,

- The leadership and culture of the centre supported the delivery of high quality person-centred care.
- Staff felt actively engaged by the senior leadership team.

Leadership / culture of service

- Staff told us the leadership for the UCC was restructured in January 2016. Up until that time, a clinical manager was in post and had oversight of the running of the department.
- From January 2016, day to day running of the UCC was the responsibility of the deputy chief nurse. One junior nursing sister had line management responsibilities for the remainder of the nursing team along with some management tasks. The deputy chief nurse told us the junior sister had one supernumerary day per week. We looked at the nursing duty rota for 4 weeks before the inspection which showed two supernumerary days allocated in total, which the sister was unable to use for management days as scheduled because she was covering vacant shifts.
- A GP from the HCA primary medical service had oversight of the GP service provided in the UCC. The lead GP was not a member of the GP team covering the rota at the UCC, but visited the department twice a week to provide additional support and was available by telephone.
- All staff we spoke with were well aware of the leaders of the service and could identify the Chief Nurse and CEO. All of the staff we spoke with talked openly about the supportive and motivational culture of the service. One doctor informed us that "the CEO is very friendly and you are able to approach anyone if you need help". A nurse we spoke with stated, "I know who the CNO is and I am able to speak openly to all staff".
- Doctors informed us that board members were very present in the centre and staff felt valued by the senior leadership team.
- Doctors and nurses within the department spoke positively about the care they provided for patients. Quality and patient experience were seen as everyone's responsibility.

Vision and strategy for this this core service

- The main vision of the hospital was to 'deliver excellence in care'. The hospital values were defined as "consideration and professionalism, valuing our people, information and communication and safety first".
- The UCC did not have an individual vision or values. Hospital wide vision and values were not embedded amongst staff. When we asked staff what the vision of the centre and the hospital was they did not know.
- There was no local strategy for the development of the UCC.

Governance, risk management and quality measurement for this core service

- Whilst on inspection we were informed by a doctor that governance meetings did take place. We observed minutes from a UCC governance meeting dated April 2016 and found them to be thorough. The meeting discussed waiting times and complaints amongst other things.
- The service could input to a hospital wide risk register. During the time of our inspection there was one active risk on the centre risk register. This risk related to the ability of the staff to summon for assistance if they felt vulnerable and as such was not a clinical risk.

Requires improvement

Urgent and emergency services

- The risk register did not include the areas for improvement we identified during inspection. For example, the patient 'time to assessment' data demonstrated poor performance for 6 months, but no action was taken to improve this.
- Whilst on inspection we spoke with a receptionist who assured us that it was easy to contact security if staff within the unit felt threatened.
- There was consistency between what front line staff and senior staff said were the key challenges faced by the service. Staff were clear on the risks and areas in the department that needed improvements. However, these were not included on the risk register.

Public and staff engagement

- The hospital had an 'employee of the quarter' scheme, where other members of staff could nominate their colleagues for a prize as well as the hospital making a cash donation to a charity of the staff member's choice.
- Staff felt very engaged with each other and we witnessed a collegiate spirit amongst staff. Patient survey forms were available both in the waiting area and in the centre itself. The hospital employed an external company to analyse and report on patient feedback.
- Employees of the Princess Grace Hospital were entitled to a 50% discount for non-work related concerns. Staff that became unwell or injured at work could be seen in the UCC free of charge.
- We were assured by evidence from the hospital as a whole that there was a hospital wide patient survey but the UCC results were not published as response rates were not significant enough. We were shown patient feedback survey forms for the UCC, however there was no evidence that results were collated, analysed or acted upon.

Innovation and sustainability

- There were no examples of innovation coming out of the department.

Good

Medical care

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

Information about the service

Medical care services at The Princess Grace Hospital consisted of acute and general medicine, endoscopy and oncology services. The medical oncology service provided inpatient and day case chemotherapy treatment often in conjunction with a neighbouring oncology centre.

There was a nine bedded medical ward, a 19 bedded oncology ward and an endoscopy unit with two procedure rooms.

Between April 2015 and March 2016 the endoscopy unit treated 1,980 patients. We did not have numbers of inpatient admissions for medical services alone.

End of Life Care was also reviewed by the team and is included in this report as the numbers of patients receiving end of life care at the hospital was low.

We visited the medical ward, oncology ward and the endoscopy unit. We also visited a surgical ward in addition to the medical and oncology wards, to review end of life care. During the inspection, we talked with 14 patients. We talked with 21 staff, including ward managers and ward sisters, staff nurses, a health care assistant, consultants, resident medical officers (RMOs), and an endoscopy decontamination assistant. We also met with the senior leadership team for medical services and the lead nurse and consultant for end of life care. We reviewed nine care records and observed care provided. We also reviewed documentation provided by the hospital including performance information.

Summary of findings

Overall we rated medical care services at the Princess Grace Hospital as good.

- The infrastructure for medical services had been progressively developed to enable the delivery of safe and effective care for patients. This included the identification of risks at a service and individual patient level, and taking steps to limit the number of patients on the ward when challenges in achieving appropriate staffing levels occurred. There was access to specialist services when patients deteriorated. Sufficient staff, with the appropriate level of knowledge and skills for their job role, were available and they had access to appraisal and support.
- Staff were kind and compassionate and patients felt involved in their care and treatment. Psychological support was available for patients to help them cope emotionally with their diagnosis and treatment.
- Patients had timely access to care and treatment and investigative and diagnostic services were available seven days a week when required.
- There was good access to interpreting and translation services for patients for whom English was not their first language.
- There was effective leadership at all levels of medical care services and staff felt supported, valued and engaged. Steps were taken to ensure the safety and

Good

Medical care

quality of services when challenges occurred. The consultant team for oncology brought significant expertise and were actively engaged in research and development.

However,

- The requirements of vulnerable patient groups were not always fully recognised and met. For example, the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards were inconsistently applied and the needs of people living with dementia were not fully explored and addressed.
- Audits to assess the outcomes of care and treatment and benchmark them with other services needed further development.
- Care records did not always meet professional standards for documentation and some lacked the detail necessary to provide personalised and effective care for patients.
- End of Life Care (EoLC) services required further development and documentation of discussions with patients and decision making in relation to palliative care, required improvement.

Are medical care services safe?

Good

We rated safe as good because:

- When incidents occurred processes were in place to learn from them and disseminate learning across the service. Staff were aware of learning from incidents and changes that had been put into place in response.
- Nurse staffing levels had been assessed and bed capacity had been limited in oncology in order to ensure safe staffing levels were maintained.
- Processes were in place to identify and control patient risks. A critical care outreach team was available to provide support and advice when a patient's condition deteriorated.
- Staff were clear about the action to take to report adult safeguarding concerns.

However we also found:

- Staff did not always adhere to the "bare below the elbows" requirement for the prevention and control of infection.
- Entries in some patients' care records did not comply with professional standards for record keeping in that there were issues with legibility and the identification of staff who had entered information into the care record. Nursing care plans did not always contain all the necessary information required to provide personalised care to patients.

Incidents

- No never events were reported for medical services between April 2015 and March 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- A total of 307 incidents, including four serious incidents were reported in the same period. The serious incidents were related to the development of pressure ulcers in two patients and two patients who fell whilst

mobilising to the bathroom. We reviewed the documentation related to these incidents and found an analysis of the incident had occurred to identify the root cause and contributory factors and learning points had been identified. The most commonly reported incidents were related to medicines management and we found staff were aware of incidents and the action taken to improve.

- Staff knew how to report incidents through the electronic reporting system and told us they were encouraged to report incidents when they occurred. They said the hospital took a supportive approach when incidents occurred, in that they were provided with guidance and additional training where appropriate, to prevent similar occurrences in the future.
- Lessons learned from incidents were communicated to staff through "Learning Grids" or learning logs which were emailed to staff, and through discussions at ward and governance meetings.
- Staff were able to tell us of actions taken at ward level as a result of learning from incidents. For example, a member of staff said that as a result of incidents of pressure ulcers, they now had more knowledge of prevention, appropriate care and a better understanding of pressure relieving equipment and aids. Another member of staff identified changes to the recording and checking of patients' skin integrity and re-positioning, which had been introduced to improve the accuracy of patient assessments. Several members of staff told us of action to reduce the occurrence of medication errors. This indicated learning from incidents was communicated to staff and changes to practice were implemented where appropriate.
- Senior staff from medical services attended monthly morbidity and mortality meetings where all inpatient deaths were reviewed and discussed. A member of staff who attended the meetings said the documentation used "Makes you reflect on individual patients and anything you would have done differently."
- 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.
- Staff demonstrated a good understanding of the requirements of the duty of candour and the requirement for openness and transparency when things went wrong. Although most staff said they had not had to use the duty, one person was able to explain how it had been implemented in relation to a patient who had developed a pressure ulcer. The patient and their family had been informed and an apology given. It was explained that an investigation would be carried out and the family were offered the opportunity to see the results of the investigation.

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

- The NHS Safety Thermometer is an improvement tool to measure patient "harms" and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harm in relation to pressure ulcers, patient falls, venous thrombo-embolism (VTE) and catheter associated urinary tract infections. Independent hospitals are not required to submit safety thermometer data.
- Medical services did not submit safety thermometer data, however the incidence of pressure ulcers, falls, and VTE were monitored and the results for the hospital were displayed at ward level. Ward level data although available, was not displayed. The provider told us they did not display ward level data as patients had fed back to them that they did not wish to see patient level outcomes displayed.
- The total number of falls for medical services between April 2015 and March 2016 was 22, with eight pressure ulcers (two of which were grade 3 or 4 pressure ulcers) and three VTEs occurring within the same period.
- Actions to reduce the incidence of pressure ulcers and falls had been introduced. These included the provision of one to one support for patients at high risk of falls and the use of "Call don't fall" signs in people's rooms. Due to the small numbers of inpatients in medical services and the recent introduction of the additional preventative measures, it was not possible to identify whether the actions had resulted in a reduction of harms to patients.

Cleanliness, infection control and hygiene

- No MRSA bacteraemia were reported in medical services between July 2015 and July 2016.

- Six Clostridium difficile cases were reported in medical services in the same period. These were not clustered in any individual month, but were individual cases spread throughout the year. Investigation of the incidents by the service identified concerns with the over use of antibiotics and as a result, steps had been taken to improve antibiotic stewardship.
- The environment appeared visibly clean at the time of the inspection and in an excellent state of repair. We did not find any areas which were dusty or soiled and equipment was labelled with "I am clean" stickers indicating they had been cleaned either daily or on the first day of the inspection visit. We examined the cleaning schedules for equipment and saw that when equipment had not been cleaned daily it had been cleaned within the interval stated within the cleaning schedule.
- We observed housekeeping staff cleaning the environment thoroughly, however, we noted there were cleaning substances which are classified as hazardous (COSHH) within the cleaning trolleys which, were at times, unattended when staff were in patients' rooms. Although there was the ability to lock the compartment for cleaning substances, they were not locked when we checked. Therefore the substances were accessible and presented a potential risk to patient safety.
- Audits of the cleanliness of the environment had been carried out in March 2016 by the provider's infection prevention and control team and the housekeeping manager. The issues identified for improvement had been addressed when we checked during the inspection visit. Audit results for August 2016 showed 100% compliance for the medical ward, and endoscopy ward and 100% for all areas within the oncology ward except for the dirty utility room which scored 95%.
- The endoscopy unit was compliant with Department of Health Technical Memorandum 01-06 relating to the management and decontamination of flexible endoscopes. Arrangements were in place for the safe handling of endoscopes and the segregation, decontamination, and storage of endoscopes. We reviewed the flow of instruments through from use to cleaning, decontamination, and storage and saw there was good separation of clean and dirty instruments. Staff had their own access codes to enable tracking of the endoscopes to take place and there was appropriate labelling and documentation to track which scope had been used for which patient.
- Patients told us they were impressed with the high standards of cleanliness and said they saw staff washing their hands or using hand sanitizer, before and after providing care.
- We observed good hand hygiene practices generally but saw medical staff were not always bare below the elbows when they visited patients.
- Hand sanitising gel was available at the entrance to each ward and clinical area and within the clinical environments. Personal protective clothing and equipment (PPE) was available throughout the clinical areas. A sign was in place by the room of a patient with an infection, identifying additional precautions should be taken. PPE was available immediately outside the room. We were told one nurse was allocated to the patient to reduce the risk of cross infection.
- Data provided by the hospital indicated that staff compliance with hand hygiene procedures was 97% for the oncology ward, 99% for endoscopy and 100% for the medical ward between January and March 2016.

Environment and equipment

- Access to the wards and endoscopy unit was controlled through call bell entry with card entry for staff. This meant it was possible to monitor people entering and leaving the clinical areas. Patients were cared for in single rooms with en-suite facilities on the medical and oncology wards. These were spacious and accessible for patients to maintain the safety of patients with mobility problems and those requiring the use of mobility equipment and aids.
- The environment within the endoscopy unit comprised eight single cubicles for patients to be cared for before and after their procedure. Two of the cubicles had an en-suite toilet and we were told these were normally utilised for patients undergoing procedures on their bowel and lower intestinal tract. There were two endoscopy procedure rooms and these were spacious

and appropriately equipped to enable safe working practices. The environment throughout the endoscopy unit was suitable to facilitate the required cleaning and decontamination between patients.

- There was a schedule for the servicing and maintenance of the endoscope decontamination equipment and records of the servicing carried out by the manufacturers of the equipment.
- Arrangements were in place for the appropriate classification, segregation, handling and disposal of waste and we did not identify any concerns in relation to these during the inspection.
- A resuscitation trolley with emergency medicine, oxygen and a defibrillator was located on the wards and in the endoscopy unit. Staff documented daily checks of the equipment and the records were consistently completed.
- An extravasation treatment kit was kept in the treatment room on the oncology ward for emergency use in the treatment of patients receiving chemotherapy. We found it was sealed and in date with a protocol attached, to ensure it was used safely and effectively.
- The maintenance department completed logs of the servicing and maintenance of equipment. Staff told us they had no problems in accessing equipment in a timely manner. We specifically asked about syringe drivers for palliative and end of life care and were told there were no problems in obtaining them when needed.
- We checked that equipment in use on the wards and in the endoscopy unit had the required checks for electrical safety and found the checks had been completed and were in date.

Medicines

- Medicines were stored safely in locked cupboards and refrigerators within a locked room. Daily temperature checks of the rooms and refrigerators used to store medicines had been completed and were within acceptable limits. The wards had a range of stock medicines to enable frequently used medicines to be available promptly when required. Patient's own medicines were stored separately. We checked the storage and recording of controlled drugs and found this was in line with requirements.
- Chemotherapy drugs were stored separately from other medicines in a locked refrigerator or locked cupboard as required.
- Chemotherapy drug administration protocols were managed through an electronic system which brought together patient data and pharmacy information to increase the safety of chemotherapy prescribing for patients. A pharmacist told us they were able to challenge any prescriptions which did not follow the protocols.
- Intravenous fluids were stored securely and previous issues related to the insecure storage of intravenous fluids had been addressed.
- The wards used a prescription and medication administration record chart for patients which facilitated the safe administration of medicines. Medicines interventions by a pharmacist were recorded on the prescription charts to help guide staff in the safe administration of medicines and there was evidence of medicines reconciliation.
- We looked at the prescription and medicine administration records for five patients on the medical and oncology wards. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. Any reasons for not giving people their medicines were recorded. This meant people were receiving their medicines as prescribed.
- The hospital had an adult antimicrobial guideline for the use of antibiotics published in July 2014 which had been due for review in July 2016. One of the standards in the guideline was that the duration of therapy and stop or review date should be recorded on the drug chart. However, we noted antibiotics had been prescribed for one patient and there was no stop date recorded. This meant the patient might receive antibiotics for longer than necessary.
- We talked with patients about the administration of their medicines and they told us staff normally checked their identity before giving them their drugs and they received them in a timely manner. One patient said, "The protocol is spot on; the way they administer the medication is superb." However, one person told us there were some inconsistencies in the way staff

administered their intravenous antibiotics. They had raised this with the ward manager who said they would discuss it with the staff concerned, but the same practices continued.

- Registered nurses administering medicines were required to pass a drug calculation test on recruitment and they completed a competency assessment prior to administering drugs independently.
- There was a sedation policy for the sedation of patients undergoing endoscopy. This followed the guidance in the British Society of Gastroenterology Quality and Safety Indicators for Endoscopy.

Records

- A mix of paper and electronic patient records were in use. Electronic records had secure access through a password system. Paper records were stored in locked cupboards behind the nurses desk which prevented unauthorised access.
- We identified issues with the legibility of some paper based medical records and staff had not always printed their name in addition to signing the entries, making it difficult to identify the person who had made the entry in some cases. A plan for the patient's treatment had been documented, but there was little evidence of discharge planning in the care records.
- Nursing assessments and care plans were electronic. We found they were not always fully completed and care plans were standardised rather than being tailored to the needs of individual patients. For example, there were no on-going wound assessments to record the size and progress of a patient's wound, and initial dementia/ delirium screening had not always been completed. However, individual risk assessments to assess patient's risk of developing pressure ulcers, nutritional risk and risk of falls had been consistently completed and reviewed daily.
- Some agency staff did not have access to the electronic care planning system; therefore they were provided with paper documentation to record the patient's progress and risk assessments. This meant there were gaps in the electronic record and the records were disjointed. We were told all paper medical and nursing records were scanned and maintained as one medical record; however, during the inspection we found records were disjointed.
- Standardised endoscopy records were used to record the admission assessment, completion of pre-procedure checks, the information about the procedure, and a record of the sterile items used. Post procedure checks were also recorded and discharge information. The two records we reviewed were legible and fully completed.
- An electronic system brought together all patient's chemotherapy records including radiology reports, pharmacy and home care.
- Patients' care records did not always clearly document discharge planning. For example, a patient's record stated the patient wanted to go home the following day and there was no documentation of discussion in relation to their discharge plans and about the management of their insulin for diabetes (they were being given variable amounts of insulin due to unstable blood sugars) and they were also receiving medication through a syringe driver.

Safeguarding

- A "Safeguarding Adults at Risk" policy dated March 2016 was in place. This contained a quick referral flow chart to guide staff through the process of raising and reporting a safeguarding concern.
- Adult safeguarding information was displayed in staff areas on the wards and endoscopy unit.
- Staff were aware of the signs of abuse and they told us they would report any concerns to the ward manager initially and then to the hospital safeguarding lead.
- Both adult safeguarding and children's safeguarding training was part of mandatory training for staff in medical services. Data provided by the hospital indicated 100% of staff had completed both sets of training.

Mandatory training

- Mandatory training included training in basic life support, equality and diversity, ethics, fire safety, health and safety, infection control, information security, moving and handling theory, safeguarding adults and safeguarding children.
- Data provided by the hospital indicated that in July 2016, over 90% of staff in medical services had completed mandatory training for equality and

diversity, ethics, infection control, information security, and adult and children's safeguarding. Compliance with moving and handling training was 89% and fire training compliance was 86%. 71% of staff had completed health and safety training. The hospital had set a target of 80% to have completed mandatory training.

- There was a policy for the management of sepsis and staff we talked with were aware of the policy. However, specific training in the management of sepsis was not part of mandatory training.

Assessing and responding to patient risk

- An electronic system was used for recording and analysing patients' vital signs, to identify when patients were deteriorating and provide risk scores to trigger the need for further necessary care. This was based on the national early warning score (NEWS).
- NEWS scores were consistently recorded with each set of observations. Although we reviewed several patient records, we only identified one where the score had risen and should have triggered escalation. In this case, we could not find any evidence of escalation in the care records and in fact the records stated the patient's observations had remained stable throughout the 24 hour period when this had occurred. The patient's score had reduced at the next set of observations but there was no record to indicate the observations had been repeated to check on the accuracy. Therefore we concluded the score had not been recognised as requiring escalation. This meant we could not be certain that when a patient's condition deteriorated, the issue was always identified and escalated according to the hospital protocol.
- Staff told us that when they needed to escalate a deteriorating patient, they received a very prompt response from the critical care outreach team or RMO.
- The identity of the patient and procedure was checked when patients requiring endoscopy were collected from the ward and when they arrived in the endoscopy unit. We saw a checklist was used in endoscopy to ensure all pre-procedure checks were completed. Following the procedure, patient's vital signs were checked every five minutes for at least 15 minutes along with a sedation score, pain score and nausea score. These checks reduced the risk of errors occurring and would alert staff post procedure to any deterioration in the patient's condition.
- Patient's risk of developing venous thrombo-embolism (VTE) was assessed in line with national guidance and data provided by the hospital indicated there was over 95% compliance with assessing this risk in medical services.
- The hospital had an admissions policy with agreed criteria for admission. However, the only patient exclusion criteria relevant to medical services which had been identified, were patients with neurological conditions. When we talked with the leadership team for medical services we were told they would not admit some patients who required emergency care such as an acute myocardial infarction (heart attack) or acute stroke. Access to the medical and oncology wards was via a consultant.
- An RMO was based on the medical ward and oncology ward and therefore patients were seen and assessed by an RMO within 30 minutes. They were seen by a consultant within 24 hours of admission.
- There was access to levels 2 and 3 critical care on site as required and therefore when patient required intensive care facilities this was normally provided on site. The critical care outreach team provided a good service to the wards.
- Pathways were in place for the referral and transfer of patients to neighbouring NHS hospitals if this was required.
- Consultants were present in endoscopy and were able to admit patients to the medical wards if they were clinically unwell and required a hospital admission.

Nursing staffing

- The hospital was undertaking a review of nurse staffing levels on the medical ward using the Shelford safer nursing care tool. At the time of the inspection, staffing levels were based on a set staff to patient ratio. The oncology ward had a ratio of one registered nurse (RGN) to three patients during the day and a ratio of 1:4 at night with an additional supervisory nurse in charge. The medical ward operated on a 1:5 RGN: patient ratio during the day and 1:6 at night, again with a supervisory nurse in charge.

Good

Medical care

- The oncology ward had reduced their capacity from 19 beds to 12 beds in order to maintain their core staffing levels due to registered nurse vacancies on the unit. Managers told us it had proved difficult to recruit nurses with oncology and chemotherapy skills. They had appointed a clinical practice facilitator to coordinate training and provide additional support to increase the specialist skills required in oncology.
- The endoscopy unit allocated two RGNs to the procedure room with two RGNs in the ward area.
- Staff felt they were adequately staffed and told us they received a positive response from the duty manager if they had to request additional staff. Staff told us that when a patient was at high risk of falls or had complex needs they were able to request an additional healthcare assistant to provide one to one support.
- We attended a nursing handover and observed it was well structured, a good overview of the patients was provided and a careful review of the treatment charts was carried out. The ward manager on the medical ward had developed handover documentation which was comprehensive whilst being concise, and focused on the information needed to provide care for each patient.
- An oncology clinical nurse specialist was the nominated lead for end of life care. However, they were also providing support to the oncology ward following the resignation of the oncology ward manager in addition to their other duties. They therefore had limited time available to further develop end of life care.
- The hospital had an agreement for the provision of specialist palliative care input from a neighbouring NHS hospital's palliative care team.

Medical staffing

- Resident medical officer (RMO) cover was provided separately for oncology and the medical ward. During the day there were two RMOs on duty for oncology, one of whom started work at 8am and received handover from the night RMO and a second RMO who started work at 10am and handed over to the night RMO in the evening.
- One medical RMO was available from 8am to 5pm and they covered the medical patients admitted through physicians from a nearby independent outpatient medical consultation service. Other medical patients were covered by a general RMO.
- RMOs were trained to level ST3 or above or equivalent. They all had completed advanced life support training. This meant they met the requirements of the Quality Standards for Acute Hospitals.
- Overnight and at weekends there was a general RMO to cover all the inpatient beds.
- Patients were reviewed by their consultant within 24 hours of admission and there was a physician on call rota which provided consultant cover out of hours and at weekends. Consultants carried out ward rounds at the weekend.
- RMOs told us they received a good level of support from the consultants and consultants made themselves available when required, either on site or on the telephone.
- RMO to RMO handovers were held at 9:30pm and an informal handover was given at 9am.
- A formal process was in place for consultants requesting practising privileges and applications were assessed by the medical advisory committee (MAC). There was a regular review of practising privileges, which included reviewing their scope of practice and activity.

Major incident awareness and training

- 86% of staff in medical services had completed fire training.
- A box with action cards for each staff group and all the information required in a major incidents was located on each ward. A walkie-talkie was available on each ward to enable direct communication in an emergency.

Are medical care services effective?

Requires improvement

We rated effective as requires improvement because:

- The requirements of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards were not well understood and applied.
- The combined use of electronic and paper based records resulted in difficulties in obtaining a full contemporaneous picture of the patients' health care information. Documentation such as fluid charts were not consistently completed.
- On the medical ward, systems to monitor and manage patients' pain were not always effective.
- Audits to assess clinical outcomes and benchmark them with other services were not well developed.
- An End of Life care plan had only recently been introduced and was not fully embedded in practice.

However, we also found:

- Clinical guidelines and protocols were used to ensure adherence to best practice. Controls were in place to ensure that only approved chemotherapy regimes or protocols were utilised for the treatment of oncology patients.
- Staff had access to annual appraisal and were supported to develop their knowledge and skills.
- Patients had access to services including interventional radiology seven days a week.

Evidence-based care and treatment

- Guidelines and protocols had been developed based on national guidance and best practice evidence from professional bodies, for example the American Society of Clinical Oncologists (ASCO).
- Several of the consultant oncologists were nationally recognised as leaders in their field and had published widely on new cancer treatments.
- Initial management guidelines for acute oncology had been agreed and accepted for use by all consultants in oncology. These included guidance on the management of sepsis.
- Oncology and chemotherapy protocols were not always based on National Institute of Clinical Excellence (NICE) guidance, as drugs could be approved for use prior to NICE approval or when NICE had initially rejected them on cost effectiveness grounds but they provided some gains to outcomes. All chemotherapy protocols were approved for use through the local oncology centre and the appropriate London Cancer Tumour Board.
- We were told that medical staff were required to adhere to the protocols and would be challenged by pharmacy, who cross checked all regimes, if they did not follow the protocol. If medical staff wanted to use a different protocol, they submitted a request to the protocol team with associated evidence. This would be reviewed by the tumour group specialists and agreement from these had to be obtained before the protocol could be approved.
- Clear criteria had been developed and were used by nurses to assess whether chemotherapy should be given at each visit and any issues were referred to the patient's consultant.
- NICE guidance on the management of sepsis (NG51) was published in July 2016. Prior to this the UK Sepsis Trust developed the "Sepsis Six" care bundle which was a bundle of six interventions to be implemented within the first hour of admission to diagnose and treat sepsis and reduce mortality.
- There were clear guidelines for the management of neutropenic and non-neutropenic sepsis and these were based on the NICE guidance. An audit of adherence to NICE guidance in the management of neutropenic sepsis between December 2014 and December 2015 had been completed within the hospital and found varying levels of compliance with the criteria. An action plan to address the main findings had been developed. They were planning to implement the sepsis six care bundle from October 2016.
- Audits to assess compliance with other NICE guidance relevant to medical services such as NICE quality standard (QS9) Chronic Heart Failure, Quality standard (QS6) Diabetes in Adults and guidance for kidney injury and gastrointestinal bleeding had not been completed.
- An end of life care policy entitled "Excellent care in the last days of life" had been approved by the Princess Grace hospital in May 2016. This policy set out to apply the NICE guidance on the same subject and published in December 2015, to a care pathway for the care of individual patients and their families. It was developed in conjunction with a neighbouring NHS hospital. The

policy was supported by the development of a care plan which had been used for six patients at the time of the inspection. However, staff on the medical ward were not conversant with the content of the care plan and one senior member of staff said the development of the care plan was "still in progress." There was a plan to audit the use of the care plan after it had been in place for six months.

- A gap analysis to assess the processes in place for end of life care against the NICE guidance "Caring for dying adults in the last days of life" (NG31) had been undertaken in January 2016 and was reviewed in May 2016. The excellent care in the last days of life care plan was put into place to address the gaps.
- Although the oncology team identified the requirement to involve palliative care specialists early, and End of Life Care is described by NICE as care within the last year of life, the hospital end of life policy only covered care in the last days of life. In addition, there was no reference to supporting patients to die in their preferred place, whether this was at home, in hospital, or in other services.

Pain relief

- A pain score (0 to 3) was used to record patients' pain on admission and when vital sign observations were recorded. There were no easy access pain scoring tools for those with difficulties with understanding numbers.
- A pain consultant was available for advice on the management of acute and chronic pain. They visited the oncology ward daily and visited patients as necessary.
- Patients on the oncology ward told us staff monitored their pain and offered them pain relief. One person said, "I always get pain relief and they give you more when needed."
- Two patients we talked with on the medical ward told us they had received pain relief which had controlled their pain. However, one patient told us staff did not always attend to them as quickly as they should. When we talked with them they said they were in pain and they had been waiting a long time for pain relief. They said, "They (staff) know I need it, but they think they know better than me." The patient appeared visibly to be in pain. We talked with a nurse who said the patient had been asking for pain relief for half an hour. When asked about the delay, they initially said there had not been a sufficient gap since their last dose, then said they needed the controlled drug keys, and they needed a second person to check the drugs (there were three nurses at the nurses station at the time). We asked if there had been a request for the patient's pain to be reviewed, if the pain relief wasn't adequate and they said they weren't sure. When we returned to the ward the following day the patient again appeared to be in pain and we therefore reviewed their records to assess whether the patient's pain was being monitored and reviewed. There was no nursing care plan in place for pain management. There were four entries in the patient's medical notes over a period of seven days indicating the need for a referral to the pain specialist but there was no indication that a referral had been made or that they had been seen by a pain specialist. This meant a patient's pain was poorly controlled over a period of a week without referral to an appropriate specialist. We talked with the ward manager who told us they would follow it up the same day with the patient's consultant.
- Patient feedback about the management of their pain was collected as part of the hospital discharge survey. Monthly results in medical services ranged from 50% satisfaction to 100% on the oncology ward and from 57% to 95% on the medical ward.

Nutrition and hydration

- Nutrition risk assessments were completed when patients were admitted and reviewed regularly throughout their admission. Care plans for people who needed support to maintain their nutrition were in place for some patients, but we found one patient who was identified as having a poor appetite and had a nutritional risk assessment, did not have a nutritional care plan to identify the actions needed to support them to maintain an adequate nutritional intake.
- We talked with a patient who told us, "The food is fine but I haven't got an appetite." We asked if their appetite had been discussed with them and whether they had been asked if there was anything they felt they would like to eat in view of their poor appetite. They said staff had not discussed their appetite with them. As a result we could not be sure that people's nutritional needs were always identified and action taken to maximise their nutritional intake.

- Most patients had fluid charts to record their fluid intake and output, but some of these were not completed or were inconsistently completed. We talked with a nurse about this and they said some patients could be asked to maintain a record of the drinks they consumed as when people were able to drink independently, the nursing staff did not have an input and therefore their fluids were not recorded.
- Most of the patients we talked with said the quality of the food was good and there was a good choice. One person said, "The food here is excellent, my favourite is poached salmon; it is fantastic. I never get hungry." However, we also received some less positive comments about the meals such as, "The staff that bring it up try very hard but there's not much taste."

Patient outcomes

- The service was working towards Joint Advisory Group Accreditation (JAG) for endoscopy. They had completed initial work to improve patient experience and safety in relation to the decontamination of equipment, and told us that following changes to the management and leadership of the unit they were now able to progress this further.
- A blood transfusion audit had been completed between January and March 2016 to assess the quality and safety of blood transfusions and adherence with national guidance including consent for blood transfusion. This included medical services but the results were not broken down by ward. Areas of good compliance included the checking of patients' haemoglobin prior to the transfusion and it being within the threshold for transfusion and the recording of vital signs observations.
- A chemotherapy documentation audit was completed between January and March 2016 to assess compliance with the Comparative Health Knowledge Systems (CHKS) standards. This showed an overall compliance of 86% and an action plan was developed to address the areas of poor compliance.
- Quarterly audits to assess whether NICE and Department of Health guidelines were being followed in relation to VTE risk assessment and prophylaxis were completed and found a compliance of 88% between January and March 2016 and an increased compliance of 95% between April and June 2016.
- The service did not participate in any national audits related to medical care or end of life care as the numbers of patients who would be eligible to be included was very small. We asked if there were any plans to collect data and benchmark their outcomes against the national audit criteria to provide some indication of their performance, however we were told there were currently no plans to undertake this.
- The number of unplanned readmissions following day case and inpatient attendances at the Princess Grace hospital was not high compared to a group of independent hospitals that submitted data to the CQC. The unplanned re-admission rate for medical services was 1.9%
- The service did not participate in the national audit of EoLC in hospitals.

Competent staff

- The hospital reported that over 98% of nursing staff and health care assistants had had an annual appraisal in the current year and staff we talked with confirmed they had had an appraisal which they felt was constructive and enabled them to identify their development needs. One person said, "My appraisal was supportive and I was challenged to think of an area of expertise I wanted to pursue."
- We talked with four members of staff who had commenced work in the previous year and they told us they had received an induction and had been supernumerary until they had completed their competency assessments and were confident to work independently. A member of staff said they had a meeting after six months to review their progress and a formal appraisal at the end of their first year.
- We talked with staff in the Endoscopy unit (including the decontamination unit) and they told us their endoscopy training certificates were checked on appointment and they had received training on the decontamination, handling and processing of endoscopes, with refresher courses annually.
- The managers told us it was difficult to recruit nursing staff with expertise in oncology and for this reason the beds on the oncology ward had been reduced until the

numbers of staff were increased. A clinical practice facilitator had been appointed to coordinate training for staff, assess competency and work alongside staff to increase their skills and confidence.

- A small number of experienced oncology agency staff were utilised regularly and they were familiar with the hospital and the oncology ward. They were able to give chemotherapy if they could provide evidence of their training and following an assessment by the clinical practice facilitator. They also had an assessment prior to being allowed to give intravenous antibiotics. An agency nurse told us they were able to access study days which were being provided for permanent staff to enable them to keep themselves up to date and further develop their skills.
- Staff working in oncology completed competency assessments in chemotherapy administration. Of the 14 staff working in the oncology unit, 100% had been assessed as competent in four of the areas assessed, 93% had been assessed as being competent in the management of extravasation and in scalp cooling whilst 79% were competent in delivering anti-cancer therapy intravenously.
- Consultants were responsible for prescribing chemotherapy in oncology and RMOs did not have the necessary access to amend prescriptions. If a dose amendment was needed, they contacted the consultant.
- Consultants told us HCA had robust processes in place to update practising privileges data and monitor compliance. A consultant said they were monitored by the human resources department and they had to keep the RCP (Royal College of Physicians) diary up to date and have an evaluation and accreditation annually. They said their indemnity insurance was checked. We reviewed the data from the hospital and saw some consultants had their practising privileges removed following a review of their activity levels.
- The RMOs we talked with said they had support from the hospital to do post graduate training although one RMO told us they did not receive study leave for training. They told us they felt well supported by the consultants and received informal training from them on a regular basis. All RMOs had completed advanced life support training.
- A generalist RMO covered the medical wards at night. While these were relatively senior in their training they could be surgical in their background and experience rather than having an acute medicine background. However, they could contact the consultant for advice when necessary.
- A one hour training session about end of life care and the use of the excellent care in the last days of life care plan was commenced in June 2016. At the time of the inspection at the beginning of September 2016, 64% of staff had received training which included 100% of staff working on the oncology unit. A consultant from the NHS hospital involved in the development of the care plan had provided training for the RMOs.
- Training on symptom control was provided in the form of grand rounds and attendance was not recorded.

Multidisciplinary working

- Weekly multi-disciplinary team (MDT) meetings were held for oncology patients with an RMO, nurse, pharmacist, dietician, psychologist, physiotherapist and occupational therapist regularly present.
- There were monthly case based MDT meetings for medical patients registered with a nearby independent outpatient medical consultation service.
- For general medical patients, informal MDT meetings took place when there was a complex discharge in which the involved professionals met up to discuss the discharge and ensure the necessary arrangements were in place.
- Staff were able to describe the arrangements for involvement of social services when patients required support following discharge.
- When patients required referral to other consultants this was done on a consultant to consultant basis. There were clear criteria in place for the transfer of patients to NHS hospitals when this was required.
- Staff told us communications between the professionals was generally very good and staff worked well together.

Seven-day services

- Consultants visited their patients at the weekend and there was a consultant on call rota. Staff told us that if a consultant was not going to be available they were notified of the cover arrangements.
- The palliative care team visited the oncology ward regularly during the week and could be accessed at weekends.
- We were told there was good access to diagnostic and interventional radiology at weekends and that CT scans and pulmonary angiograms could be accessed at weekends.

Access to information

- The combination of electronic and paper based records meant it was difficult to access all the information about each patient and obtain a contemporaneous record of progress.
- However, some parts of the record brought together several aspects of care and treatment and were viewed as being very positive by staff. For example the electronic record for medical oncology improved the safety and accessibility of information about patients receiving chemotherapy.
- Consultants told us the IT system was excellent as they could access the hospital systems and their own notes via an app.
- When using the electronic system to access patients' observations over a period of time, it was frequently slow and unresponsive.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to endoscopy had been completed appropriately and signed by patients. We were told patients were provided with information about the procedure initially and on the day of the procedure, it was explained again by the consultant undertaking the procedure and the consent form was signed.
- A consent form for a patient for whom English was not their first language documented that an interpreter had been involved in the consent process and the consent form contained the signature of the interpreter and the signature of the patient.
- Patients told us they had been provided with information and were able to make their own decisions about the course of treatment and investigations. A patient said, I am able to make the decisions; they provide you with the information, but don't overload you." Another patient told us they had been asked for consent prior to a contrast CT scan. They told us the procedure had been explained to them and they had signed a consent form.
- We were told that the number of patients accessing the service who did not have the capacity to consent was low but was increasing due to increasing numbers of patients living with dementia. At the time of the inspection, we were able to review only two patients living with dementia and who may not have had the capacity to make some decisions for themselves. We reviewed the care of one patient whose consent to a procedure was signed by both themselves and their close relative. The medical notes stated the patient had cognitive impairment and an allied professional had noted, "(Patient) is confused and does not know what is happening." However, there was no reference to the patient's capacity to make decisions and no capacity assessment. A relative cannot sign on behalf of a person unless there is a power of attorney in place for health and welfare, therefore the consent may not have been valid in this case.
- We also reviewed the care record of a patient who had been cared for shortly before the inspection who we were told, was not able to make their own decisions and had initially wanted to leave the hospital. We were told a Deprivation of Liberty Safeguarding (DoLS) application had been made as required, to authorise the staff to ensure the patient remained on the ward. There was reference in the care record to the patient not having capacity to make decisions and a range of professionals had been involved in concluding that the person did not have capacity to make decisions and that a DoLS authorisation was required. However, there was no evidence of a DoLS application having been made and a member of staff said if it was not within the care record then it had not been made. When it was investigated further, we were told the application had not been made because the patient accepted the need for them to stay and be cared for. This indicates a lack of understanding of the deprivation of liberty safeguards as a DoLS authorisation should still be sought in these circumstances if a person does not have the capacity to make the decision.

Good

Medical care

- We saw the principles of the Mental Capacity Act (2005) were displayed in each of the ward areas, but there was variable understanding amongst staff about the implications for their practice. When asked what they would do if a person could not make decisions for themselves, some staff said they would ask the next of kin.
- Medical and nursing staff were not clear about their responsibilities for completing mental capacity assessments. An RMO we talked with said the nurses did the capacity assessments and the nurses we talked with said the doctors did the capacity assessments if they were needed. Therefore we were not confident mental capacity assessments would be undertaken when needed. There was no documentation of a formal two stage mental capacity assessment and best interest decision in the two sets of records we reviewed for patients without capacity to make some decision for themselves.
- Staff told us that when patients were receiving palliative care and reaching the end of their life, "ceilings of care" were discussed with them to ensure there was a shared understanding of the patients' wishes in relation to the life preserving treatments that would be given in the event of their deterioration. They said the decision as to whether cardiopulmonary resuscitation should be attempted was also discussed.
- We were told the palliative care team were involved from an early stage and we observed several oncology patients were receiving input from the consultant in palliative care. However, we found no documentation of discussion about whether a DNACPR decision was needed for some patients with advanced metastatic disease who were receiving palliative care. We also attended handover when these patients' care was discussed in detail and it was clear the issue had not yet been thought about in any depth. Resuscitation may have been appropriate for the patients, however the position in regard to the patients' wishes would not have been clear to staff in the event of the patients sudden deterioration. Without a valid DNACPR or advanced directive in place, in the event of a cardiac arrest, patients should be resuscitated.
- Some issues had previously been identified by the service when reviewing the results of the NEWS audits, which indicated that decisions about DNACPR were not always taking place in a timely manner and actions had been taken to highlight and address this. Staff told us that discussion and decision making around DNACPR had improved.

Are medical care services caring?

Good

We rated caring as good because:

- We observed staff interacting with patients in a friendly and caring manner and patients were positive about the relationships they built with staff.
- Patients were well informed and involved in their care and treatment.
- Patients had access to support to help them cope emotionally with their care and treatment. A psychologist attended the oncology ward regularly and patients told us they had been offered support.

However, we also found:

- An absence of documentation of discussions with patients about their prognosis and discussions about their options in relation to their care and treatment when they had a poor prognosis.

Compassionate care

- Patients were cared for in single rooms on the wards and in single cubicles within the endoscopy unit. We observed staff knocking on people's doors before entering and respecting their privacy.
- Patients were positive about the attitude of staff and their friendly, caring approach. Two patients who had been cared for over a period of time, told us staff treated them as they would their family. One patient said, "The staff are like family here; they give me a cuddle." Another person said, "I think the staff are fabulous; very caring and informative."
- Patients told us they felt safe as staff frequently came in to check on their well-being. However, one patient said although the nurses came in and completed all the tasks in a timely way, they did not spend time with them and they felt quite isolated in their room. They said, "It would have been nice if there was a bit more patient contact from the nurses."

Good

Medical care

- We observed porters interacting with patients and found they were polite, friendly and helpful.
- Patients were asked to complete a questionnaire on discharge about their experience and the service used the Friends and Family Test (FFT) question to assess patients' overall experience. Between April 2015 and March 2016 the FFT score for the oncology ward was 100% in nine of the 12 months. Data for the medical ward was not separated from the surgical ward on the same floor, but the score for the floor was 100% in four of the 12 months and over 93% in the remaining months

Understanding and involvement of patients and those close to them

- Patients told us staff discussed the plan for their care with them and they felt fully involved. One patient said, "The consultants have always told me what they are doing and what was involved." Another patient said, "I am very involved and I ask lots of questions, but it has never been a problem."
- Written information leaflets were available for patients about a range of treatments and procedures. A patient told us the verbal information they had been given was supplemented with written information, which they had found helpful.
- When patients were coming towards the end of their life, staff said medical staff were good at recognising this and involved the palliative care team. However, we found there was little documentation in patients' care records of conversations with patients about their prognosis when they had a poor prognosis.

Emotional support

- A psychologist was available for patients and patients could be referred as appropriate. The psychologist visited the oncology ward weekly and spoke with all patients to see if they wished to have regular visits. The psychologist would visit on request outside the weekly visit.
- Patients on the oncology ward told us the psychologist had been to see them and one person said, "The support is always there if I need it." Another patient said they were given emotional support immediately and the psychologist called to see them every week.
- Oncology clinical nurse specialists were available and on the ward on a daily basis.
- The hospital had access to a multi-faith chaplaincy service. Patients were visited on request and a leaflet about chaplaincy services was available for patients. An annual service was held for those who had lost a loved one in the last year. We were told of a wedding which had taken place on the ward when this was important to a patient a few days before they died.

Are medical care services responsive?

Good

We rated responsive as good because:

- Patients were able to access care and treatment in a timely way. They had timely access to initial investigations and action was taken to minimise the time patients had to wait for investigations.
- There was good access to interpreting and translation services for patients for whom English was not their first language.
- When complaints were received they were used to identify learning and improve patient experience.

However we also found:

- The coordination and delivery of services did not take account of the needs of people living with dementia and those with a learning disability.

Service planning and delivery to meet the needs of local people

- Consultants were actively involved in the development of medical services at the hospital. The service had expanded over the previous five years and consultants told us the hospital had responded as the numbers of patients had increased, through recruitment of suitably qualified nurses and a ward sister.
- Some patients and their families were not local to the area and facilities were available for them to stay with the patient and one family member could stay in the patient's room if the patient wished. A folding bed was supplied for this. They were able to access meals and drinks.

Good

Medical care

Access and flow

- Admission to the medical ward was via a referral to the acute on call consultant. If an inappropriate referral for admission was received, the consultant advised the referring clinician immediately and they were provided with advice of the most appropriate pathway for the patient.
- We were told there was no waiting list for chemotherapy and no problems with bed availability. Chemotherapy was not given at weekends and bank holidays.
- Patients talked positively about the ease of access to services and the communication between departments. One patient said, "When I have a scan here, the results are there within two or three hours and then they carry out the procedures."
- Discharge was discussed at handover and a multidisciplinary approach was taken with the involvement of physiotherapists and occupational therapists as appropriate.
- Patients were given a discharge letter for their GP on discharge. Patients were also given a card with a telephone number to use if they experienced any problems after discharge. Oncology patients were also given contact details for oncology nurse specialists.
- The endoscopy unit was open from 7.30am to 9pm Monday to Friday and there was an on call service at night and over the weekend.
- When inpatients required endoscopy they were collected from the ward by a nurse from the unit and a porter. They were collected from the ward in a timely way and we did not observe any unnecessary waits. A consultant told us they did not have any issues in scheduling patients for endoscopy. They told us they had regular sessions but could also carry out procedures at other times, by contacting the unit.
- Staff told us they had discussions with patients who were reaching the end of their life about where they wished to die. However, we did not see any specific documentation in relation to this. The excellent care in the last days of life care plan did not identify the person's preferred place of death.

Meeting people's individual needs

- Patients told us they were able to use their call bells when they needed assistance and staff normally responded in a timely manner. One patient said staff responded quickly initially and attended to them if it was urgent, but if the issue was not urgent, staff would tell them how long it would be before they came back to assist them.
- A significant number of patients were from overseas and English was not their first language. Interpreters were used where necessary and staff were aware of how to access an interpreter. They told us they did not have any issues in obtaining an interpreter and a telephone translation service was also available. A face to face interpreter was always used when a discussion was planned with the patient to discuss their condition or break bad news.
- Staff told us that if a patient wished to be cared for by staff of the same gender they were able to accommodate their wishes.
- There was a range of different menus for patients to choose from, such as a light menu, snacks menu, all day menu, neutropenic menu, and chef's daily specials. However, patients we talked with were not always aware of the full range of menus and some found it confusing.
- Screening for dementia and delirium was completed for patients over 65 years on admission to medical services. Staff told us they had completed on line training in dementia but they were not aware of the "This is me" or patient passport document to provide additional information about the person when they were living with dementia.
- The hospital had provided dementia friendly clocks in patient rooms and signage, however other environmental adaptations to improve the safety and experience of people living with dementia such as the use of contrasting colours were not in place. Data provided by the management team indicated the number of patients living with dementia and using the service was extremely low.
- Staff were not aware of any access to a learning disabilities liaison nurse to provide additional support and guidance for staff and support to patients with a learning disability.

Good

Medical care

- Endoscopy staff told us patients with a learning disability were scheduled to be first on the list to reduce unnecessary waits and a larger bay was used to provide more space for the patient's family or carer to stay with them if they wished. They told us this area would also be used for other patients with family or carers in attendance, such as those living with dementia.
- A patient commented on the lack of any facilities or arrangements to allow for the laundering of patients own items of clothing. They said that as they did not live locally, they did not always have relatives who could take their items of laundry and they did not always want to give soiled items to their children.
- The hospital did not have a mortuary and patients who died in hospital remained on the ward until the local funeral director transferred them. The death certificate and any cremation papers were completed at the time of death and family were able to collect these from the ward.
- Porters escorted the funeral director to the ward and back to the vehicle with the deceased person. Ward staff said they made the unit as private as possible by using screens. The funeral directors entered the hospital via the staff entrance rather than using the public entrance to maintain as much privacy as possible.
- A patient information booklet about "Do not attempt Cardiopulmonary Resuscitation" had been produced, but the information in it was a little misleading in places. For example, it stated that if a DNACPR decision had not been made and a person had a cardiac arrest, the doctor in charge of their care would make a decision about what was right for them. However, in an emergency situation, resuscitation would be commenced if a DNACPR order was not in place. The booklet also stated that an advanced decision to refuse treatment was needed if they wished to refuse CPR, but this would not be needed if a patient had discussed their wishes with the doctor and a DNACPR order was put into place.

Learning from complaints and concerns

- Patients told us they had not been provided with any information about how to make a complaint, and the patients we talked with said they had not had the need to complain. One patient said, "If something is not quite right, they put it right." The folder with information for patients which was provided in every room did not contain this information.
- A total of 15 complaints were received for medical services between April 2015 and March 2016. There were no complaints related to end of life care in the same period.
- Staff told us they received information about complaints and actions to reduce complaints. Information about complaints and thank you letters were displayed in the staff areas of the wards.

Are medical care services well-led?

Good

We rated well led as good because:

- Leadership was visible and supportive at all levels in medical services and staff felt valued by the senior leadership team. They were able to contribute their views and felt new ideas were welcomed.
- Medical care services had been progressively developed and steps taken to ensure the safety and quality of services when challenges occurred. The consultant team for oncology brought significant expertise and were actively engaged in research and development.
- Communication about quality and governance issues was cascaded through the organisation and staff were aware of quality improvement initiatives.
- The corporate risk register reflected the main risks for medical services and action was being taken to control the risks.

However, we also found:

- Nominal leadership roles for End of Life care had only recently been identified. Although there was a policy in place for care in the last days of life there was no End of Life Care strategy and no policy which covered patients in the last twelve months of life. The governance framework for EoLC required development.

Leadership and culture of service

Good

Medical care

- The ward and unit managers were knowledgeable about their areas and demonstrated good leadership skills. They were visible and were good role models for staff.
- Staff felt well supported by their immediate line managers and the senior management team. One member of staff said, "Sister is amazing, our clinical nurse manager is excellent and both are very supportive. They provide excellent advice and guidance." Another member of staff said, "I can be creative here; people listen."
- A ward manager told us, "I often do a night shift to see what goes on."
- Staff also told us the chief executive frequently visited the clinical areas and one member of staff said, "the chief executive greets me by name and asks how I am; she is very approachable."

Vision and strategy for this this core service

- The vision for the hospital was displayed in both of the wards and the endoscopy unit and staff were aware of the vision.
- There was no separate strategy for medical services at the hospital. A business plan had been developed for the hospital and medical services were included in this, but from the information provided, it was not possible to identify any plans for development of medical services specifically.
- There was no End of Life Care strategy. A consultant told us end of life care was the "cornerstone" of oncology and the palliative care team was involved as soon as possible.
- Since the launch of the new excellent care in the last days of life care plan, the profile of end of life care had been raised and staff had attended training.

Governance, risk management and quality measurement for this core service

- A governance structure was in place for the hospital. There were three main governance committees, the clinical governance committee, the mortality committee and the medical advisory committee. There was medical representation from medical services at each of the governance committees. Minutes from the meetings indicated the committees included discussion of a full range of governance issues related to medical services
- The chief nurse cascaded information from the governance committee meetings to the monthly senior nurses meetings and from there, information was cascaded to the wards. We reviewed the minutes of ward meetings and found that quality and governance issues were discussed.
- Information was cascaded to physicians through the monthly governance newsletters sent by email. This provided information on incidents, training and NICE guidance. We saw a copy of the governance learning and feedback document for August 2016; this was a 23 page document which was emailed from the clinical governance team.
- A range of quality audits were completed monthly and there was an audit plan for the year. Medical staff told us they would welcome additional support for clinical audit to enable the collection of data, such as those required to benchmark clinical outcomes.
- Risks were identified on the corporate risk register and in respect of medical services, these mainly related to the use of agency nurses in oncology for which a plan was in place. A risk in relation to the storage of intravenous fluids had been resolved.
- Performance in relation to safety indicators were displayed on each of the wards but there was no ward specific information.
- The hospital was in the process of implementing a care in the last days of life strategy, aligned to NICE guidance in collaboration with a local NHS trust. The oncology CNS and clinical practice facilitator had lead roles in the implementation of this, in addition to their normal duties. Although training had been commenced, limited progress had been made at the time of the inspection.
- We were told End of Life Care was on the governance agenda as in-hospital mortality was discussed at the governance committees. However, there was no evidence of any other review of End of Life Care and therefore the care of patients who were transferred to other services for on-going palliative care such as the hospice or home prior to death was not reviewed.

Good

Medical care

Public and staff engagement

- Patients' views and experiences were gathered using a questionnaire provided on discharge. The questionnaire covered nursing care, discharge, pain management, quality of care and the Friends and Family Test (FFT).
- Although we were not provided with the results of patient feedback surveys from endoscopy, staff told us surveys were posted to patients after their procedure. They told us of changes to the patient pathway in endoscopy which had occurred as a result of patient feedback to improve patients' experience when arriving at the unit.
- Staff felt well informed about the changes in the organisation and said the managers were responsive to new ideas, which were quickly implemented.
- A member of staff said they would score their employer ten out of ten. They said, "It is the best place I've ever worked."
- Staff forums were held which updated staff on quality issues, incidents and other performance issues along with business plans for the future.

Innovation, improvement and sustainability

- Consultants told us they were able to gain approval for the use of new cancer drugs in a timely manner and were therefore able to offer patients the newest treatments, which were often less toxic and extended patient survival times. There were close links with the local oncology centre and this brought benefits for the hospital and for patients. The oncology consultants were actively involved in the forefront of oncology practice. For example one of the consultants was a member of the steering committee of the Association of Cancer Physicians of the UK and advised on the introduction of new drugs through the London Cancer Drugs Group. Other consultants had authored many peer reviewed papers in respected oncology journals and presented at major international conferences.
- The hospital was responding to national shortages of oncology nurses by providing in house training and support to enable staff to develop their skills.
- Medical services had been progressively developed since their inception. The endoscopy suite had been refurbished in 2015 and quality accreditation was being sought for chemotherapy and endoscopy services with national accreditation schemes.

Requires improvement

Surgery

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

Information about the service

The Princess Grace Hospital (PGH) provides day case surgery and inpatient care for adults requiring a variety of surgical procedures. This includes surgery such as orthopaedic, urology, breast, ear, nose and throat and gynaecological procedures. The hospital provides surgical treatment for private patients from the UK as well as from overseas and also provides treatment to a small number of National Health Service (NHS) patients. From April 2015 to March 2016 there were 7,371 surgical procedures performed 1.7% of these were NHS patients. There were 73 unplanned surgical admissions from September 2015 to August 2016. All other surgery was elective.

There were eight operating theatres at the PGH. Theatres were divided with four theatres in the basement and four on the first floor. Each theatre floor had its own recovery area with three patient bays each. There was a first floor day case suite which consisted of 15 private rooms. Surgical inpatients were cared for on the second, fourth and fifth floor (south) wards of the hospital. During inspection the 2nd floor ward was closed due to refurbishment. The wards provided 24 hour, seven day a week care.

During our inspection, we visited the surgery services on Wednesday 31 August, Thursday 1 and Friday 2 September and during an unannounced visit on Wednesday 14 September when we visited the 2nd floor ward. We followed the patient journey from admission through operating theatres and immediate post-operative recovery, then on to the surgical wards and finally discharge.

We visited the surgical floors, the main operating theatres and the recovery area. In addition to this, we interviewed service leads and ward managers of the services. We spoke with over 15 members of staff including managers, doctors, nurses, allied health professionals, health care assistants, support staff and admin staff. We spoke with 5 patients and their family members. We observed their care and treatment and looked at 10 care records. In addition to this, we reviewed local and national data and performance information about the service.

Requires improvement

Surgery

Summary of findings

We rated the surgery services at the Princess Grace Hospital as 'requires improvement' overall because:

- Infection Prevention and Control (IPC) did not always reflect current evidence-based guidance, hospital policies and best practice. We observed that best practice guidelines and hospital policies were not always implemented in practice. For example we saw that theatre floors were not cleaned in between patients and observed during inspection that they were dirty, staff in clinical areas did not adhere to the bare below the elbows policy.
- Information sharing did not inform nursing staff of incidents and learning that had occurred within their own ward areas. Staff were unable to recall recent incidents or learning from their areas and told us they had not reported any incidents within the previous 12 months. Incident reporting in surgery areas of the hospital was low when compared with other services.
- Basic life support training (BLS) was poorly attended when compared to other mandatory training topics. In theatres only 50% of staff had attended this training. The staff that had not completed BLS training had not completed other forms of life support training.
- Records were not consistently kept up to date when doctors visited their patients and we saw documentation that did not meet the General Medical Council (GMC) standards.
- Medicine administration and medicine record keeping did not follow best practice guidance.
- We saw that staffing in theatres did not always comply with The Association of Perioperative Practice (AfPP) guidelines.
- Risks and issues identified during inspection had not been identified or dealt with in a timely way. The risks described did not correspond to those reported to and understood by leaders.
- Staff who had identified issues such as consultant documentation did not always speak up about these concerns.

However

- Care and treatment was planned and delivered in line with current evidence-based guidance, standards and best practice. This was monitored through audits to ensure high standards and consistency.
- The World Health Organisation (WHO) safer surgery checklist was clearly defined and we observed that the three mandatory steps; sign in, time out and sign out were fully embedded in practice.
- We saw staff responding to patients and their families compassionately. Patients' privacy and dignity was respected at all times. Feedback attained from patients and their families during our inspection was positive.
- Services were flexible, individual patient needs and preferences were prioritised and patients were able to access services in a way and at a time that suited them.
- The surgical services were using outstanding cutting edge technology including robotic surgery for orthopaedic and prostate surgery with outcomes monitored appropriately.
- Leadership was visible and supportive at all levels in the surgical services and staff we spoke with felt valued by the senior leadership team. Staff told us they were able to contribute their views and felt new ideas were welcomed.

Requires improvement

Surgery

Are surgery services safe?

Inadequate

We rated the surgery services as "inadequate" for safe because:

- Infection Prevention and Control (IPC) did not always reflect current evidence-based guidance, hospital policy and best practice. We observed that best practice guidelines and hospital policies were not always implemented in practice; we saw that theatre floors were dirty and we saw staff who did not follow the bare below the elbows policy.
- Information sharing did not comprehensively inform staff of the incidents, risks and learning in their local areas. There was little evidence of learning from events or actions taken to improve safety that was local to the areas staff worked in. Incident reporting in some areas such as theatres was low and staff were unable to tell us about incidents they had reported or had been reported in their wards or departments.
- Medicine administration did not always follow Nursing and Midwifery (NMC) Standards for medicines management. We saw the reasons for drug omissions were not always recorded and we saw staff administrating medication without checking the patients name and date of birth.
- Risk assessments were not always completed in a timely manner and we saw venous thromboembolism (VTE) risk assessments that were incomplete in nine patient notes.
- Throughout the surgery departments basic life support training (BLS) was poorly attended when compared to other mandatory training topics. In theatres only 50% of staff had attended this training and these staff had not completed other forms of life support training such as intermediate or advanced.
- Records were not consistently kept up to date and we saw documentation that did not meet GMC standards. Nurses told us that consultants did not always document in the notes when they visited their patients.
- Staffing in the theatre department did not always meet the AfPP guidelines as we saw theatres operating with only one qualified scrub nurse.

However

- Staffing levels and skill mix for ward areas was planned, implemented and reviewed to keep people safe at all times. Staff shortages were responded to quickly.

Incidents

- There were no never events reported for surgical services between April 2015 and March 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The hospital used an electronic incident reporting system and all staff we spoke with were familiar with how to report incidents. Incident reporting training was included in the staff induction programme which all staff attended when they commenced employment at the hospital and must complete to pass their probation period.
- The hospital reported 730 clinical incidents between April 2015 and March 2016. Out of these 79% (503 incidents) occurred within the surgery services. The hospital reported a lower number of incidents compared with other independent acute hospitals.
- In theatres there were 21 incidents reported within the six month period from March to August 2016. This number is low when compared to other theatre departments of a similar size and may demonstrate the under reporting of incidents that have occurred.
- Staff across surgical services were able to identify and describe situations requiring completion of an incident form. Staff told us there was a good reporting culture and that they were encouraged to report 'near miss' situations in addition to incidents that had occurred.
- Staff on the surgical wards told us they received feedback and learning from incidents through learning grids, via email and at nursing handovers.
- We spoke with five nurses in theatres who were aware of recent hospital incident themes which included medication and patient falls. However, these staff were unable to tell us about incident themes within their own department and none of the five staff we spoke with had reported an incident within the previous 12 months.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of

health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- All staff we spoke with had good awareness of duty of candour requirements. Staff explained that patients should be informed an incident had occurred, given an apology and told that an investigation would take place. Ward managers and senior nurses were able to give examples where this had been applied for example a patient fall.

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

- The hospital did not use the NHS Safety Thermometer; this is a tool which measures harm to patients which may be associated with their care. However, the hospital had developed a dashboard which monitored pressure ulcers; falls and VTE. These were monitored and benchmarked against other services in the hospital. However, nurse managers and senior nurses were unaware of the numbers within their own departments.
- Data provided demonstrated 2 falls on the fifth floor surgical ward from May to June 2016. This was low when compared to other departments in the hospital.

Cleanliness, infection control and hygiene

- All the patient rooms were single occupancy on the wards and therefore additional isolation areas were not required.
- Staff in all areas had access to personal protective equipment (PPE) such as gloves and aprons. We observed that theatre staff and ward staff wore the appropriate PPE during procedures.
- The hospital bare below the elbows (BBE) policy was not always followed by some staff. We saw on three separate occasions that consultants in ward areas who were seeing patients were not BBE and were not challenged by other staff.
- We saw staff washing and using antibacterial gel to clean their hands. Hand hygiene audits were completed monthly. Results from June 2016 demonstrated 100% compliance for all surgical areas within the hospital.
- Theatre scrubs were not always worn in the theatre department. We saw staff walking through theatre corridors that had not changed into scrubs and saw that there was no clear line defining where scrubs were required to be worn. This was in line with the hospital policy which states that 'clinical staff and consultants who are visiting the department, but do not intend to enter the theatre itself, may remain in outdoor clothing'. We also saw staff wearing scrubs outside of the theatre departments in other areas of the hospital.
- We saw maintenance staff in dirty overalls entering the theatre department who left windows open in the theatre corridors while procedures were taking place.
- We observed on five separate occasions staff exiting and entering the theatre during an orthopaedic procedure using the main theatre doors. This opened the doors onto the unclean corridor where waste was disposed and onto the main corridor. We asked staff why the traffic in and out of the main theatre doors was high and were told it was due to the theatres sharing the anaesthetic rooms.
- We observed in theatres the floor was not cleaned in between patients.
- Waste management practices we observed in theatres did not comply with the hospital policy and good practice guidelines for segregation of waste. We observed staff putting clean packaging into orange clinical waste bags. Sharps bins were labelled and dated and bed linen was bagged appropriately.
- The provider developed an infection control dashboard in 2014 which included mandatory reporting statistics to Public Health England (PHE) for bacteraemia, C.diff and surgical site infection (SSI). There had been one incident of MRSA, seven incidents of E-Coli and six incidents of C.diff for the reporting period April 2015 to March 2016. This dashboard did not break the infection rates down by service.
- There were 17 surgical site infections (SSIs) in total during the reporting period April 2015 to March 2016. The rate of infections during primary hip arthroplasty and spinal procedures were below the average for NHS hospitals. The rate of infection for primary knee arthroplasty was above the average for NHS hospitals. However numbers remained low with only one infection out of 120 procedures.

Environment and equipment

- Resuscitation equipment was audited on a regular basis by department managers. Results from an audit in August 2016 demonstrated 100% compliance. We saw that resus trollies in all areas of the surgical services were checked daily and we found no omissions in the checklists.

- Anaesthetic equipment was stored in drawers in each anaesthetic room. These drawers were not labelled and therefore agency staff may find it difficult to locate equipment quickly in an emergency situation.
- Difficult intubation trollies were available in each of the theatre floors. However in the first floor theatre department we found the difficult intubation trolley located in the corner of an anaesthetic room. Staff told us this was its permanent location and was the only difficult intubation trolley in the department. We noticed that if a patient was in the anaesthetic room the trolley would not be accessible through the anaesthetic room and this would need to be wheeled through the main theatre.
- The lack of storage for equipment was on the hospital risk register and in theatres we saw equipment stored in corridors and in recovery bays and the department appeared cluttered. In CSSD we saw sterile equipment stored above shoulder height. There were no weights recorded on these in line with best practice to prevent staff injury.
- Each theatre did not have its own anaesthetic room. Staff told us this was of no concern as they could stagger cases throughout the day. However we saw staff having to enter and exit the theatre through the main doors during procedures.

Medicines

- Medicines were stored safely in locked cupboards and refrigerators within a locked room which was accessed via keypad. The wards had a range of stock medicines to enable frequently used medicines to be available promptly when required. Patient's own medicines were stored separately.
- Intravenous fluids were stored securely and previous issues related to the insecure storage of intravenous fluids had been addressed on all the surgical wards.
- The wards used a paper based prescription and medication administration record chart for patients which facilitated the safe administration of medicines.
- We looked at 10 medication records of patients within the surgery services. We saw appropriate arrangements were in place for recording the administration of medicines. However we saw two records where the reasons for not giving people their medicines were not recorded.
- We observed medication rounds and noted on two separate occasions that staff did not always check the patients name and date of birth prior to the administration of medicines.
- Controlled drugs were checked twice daily, with a separate signing sheet seen. Controlled drugs were correctly documented in the controlled drug register, with access to them restricted to registered nurses who held the keys.
- Room and fridge temperatures were recorded on a daily basis, and were found to be within the recommended range. When asked what would happen if the normal fridge temperature of 2 to 8 degrees went out of range, the nurse stated that a member of clinical staff would be responsible for taking the appropriate action to rectify the anomaly, which included contacting the pharmacist and estates management.
- Staff had access to British National Formulary (BNFs) as well as all policies/information relating to medicines management (including the antimicrobial formulary) via the hospital intranet.
- Staff understood and demonstrated how to report medicines safety incidents. Learning from these incidents was then fed back through various channels, such as emails, nursing handovers and monthly meetings.
- Medicines were reconciled on admission and an audit from July 2016 demonstrated the surgery wards to be non-compliant with four of the five questions audited. This included the medicine reconciliation section of the prescribing chart signed and dated, a minimum of two recent reliable sources of information used and current medications on admission prescribed. We saw action plans in place to improve with a plan to re audit.

Records

- Patient information and records were stored securely on all the wards and in all departments we visited. Electronic records were not left on screens. Access to the computers and patient confidential information was password protected.
- Most agency staff did not have access to the electronic care planning system; therefore they were provided with paper documentation to record the patient's progress and risk assessments. This meant there were gaps in the electronic record and the records were disjointed or entered in retrospect by someone other than the nurse looking after the patient.

- We looked at 10 sets of patient paper records and identified concerns with the legibility of some paper based medical records. Records we reviewed did not meet GMC standards for documentation as consultants who had reviewed patients did not sign, date and write their name legibly. We saw seven examples where there was no legible name next to consultant signatures. We spoke with a ward manager who told us that some consultants would review patients without documenting anything in the notes. This was not challenged and appeared to be accepted practice by the nursing staff.
- VTE assessments were part of the paper based notes. Nurses told us it was the doctors responsibility to complete these. Out of the 10 records we reviewed only one of these had been completed. However, audits provided by the hospital demonstrated a greater compliance in the completion of these.
- Risk assessments were completed and entered on the electronic care planning system. Staff were prompted to enter information by the system, and patients were given a specific care plans relevant to their condition and the procedure they were undergoing.
- Copies of perioperative treatment records were kept in patient notes. These included the five step surgical safety check list which were fully completed and details of any implants or prosthesis used.
- We viewed a nursing records audit report, dated January to March 2016. Results demonstrated overall compliance of 75% for the second floor ward, 93% for the fourth floor ward and 92% for the fifth floor ward. The report included lessons learned to aid improvements.

Safeguarding

- The hospital had a named nurse and named doctor in post, responsible for safeguarding as dictated by statutory guidance. There also were safeguarding leads on individual wards, trained up to safeguarding adults level four. Processes were in place to provide appropriate safeguarding supervision for all staff.
- Staff we spoke with were aware of how to access the safeguarding policies on the hospital's intranet. Most staff we spoke with were able to identify the different types of abuse and were aware of how to escalate concerns through senior nurses or the site manager.
- There had been no reported safeguarding to the CQC in the reporting period from April 2015 to March 2016.
- Data provided by the hospital demonstrated that 75% of nursing staff had completed adult safeguarding training.

Mandatory training

- Mandatory training topics included: health and safety, manual handling, infection control, safeguarding, fire safety, code of conduct, information governance, equality and diversity and basic life support. Completion rates varied across the service and ranged between 50% to 90%.
- Throughout the surgery departments basic life support training was poorly attended when compared to other mandatory training topics. In theatres only 57% of staff had attended this training.
- We were told that theatre anaesthetic and recovery staff were encouraged and supported to complete intermediate and advanced life support training. However, information provided to us demonstrated that 0% of anaesthetic staff and 29% of recovery staff had completed this training.
- An induction programme for all new staff included all mandatory training for their individual roles. All new staff we spoke with said they had completed the induction training and had found it detailed and comprehensive. New staff were unable to pass their probationary period if mandatory training was outstanding.
- Senior staff monitored completion rates of mandatory training using an electronic tracking system. They told us this was quick and easy to access. Clinical practice facilitators in each area ensured line managers updated staff training as part of their role.
- There was a new computerised system which recorded all staff mandatory training. Staff had access to their own profiles and were able to see when mandatory training had expired and needed to be completed.
- Managers were responsible for ensuring all staff were up to date with their mandatory training and completion was linked to salary increments. Nurse managers were able to see mandatory training figures for all staff in their area on the online system.

Assessing and responding to patient risk

- The hospital had a pre- operative assessment team for high risk patients which provided advice and

information to patients prior to their surgery, this included tests, screening and offered the patient an opportunity to clarify any details of their surgical journey.

- Nursing staff told us patients were assessed for the risk of hospital acquired venous thromboembolism (VTE) at preadmission and on admission prior to surgery however, we did not see this in practice. The electronic patient record (EPR) included mandatory risk assessments such as falls and skin integrity which were to be completed by the nursing staff. We were told doctors would complete the VTE assessment in the patients' notes however out of the nine records we reviewed only one VTE assessment was completed by the doctor.
- Audit results from April 2016 demonstrated that only 25% of patients on the second floor ward had a baseline assessment and clinical observations recorded on admission.
- Staff told us that if they had concerns relating to a patient's condition the on-site surgical resident medical officer (RMO), would be called to assess the patient and the patient's consultant would be informed if there were concerns. Staff told us the RMOs were accessible when needed. There was no information and no audits completed which monitored RMO or consultant response time.
- Patients' clinical observations were recorded and monitored in line with the National Institute for Clinical Excellence (NICE) guidance 'Acutely Ill-Patients in Hospital.' A scoring system known as a national early warning score (NEWS) was used to measure patients' vital signs and identify patients whose condition was at risk of deteriorating. We saw staff on the surgical wards and in recovery recording patient observations such as heart rate, respirations, blood pressure, temperature and pain.
- Observations were recorded on an electronic system on the second and fourth floor. On the fifth floor they had stopped using the electronic system and were using a paper based record due to the electronic system taking extra time for nurses to log on. This did not seem to be a problem on the other wards. The electronic system automatically calculated the level of risk, when a certain level was reached the on-call RMO was automatically informed and would review the patient.
- We looked at five observation charts on the fifth floor and noted observations were fully completed with accurate NEWS documented.
- There were processes in place to reduce the risks to patients undergoing surgery. These included the use of the World Health Organisation (WHO) surgical safety checklist a checklist which was developed to reduce errors and adverse events, and increase teamwork and communication in surgery.
- We observed that the mandatory steps of the WHO checklist were fully embedded in practice. We observed three of the steps which included the sign in, time out and sign out. We observed the whole theatre team were involved and staff stopped what they were doing to participate. However, we noticed that the team brief, the first step of the checklist sometimes occurred without the consultant present.
- Audits completed in March 2016 demonstrated 99% compliance when looking at the documentation of 20 WHO checklists. Observational audits which looked at quality or the behaviours of staff when the WHO checklist was carried out were completed. However, audits did not include all five steps.
- There were clear guidelines for the management of sepsis and these were based on NICE guidance. An audit of adherence in the management of sepsis between December 2014 and December 2015 had been completed within the hospital and found varying levels of compliance. An action plan to address the main findings had been developed.

Nursing staffing

- Vacancy rates across the surgical services varied from 2% to 28% with the fifth floor ward having the highest rate. The vacancy rate for surgical inpatient nurses was above the average compared with other similar hospitals. Bank and agency nurses were used throughout the surgical services.
- The rate of theatre and inpatient nurse turnover was above the average when compared with other similar hospitals.
- The Royal College of Nursing (RCN) recommends a nurse to patient ratio of 1:8 (RCN 2012). This meant one registered nurse (RN) for eight patients; surgical services were compliant with this. We saw on the ward the nurse

to patient ratios varied between 1:5 and 1:6, this was above the RCN recommendations. Senior staff told us staffing levels were flexible and bank staff were used when the acuity of patients was higher.

- We were told that the staffing levels in theatre during surgical procedures were compliant with recommendations from the Association for Perioperative Practice (AFPP) guidelines for patients in the perioperative setting. The AFPP guidelines recommend a minimum of two scrub practitioners, one circulating staff member, one anaesthetic assistant practitioner and one recovery practitioner for each operating list. However, on the day of our visit we noticed theatres working with only one scrub nurse
- Staff we spoke with said staff vacant shifts in theatres were covered by staff working additional hours, bank or agency staff. During inspection we shadowed a new agency nurse during orientation. We noted that there was no formalised induction checklist used and the nurse was not shown the locations of the resuscitation or difficult airway intubation trolleys
- Nursing handovers within surgery were carried out at the beginning of each shift. Surgery handovers consisted of a full briefing of all patients on the ward that day. Handovers were also used as a communication tool to discuss incidents and learning.
- Theatre staff were allocated to an out of hour's emergency rota to ensure there was cover if a patient had to return to theatre in an emergency. These staff were on-call from home and were expected to be available within an hour.
- The rate of staff sickness for theatre nurses was above the average of other similar services from April 2015 to March 2016. This included long term sickness.
- The sickness rate for inpatient nurses was below the average of other similar services from April to December 2015 but above the average from January to March 2016.
- The rate of inpatient nurse turnover was above the average of other similar independent acute services that we hold this type of data for during the reporting period April 2015 to Mar 2016.
- The rate of theatre nurse turnover was above the average of other similar independent acute providers that we hold this type of data for during the reporting period April 2015 to March 2016.

Surgical staffing

- There was 24 hour, seven-day resident medical officer (RMO) surgical cover for the wards. During the day Monday to Friday there were two RMO's to cover the three surgical wards. At night there was one RMO that covered the three surgical wards.
- The vacancy rate for RMOs was 42%. Staff told us that regular bank RMO were used to cover shifts. During inspection we saw an RMO that was working a 24 hour shift. We were told that the site manager would help manage patients and stream calls to the RMO to ensure adequate rest periods.
- There was an on-call anaesthetic rota which covered both the PGH and another HCA hospital for emergency returns to theatre.
- The hospital told us patient services were consultant led. Records we viewed and staff we spoke with confirmed that consultants did not review patients on a daily basis. We saw records of patients who had not seen a consultant doctor for three days.
- One staff member told us that in some cases consultants reviewed patients but did not document this in the medical records.
- Staff told us that the anaesthetist did not leave the hospital until the patient had returned to the ward and recovered from the anaesthetic. The surgical consultant also saw the patient prior to leaving the hospital to ensure they were stable.

Major incident awareness and training

- The hospital had up to date major incident and business continuity plan in place. Staff we spoke with and staff showed us that they were familiar with how to access the guidance online.
- During inspection an un-planned fire alarm occurred. We saw that the building was evacuated quickly however, there were no fire marshals or staff to guide patients and their relatives out of the building.
- In the theatre recovery we saw the fire door was blocked by patient trollies. These had been moved for the second day of inspection.

Are surgery services effective?

Good

We rated the surgery services as "good" for effective because:

- Patients care and treatment is planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- There was participation in relevant local and national audits where appropriate. Accurate and up-to-date information about outcomes was shared internally amongst staff.
- Staff were supported by managers, mentors and practice development nurses to deliver effective care and treatment, through meaningful and timely supervision and appraisal.
- Patients received coordinated care from a range of different teams. We saw relevant staff involved in assessing, planning and delivering care and treatment.
- Staff obtained and recorded consent in line with relevant guidance and legislation.

However

- Staff were not always supported to participate in training and development and there were gaps in the support arrangements for staff such as personal and career development for Health Care Assistant staff.
- Pain was assessed using different scoring systems and patient feedback and audits demonstrated post-operative pain was not always effectively managed.

Evidence-based care and treatment

- We viewed a selection of surgical and theatre clinical policies and procedures and saw they referenced the relevant NICE, Nursing and Midwifery Council (NMC) and Royal College guidelines. For example, the 'sepsis 6' pathway was displayed on the ward.
- Adherence to best practice, NICE, and Royal College guidelines was monitored and audited by the hospital's standards committee.
- Clinical pathways used in the Breast Institute demonstrated adherence to the association of breast cancer guidelines
- The pre-operative assessment clinic (POAC) team used NICE preoperative assessment guidelines to ensure safe assessment of patients.
- The hospital contributed data to the national joint registry (NJR). The NJR was set up by the Department of Health (DoH) to monitor performance of joint replacements in orthopaedic surgery.
- The hospital provided data to national Patient Reportable Outcomes Measures (PROMS).Patient recorded outcome measures (PROMs) is mandatory for all NHS hospitals performing hip replacement, knee replacement, varicose vein and groin hernia surgery. PROMS uses patient questionnaires to assess the quality of care and outcome measures following surgery.
- We were told there was a new system in place where automatic notifications were sent to staff when a policy needing to be reviewed or updated. Staff told us there would be a three month notification to the policy author when a policy was due to be updated. We saw alerts next to policies that would be ready for review within the next three months.
- Care was delivered in line with the relevant NICE and Royal College guidelines as well as taking account of individual consultants' preferences. There were patient pathways and protocols available in the day-case surgery unit which were specific to each consultant. However, we saw there was no review date on these.
- We observed patients receiving regular observations, for example, blood pressure and oxygen saturation, to monitor their health post-surgery. This was in line with NICE guideline CG50: Acutely ill patients in hospital - recognising and responding to deterioration.
- In theatres, and in the patient notes, we saw evidence of the hospital providing surgery in line with local policies and national guidelines such as NICE guideline CG74: Surgical site infections: prevention and treatment. For example, in theatre we saw that the patient's skin was prepared at the surgical site immediately before incision using an antiseptic (aqueous or alcohol-based) preparation: povidone-iodine or chlorhexidine.
- Enhanced recovery after surgery (ERAS) programs were used to improve patients recovery post- surgery. This involved an MDT input for example pre assessment, physiotherapy and pharmacy. ERAS was currently only used for bowel surgery patients however, nurses told us there were plans to implement this for other patient types.
- An article of the week was used on the fifth floor ward to promote continuous learning and improve evidence based care and treatment. We were shown the article for the week of inspection which was a randomized clinical trial of post-operative chewing gum versus standard care after colorectal resection.

Pain relief

- Patients' records showed the level of pain was assessed regularly as part of their observation records. On the fifth floor where paper observation records were used we saw staff regularly checked patient's pain.
- As part of the patient satisfaction questionnaire patients were asked about the quality of the pain management they had received. Results from the questionnaire ranged from 61% to 88% of patients being satisfied with how their pain was managed. This demonstrates that pain management was not always managed effectively for all patients.
- We asked nurses about the pain scoring system used to assess patient's pain. Three nurses we spoke with advised us they used a scoring system of 0 to 3 and two other nurses told us they used a system of 0 to10. Using two different tools may prevent that patient from accurately describing their pain and lead to inadequate pain relief administration.
- We were told by ward nurses that there was no specialist pain team and no clinical nurse specialist to assist them with managing patient pain. The hospital provided us with information that demonstrated a 24/7 access to both pain management consultants and the palliative care team at a near by NHS trust via a service line agreement. The Critical Care Outreach CNS provided guidance on pain management and the use of PCA pumps in hours, and the Duty Nurse Managers provided PCA assistance out of hours.
- Theatre nurses told us that all patients were reviewed prior to leaving the recovery area to ensure they were comfortable and their pain was managed. During inspection we observed handover between a recovery nurse and the ward nurse where pain was not addressed.
- Ward nurses described how they would not accept a patient back to the ward from recovery who demonstrated signs or symptoms of pain.
- The ten sets of patient records we reviewed demonstrated that patients had been given regular pain relief medication post-operatively. Patients confirmed that they were asked by staff what their pain level was and were not kept waiting for analgesia when it was required.
- Pain relief audits from January to March 2016 demonstrated the level of pain management compliance. The audit looked at 10 patient records to assess aspects of pain management covering patient information, monitoring the effectiveness of the prescribed analgesia and appropriate. Surgical areas demonstrated 64% compliance on the fifth floor ward, 85% compliance for the fourth floor and 97% compliance on the second floor.

Nutrition and hydration

- The Malnutrition Universal Tool (MUST) was used to identify patients at risk of malnutrition. Audits of the use of this tool were completed to assess compliance against national standards. Results from March 2016 demonstrated compliance of 77% on the fifth floor, 93% on the fourth and 98% on the second floor.
- Records showed food and fluid intake on the wards was recorded to monitor patients post-operatively.
- Dieticians were available Monday to Friday and an out of hours on call team were available if required to provide support.

Patient outcomes

- Data provided showed there had been 12,068 inpatient and day cases attendances between April 2015 and March 2016, in the same period there had been 55 unplanned readmissions within 28 days of discharge. However, this number was not high when compared to a group of acute independent hospitals which submitted data to the CQC.
- In the period April 2015 to March 2016 there were two unplanned transfers of patients to other hospitals. The number of unplanned transfers was not high when compared to the performance data submitted by other acute independent hospitals.
- There had been 19 cases of unplanned return to the operating theatre between April 2015 and March 2016.
- Survival rate figures demonstrated a greater survival rate for breast cancer patients who had their entire treatment including surgery at the PGH. This study was based on a 200 patient cohort and was conducted by PGH staff.

Competent staff

- There were processes in place to ensure staff employed by the hospital had access to regular appraisals. Information provided by the hospital showed that across the hospital there were high levels of staff appraisal. Data provided by the hospital demonstrated

100% of staff working in theatres and 100% of ward nurses had received their annual appraisal. Staff told us annual pay increments were linked to training and appraisal and this ensured staff kept these up to date.

- Staff told us there was no current preceptorship program in place for new staff. We were told new staff were mentored and given opportunities to develop on an individual basis.
- Staff differed in their opinions about access to development opportunities. One member of staff told us they had tried to access training for several years and one other HCA told us there were no development opportunities available to them. Other staff were positive and told us access to external qualifications were possible and it depended upon how proactive your line manager was seeking approval for these.
- Theatre's had eight qualified 'first assist' nurses. These were practitioners who had completed specialist training in surgical first assistance. First assistants were supernumerary and therefore not included in the nursing numbers.
- We were told that consultants could bring their own surgical assistants and that their qualifications, insurance indemnity and criminal record checks were carried out prior to them assisting in a surgical procedure. We viewed a log of this information which was kept in theatres to confirm these checks had been carried out.
- Consultants who requested practising privileges were reviewed by the medical advisory committee (MAC). The MAC monitored the practice of consultants and other medical staff.
- Consultants holding practicing privileges were required to demonstrate their revalidation had been undertaken by their employing NHS trust. There was a nominated responsible officer in HCA for consultants who worked exclusively private practice who would ensure correct revalidation procedures were followed.
- Agency nurses completed a corporate orientation checklist on their first shift. We reviewed four fully completed agency checklists on the fifth floor ward. However, we shadowed an agency orientation in theatres where the checklist was not used.
- Corporate clinical assessment competency booklets were in use in theatre. We saw completed copies of both the anaesthetic competency and theatre scrub competency booklets.
- We saw that eight theatre staff were qualified mentors and saw evidence that their qualifications were updated regularly.

Multidisciplinary working

- At The London Breast Institute we saw services offered to patients by a team of radiographers, consultant breast radiologists, breast surgeons, clinical nurse specialists and psychologists.
- Clinical nurses specialists were in post to support the ward nurses. For example there was a tracheostomy link nurse available to provide support and provide training in the care of patients with tracheostomies.
- A discharge letter was generated and sent to the patient's general practitioner (GP) or given to the patient to take with them if they preferred, to ensure the GP was aware of the procedure and post-operative treatment recommended. The discharge letters also included contact details for the hospital should another health professional require further advice about patients care or treatment post discharge.
- Patient notes had regular input from members of the MDT. We saw that physiotherapists saw patients up to twice a day and occupational therapists were involved in patient care prior to discharge**.**
- The MDT were not involved in ward rounds or during handovers. Staff told us the nurse in charge would update the MDT when required.
- Weekly morning MDT meetings were held by the spinal service. We were told cases were chosen to discuss and that consultants from other services attended. These meetings provided opportunities to view patients care and recommend improvement when required.

Seven-day services

- There was a 24 hour, seven day a week rota of on-call RMO to cover surgical inpatient care.
- Consultant surgeons were expected to be available 24 hours a day, seven days a week if their patients required urgent review, or if they were not available they were expected to have arranged alternative consultant cover.
- An out of hours on-call theatre team were available and staff told us it was the role of the duty manager to call the team in when required. Staff told us this was rare and that most surgery would wait until the following morning.
- Physiotherapists were available seven days a week to assess and treat post-operative orthopaedic patients.

- There was an on-call pharmacist service out of hours when the hospital pharmacy service was not available.

Access to information

- There were computers throughout individual ward areas to access information including test results, diagnostics and records systems. This ensured staff had easy access to patient information if required. Staff told us they were able to access patient information promptly from the electronic patient record (EPR) system and told us there were sufficient supplies of computers available.
- A electronic tracking system was available on each of the wards, which was regularly automatically updated with patient details. The tracking system informed staff of the location of patients, the named nurse and the admitting consultant.
- Patient notes and records were kept in a variety of places. We saw patient information on the electronic system, in medical notes and in folders. Nursing staff told us they would transcribe all necessary information onto the electronic system to ensure consistency.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The corporate policy relating to consent and capacity was updated in July 2016. Staff were aware that this policy included information regarding obtaining consent for children and young people.
- Staff told us they rarely had patients who lacked capacity. Staff told us they had received e-learning on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We saw up to date policies available on the intranet.
- Senior staff told us there had been no DoLS applications submitted from their wards within the previous six months.
- Staff we spoke with had a good understanding of their roles and responsibilities in ensuring patients had sufficient capacity to consent. However, some staff we spoke with were unable to demonstrate that they fully understood their responsibilities in relation to DoLS.
- Consent was obtained on the day of surgery and the majority of consent forms were completed by the patient's consultant surgeon. However, we saw two consent forms which were completed by a clinical fellow and not the consultant performing the surgery.
- There were checks that consent had been obtained on the ward, on arrival in theatre, and before the administration of anaesthesia in accordance with the world health organization (WHO) surgical safety check list and best practice guidance.
- We observed two consultants gaining consent for procedures from patients. Both consultants described the surgery, risks and benefits in detail and gave each patient adequate time to ask questions or raise concerns.

Are surgery services caring?

Good

We rated the surgery services as "good" for caring because:

- Patients and their relatives we spoke with were positive about the way staff treated and cared for them.
- We saw that patients were treated with dignity, respect and kindness.
- Patients told us they felt supported and informed about their treatment. Patients and families we spoke with said staff explained their care and treatment to them and visited them regularly.
- Patient feedback information from satisfaction questionnaires demonstrated that 98% of patients rated their overall impression of nursing care as excellent, very good or good.

Compassionate care

- We spoke with seven patients on the fifth and fourth floor who all provided positive feedback about the treatment and care they had received from staff.
- We observed staff being kind, respectful and polite when speaking to patients and their relatives. We saw staff knocking on patients' room doors prior to entering.
- Each patient on the ward had a named nurse looking after them and staff told us all nurses would introduce themselves at the beginning of each shift to ensure patients were aware of who they were. We observed staff at the beginning of a night shift introducing themselves to patients who were awake and ensuring they had everything they needed.
- Patients told us they felt safe as staff frequently came in to check on their well-being.

Requires improvement

Surgery

- We saw multiple examples of patient feedback in thank you cards in the nursing office on the second floor. We saw patients had praised the care they had received from staff.
- The results from the patient experience questionnaire were collated by an external company on a monthly basis and fed back to the hospital. Results for the surgical wards from April to July 2016 were positive and demonstrated that 98% of patients were satisfied with their overall nursing care.
- Friends and Family test (FFT) data was collected as part of these surveys. In July 2016, 94% of patients from the second floor ward would recommend the service to a friend or family member. On the fourth floor 95% and on the fifth floor 93%.

Understanding and involvement of patients and those close to them

- Written information leaflets were available for patients about a range of treatments and procedures. We saw patients being offered written information to supplement verbal information about their treatment.
- Patient feedback was collected by an external company and was monitored regularly by the ward managers. We were told that suggestions and comments were used to improve the service. On the fifth floor an improvement in the nursing handover was made to allow patients to rest in the morning.
- We saw nursing and consultant staff explaining to patients and their relatives the care and treatment that was being provided. Patients told us they were given sufficient information before their procedure to prepare them for their surgery.
- We saw daily plans in patients' rooms on notice boards which kept patients and their families up to date with treatment and discharge plans.
- Staff on the wards and in the day surgery unit told us patients were phoned 48 hours after discharge to ensure any concerns were addressed.

Emotional support

- Patients we spoke with told us they felt supported by both the clinical and non-clinical staff throughout their surgical pathways.
- Patients had access to psychological support and counselling services. There were also a variety of support groups for cancer patients after their surgery such as the Macmillan team.
- Patients had access to multi-faith spiritual support. We saw patient leaflets which advertised these services and explained how the team could be contacted.
- All patients received a follow up phone call 48 hours after discharge from one of the nurses to check on their welfare and recovery. This enabled patients to feel supported by staff after they left the hospital.

Are surgery services responsive?

Good

We rated the surgery service as "good" for responsive because:

- Services were flexible to individual patient needs and preferences and patients were able to access services in a way and at a time that suited them.
- Patients had access to services that met their individual needs including interpreting services for patients that didn't speak English.
- Staff worked to address any issues or complaints raised by patients at first point of contact.

However

- There was a large number of hospital cancelled operations. Data was not available to demonstrate that patients were offered another appointment within 28 days.
- Patient waiting times were not measured and there was no formal monitoring of referral to treatment times.

Service planning and delivery to meet the needs of local people

- There was a service level agreement with a local NHS hospital to carry out operations to reduce National Health Service (NHS) waiting lists. There were clear guidelines on which patients would be transferred from the NHS and this was based on clinical needs, patient risk and patient choice.
- As the hospital provided mainly private care, the majority of services were elective. This meant admissions to the surgical inpatient wards were planned in advance with the patient. Emergency admissions were also accepted from the urgent care centre with agreement from the consultant.

- Interpreters were employed by the hospital and they were accessible at any time. Staff told us there were rare occasions when an interpreter could not be booked and staff would therefore access telephone translation services.
- Some patients and their families were not local to the area and facilities were available for them to stay with the patient if the patient wished on a folding bed. We saw that they were able to access meals and drinks when required.

Access and flow

- To access surgery the consultant first reviewed the patient during an outpatient clinic appointment and booked the patient for surgery. The booking form and the clinical letter were then sent to the reservations team and the pre-operative assessment clinic (POAC).
- The POAC followed a set of standard guidelines which were used to establish how the patient would be assessed depending on the patient's clinical and personal circumstances. Assessments included face to face, telephone and web based assessment.
- Data provided demonstrated the source of pre assessment for patients from September 2015 to August 2016. We saw that around 50% of patients were pre-assessed face to face, 15% of patients were assessed on the phone and 10% via the web form. Data showed 25% of patients did not have a pre-assessment completed.
- Surgery dates were booked based on patient preference and the consultant's schedule. Private patients we spoke with told us they were able to choose from several dates available.
- The hospital told us they did not monitor patient waiting times. Therefore there was no information on how long patients were waiting for treatment. The hospital told us surgical patients were scheduled according to their preference and the availability of the surgeon, which was generally within two weeks of the decision to proceed with surgery. However, this was not monitored and no data was available to demonstrate this.
- Information provided reported 180 procedures had been cancelled for non-clinical reasons in the previous 12 months. Of these cancellations only 88 (48.8%) of patients were offered another appointment within 28 days of the cancelled operation. This is below the standard we would expect if compared with other similar services. However the hospital told us 100% of patients whose procedures have been cancelled for non-clinical reasons were offered an appointment within 28 days if a patient chose this. The hospital told us the reasons for cancelled operations included patients electing to no longer have their procedures, choosing another hospital or not being funded.
- Theatre utilisation was low when compared with other similar hospitals. Results demonstrated that theatre use varied from 49% to 60% from March 2016 to August 2016.
- The majority of admissions for surgical procedures were elective and planned in advance by the admitting consultant. However emergency admissions were facilitated and agreed with the duty nurse manager.
- Bed meetings were held daily to ensure there were sufficient beds for the expected admissions and any issues from the previous day were discussed. This approach facilitated the identification of any issues such as shortage of staff or delayed discharges.
- Patients were given a discharge letter for their GP on discharge. Patients were also given a card with a telephone number to use if they experienced any problems after discharge.
- Results from the patient satisfaction survey demonstrated 81% of patients on the second floor surgical ward were satisfied with the discharge process, with 89 % of patients from the fourth floor surgical ward, and 96% of patients on the fifth floor.
- During inspection the orthopaedic surgical ward was closed due to the floor needing to be repaired. We saw some orthopaedic patients being cared for on the fourth and fifth floor wards to avoid unnecessary operation cancellations.

Meeting people's individual needs

- Patients' individual needs were identified prior to surgery by the consultant responsible for the patients care or during the pre-assessment process.
- Dementia training was mandatory; most staff in theatres and on the wards had completed dementia awareness training to enable them to care for people living with dementia. Staff on the fourth floor had recently initiated the use of the forget me not flower to alert staff to patients with Dementia.

Requires improvement

Surgery

- Staff told us there were no specific tools available to care for patients with learning disabilities (LD). Staff told us they would be made aware of a patient with LD prior to their admission and would ensure they came with a carer who could help support them.
- Patients had call bells in their rooms. We saw call bells being answered promptly by staff. A patient told us, "They respond in less than a minute. They come very quickly when you use the call bell."
- Translation services were available and were pre booked prior to a patient's admission. Staff also had access to translation services via telephone.
- Information leaflets were provided to patients prior to their admission about their surgery. These were available in a variety of different languages.
- A corporate chaplaincy service providing spiritual, pastoral and religious care across all faiths and beliefs was available for patients, visitors and staff. Leaflets were available which informed patients of how to access this service.
- Patients commented on the excellent quality and wide choice of food. Patients told us they could order food 24 hours a day directly from the kitchen. On the day case surgery unit a house keeper was available to ensure food and drinks were readily available for patients after surgery.

Learning from complaints and concerns

- Patients were aware of how to raise concerns and information on how to make a complaint and the process was provided as part of the patients information pack on admission and in leaflets we saw on the wards.
- All patients were encouraged to complete a patient satisfaction survey during or after their admission which allowed the hospital to evaluate the service provided to patients.
- Staff told us where possible they would resolve any issues with patients informally, and prior to a formal complaint being made. This was in line with the hospital expectation that any concerns raised by patients on the wards would be addressed immediately by the manager and if possible resolved immediately to the patients' satisfaction.
- Ward managers told us all formal complaints were acknowledged within two working days and a formal response was written within 20 working days. We were told that where appropriate the MAC representative for the specific speciality would provide input when the complaint related to consultant practice. The performance of the hospital for all formal complaint responses in 2015 was 96% for acknowledgement within two working days and 85% for a full response letter within 20 days.
- The hospital received 72 complaints in the period April 2015 to March 2016. One of which was referred to the Independent Healthcare Sector Adjudication Service (ISCAS). This number of complaints was less when compared with other similar hospitals.
- A weekly complaints review meeting was held with the chief executive officer the chief nursing officer and the clinical governance lead to ensure adherence to timescales, review the integrity of investigations and identify lessons learnt to ensure responsiveness. Themes of complaints as well as learning were reviewed at the clinical governance committee meetings and fed back to staff during team meetings.

Are surgery services well-led?

Requires improvement

We rated the surgery service as "requires improvement" for well-led because:

- Improvement was required to ensure risks in each area were managed appropriately. There were no local risk registers for the ward areas and the theatre risk register did not reflect risks identified during the inspection. Staff we spoke with were unaware of the risks in their local areas.
- Risks and issues identified during inspection had not been identified or dealt with in a timely way. The risks described on the risk registers did not correspond to those reported and understood by leaders.
- Staff who had identified issues such as consultant documentation did not feel they could speak up about these concerns.

However

- Staff in all areas knew and understood the vision, values and strategic goals for the hospital and corporate provider.

- Leadership was visible and supportive at all levels in the surgical services and staff told us they felt valued by the senior leadership team. They were able to contribute their views and felt new ideas were welcomed and listened to.

Leadership / culture of service related to this core service

- The ward and unit managers were knowledgeable about their areas and demonstrated good leadership skills. They were visible and staff told us they would buddy up with new staff or temporary staff to provide support. Staff told us they felt supported by their immediate line managers and the senior management team.
- Staffing structures on the wards included a clinical nurse manager, senior sisters/charge nurse, senior staff nurses and staff nurses. There was a supernumerary nurse in charge on all wards we visited during the day. However, at night the nurse in charge also looked after patients and therefore there was no supernumerary nurse at night.
- Senior nursing staff (band 7 and above) were positive about the hospital's leadership team. They told us the CEO and the chief nursing officer (CNO) were always accessible and visible within their departments.
- Medical staff reported good working relationships with managers in the hospital and felt they were accessible.
- Wards and theatres did not display the names of the nurse in charge of the shift that day. When we arrived in theatres during the second day of inspection it was unclear and staff seemed unsure of who was in charge that morning.
- Staff who had identified issues such as consultant documentation did not feel they could speak up about these concerns.

Vision and strategy for this this core service

- Staff were aware of the corporate provider's values of integrity, respect, equality, appreciation, compassion and honesty. Staff reflected these values in the way they treated patients and their families.
- Staff could tell us about the hospital vision to be the hospital of choice for consultants, staff, patients and referrers and uphold a reputation for safe delivery of complex care. Staff were able to give examples of how their work contributed to these values.
- The chief executive officer (CEO) developed a business plan that took into account vision and strategic aims. Staff told us that performance against the business plan is reviewed monthly at senior leadership meetings and fed down to staff in their ward meetings.
- There was no separate vision or strategy for the surgery services at the hospital. However we saw surgery services such as orthopaedics and urology mentioned in the overall hospital business plan.
- Over the last five years the PGH has focused on developing six key services to promote and develop confidence and competence in specialist areas. These included musculoskeletal, upper and lower GI, breast, urology, medicine and oncology. Senior staff demonstrated how this had contributed to ensuring staff were competent in these key areas.

Governance, risk management and quality measurement for this core service

- There were clear governance arrangements in place to ensure high standards of care were maintained through regular audits, reviews of incidents and complaint data and consideration of risk.
- A governance structure was in place for the hospital. There were three main governance committees, the Clinical Governance Committee, the Mortality Committee and the Medical Advisory Committee. There were at least two representatives from surgical services at each of the governance committees. The Chief Nurse cascaded information from the governance committee meetings to the monthly senior nurses meetings and from there information was cascaded to the wards. We reviewed the minutes of ward meetings and found that quality and governance issues were discussed.
- A flowchart on the staff noticeboard clearly defined the structure for quality and risk management. There were a number of localised committees, including: patient blood management, infection control, medicines management, resuscitation, and the theatre users group; that reported to the hospital clinical governance committee (CGC). There were other committees that reported directly to the MAC and these included mortality review and infection prevention and control.
- Bi-monthly theatre department meetings took place and we saw minutes from these meetings which

followed the provider's standard agenda. Minutes included a list of the recent incidents that had occurred in the department however, there was no learning or improvements discussed.
- There were theatre user group meetings which occurred four times a year. We saw minutes from meetings which demonstrated policies and procedures were reviewed as a result from clinical audits.
- Monthly governance and learning feedback information was emailed to staff. Staff told us this was informative and included information about the hospital wide top three risks.
- We saw a hospital wide risk register with risks documented that were relevant to surgery. However, risk registers were not available for each surgical area and staff we spoke with were unaware of what was on the risk register that related to their areas.
- On the hospital risk register we did not see surgical risks that were identified during inspection. For example staff turnover, infection control and record keeping.

Public and staff engagement

- The hospital had an 'employee of the quarter' scheme, where other members of staff could nominate their colleagues for a prize as well as the hospital making a cash donation to a charity of the staff member's choice.
- Staff were involved in twice yearly forums which updated them on business and strategic plans for the hospital. This also provided and opportunity for staff to raise concerns with the senior management teams.
- We viewed the hospital's friends and family test (FFT) information for the period April 2016 to July 2016. Results varied from 92% to 100% of respondents who said they would recommend the hospital to their friends and family.
- The hospital employed an external company to analyse and report on patient feedback. The report was sent to each ward and staff told us they discussed these results in ward meetings. We saw changes that had be implemented from patient feedback including the timing of medicine rounds.

Innovation, improvement and sustainability

- The theatre department at the PGH was currently working towards Association of Perioperative Practice (AfPP) accreditation. Accreditation demonstrates a service is achieving national quality standards.
- The PGH was the first private hospital to commence the use of an orthopaedic surgical robot. Outcomes for this were being monitored closely to ensure and demonstrate effectiveness.
- The Surgical Robot System at the Princess Grace Hospital was the first laparoscopic surgical robot to be used. This was a computer enhanced system enabled the surgeon to perform minimally invasive work through tiny incisions. The robot could be used to perform surgical procedures such as general laparoscopic surgery, chest surgery, laparoscopic radical prostatectomy and thoracoscopically assisted cardiotomy procedures.

Good

Critical care

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

Information about the service

The Critical Care Unit (CCU) at Princess Grace Hospital is a nine-bedded unit on the fourth floor. The unit has capacity for nine patients in four open bays and five single rooms, one of which was a negative airflow pressure room.

The unit could be configured to provide care and treatment for both level 2 high dependency patients and level 3 intensive care patients. All nine beds had a ventilator to support level 3 patients.

The CCU cared for 457 patients between April 2015 and March 2016. There were 14 deaths in critical care during that period.

There was a Resident Clinical Fellow on duty in the CCU 24 hours, seven days a week along with a Consultant Intensivist between the hours of 8am to 5pm and on call at all other times.

Patients were admitted to critical care after becoming unwell on the hospital wards or after surgery.

A critical care outreach team was available to assess deteriorating patients on the hospital wards and to follow up patients stepped down from critical care.

We spoke with the clinical leadership team, seven nurses, one consultant intensivist, two resident clinical fellow/ doctors, three other medical professionals including a physiotherapist, dietitian and pharmacist and two support staff. We spoke with two patients and nine relatives. We reviewed 10 patient records and four prescription charts, several other items of documentary evidence including recent Intensive Care National Audit and Research Centre (ICNARC) data from April 2015 to March 2016 to come to our rating.

Summary of findings

Overall we rated the critical services as good because,

- Staffing in the unit was compliant with Intensive Care Society (ICS) guidance, with appropriate numbers of suitably qualified and registered staff. Nurse to patient and doctor to patient ratios were consistently in line with this guidance.
- An experienced team of consultants and nurses delivered care and treatment based on a range of best practice guidance. Suitably qualified nursing staff cared for patients. Medical staff were supported by consultants.
- There was good access to seven-day services and the unit had input from a multidisciplinary team
- The unit had fewer readmissions within 48 hours of discharges, compared to other similar units.
- The critical care unit provided a caring, kind, and compassionate service, which involved patients and their relatives in their care. All the feedback from patients and their relatives we spoke with was positive.
- Observations of care showed staff maintained patients' privacy and dignity and patients and their families were involved in their care.
- ICNARC (Intensive Care National Audit and Research Centre) data for April 2015 to March 2016 showed that the unit performed better than similar units in many quality indicators.

Good

Critical care

- The complaints process was effective, with appropriate investigations and there was culture of learning from complaints across the board.
- There were good governance structures within the hospital and linked with critical care unit.
- We saw good local leadership within the unit and staff reflected this in their conversations with us. Staff said the culture on the unit was supportive and any member of staff could approach the leadership team with any issues or new ideas.
- The management team had oversight of the risks within the services and mitigating plans were in place.

However we also found that,

- Although learning from incidents was shared with all staff via learning grids, not all staff were able to give us an example of any changes in the unit due to an incident. This indicated that shared learning from incidents could be improved among staff members.
- The storage area where unit waste was collected before disposal was not kept locked and did not comply with the Department of Health 2011 Safe Management of Waste guidelines.
- There were no regular joint MDTs within the unit. The unit had put a plan in place to introduce this initiative.
- The dietitian told us that they only visit when CCU staff referred patients. Although this was in line with the hospital policy but there were plans to start daily visits to the unit in line with the HCA (provider) standards.
- There was poor compliance with DNACPR policy, but action plan was in place to improve compliance.
- The unit did not meet all the standards of Intensive Care Society related to screening patients for delirium. Staff were developing a policy to meet this standard.
- The relatives we spoke with were not aware of how to make a complaint but they said that they don't need any information leaflet regarding this as they were happy with the care received and staff were always there to resolve any concerns.
- There was no quiet or prayer room facilities for relatives.

Good

Critical care

Are critical care services safe?

Good

We rated safety as good because:

- We observed staff washed their hands between seeing patients and all equipment was cleaned properly.
- Medicines were stored appropriately, with a separate locked cupboard for controlled drugs. Fridge temperatures were checked daily.
- There were clear systems to manage a deteriorating patient and patient risks were appropriately identified and acted upon.
- Staffing in the unit was compliant with Intensive Care Society (ICS) guidance, with appropriate numbers of suitably qualified and registered staff. Nurse to patient and doctor to patient ratios were consistently in line with this guidance.
- Staff were encouraged to report incidents and we saw evidence of learning taking place as a result of incidents.

However, we also found that

- Although learning from incidents was shared with all staff via learning grids, not all staff were able to give us an example of any changes in the unit due to an incident. This indicated that shared learning from incidents could be improved among staff members.
- The storage room where unit waste was collected before disposal was not kept locked and did not comply with the Department of Health 2011 Safe Management of Waste guidelines.

Incidents

- There were 53 reported incidents in the CCU between August 2015 and July 2016. 64% of these incidents resulted in no harm to the patient. Implementation of care and medications errors were the common themes reported in this period.
- There were two (low and moderate harm) incidents that were investigated utilising the root cause analysis methodology in this time frame. We looked at the root cause analysis and investigation reports of these two incidents related to management of major haemorrhage protocol and pressure ulcers. The reports included a detailed chronology of events, investigation and root cause analysis. There were recommendations for immediate and future action and arrangements for sharing these recommendations, learning and actions locally and across the hospital. However, only senior nursing and medical staff were able to tell us about the actions taken as a result of these incidents.
- The CCU reported no serious incidents during April 2015 to March 2016.
- There was no never events reported within CCU in the last 12 months. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- Lessons learned from incidents were communicated to staff through “Learning Grids” or learning logs which were emailed to staff, and through discussions at handover. Senior staff told us incidents were discussed at the governance meetings and action plans and learning arising from incidents were disseminated to staff at each shift. However, not all staff were able to give examples of any change implemented as a result of an incident and shared learning from incidents could be improved among staff members.
- We saw evidence of incidents discussed at the monthly organisation level clinical governance meetings and unit meetings. For example, there was discussion about a new poster placed on control drug (CD)cupboards to show nurses how to correct CD count errors and as a result of another incident where a patient’s central venous catheter (CVC) line was dislodged, staff were reminded to document correctly the central venous catheter insertion on electronic patient records.
- All staff were aware of the incident reporting procedures and knew how and when to raise concerns. Resident Medical Officers (RMO) and nursing staff showed us how they reported incidents on an electronic incident reporting system. Staff said they were encouraged to

report incidents. The senior nurse of the unit told us that there was a low level of incidents but she was confident all staff were fully able to utilize the electronic system of reporting incidents.

- The CCU reported nine deaths during March 2015 – March 2016. We were informed that all deaths within the unit were discussed and reviewed at the hospital mortality and morbidity meeting and there were no separate unit specific mortality and morbidity meetings.
- All staff were fully aware of the duty of candour and were able to give examples of how they applied this requirement in practice. The Duty of Candour (DoC) sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. Staff told us that they receive training on duty of candour at induction.
- The Duty of Candour was well embedded into practice in the unit. Some junior staff did not always understand the terminology. However, the process they described in communicating with patients and their relatives reflected openness and transparency. There were no incidents that met the threshold for DoC during the reporting period.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool to measure patient "harms" and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harm in relation to pressure ulcers, patient falls, venous thrombo-embolism (VTE) and catheter associated urinary tract infections. Independent hospitals are not required to submit safety thermometer data.
- Falls, pressure ulcers and VTE risk assessments were monitored as part of the cross organisation monitoring via their own dashboard and discussed at the clinical governance committee. However, we were informed that the information was not broken down by service stream and this was not displayed on the unit.

Cleanliness, infection control and hygiene

- The unit was exceptionally clean, well maintained and hygienic. The unit main entrance and corridors were clean and uncluttered. All Staff had a good understanding of their roles and responsibilities in relation to cleaning and infection control processes and practices. Staff told us they enjoy working in such a clean environment. One relative said, "the environment was exceptionally clean".
- The hospital followed their policies and procedures for hand hygiene and infection prevention and control and audited compliance in relation to World Health Organisation's (WHO) hand hygiene standards on a monthly basis. In quarter one (January 2016 to March 2016) the unit's average compliance level was 100%. Most recent data submitted to us for July 2016 and August 2016 showed consistently high compliance of 100% with hand hygiene practice.
- There were dispensers with hand sanitising gel situated in appropriate places around the unit including the main entrance to the units and inside rooms. The seven-step guidance for effective hand washing was displayed at the basins. Hand washbasins were equipped with soap, disposable towels and sanitizer.
- During our visits, we observed staff consistently complying with hand hygiene practice.
- There was a dedicated infection prevention and control link nurse who liaised with a consultant microbiologist and provided infection control advice and education to staff, visitors and patients.
- Adequate supplies of personal protective equipment (PPE) including gloves and aprons, were available and we saw staff using these appropriately. We noted that staff adhered to the "bare below the elbows" policy throughout the unit.
- All of the equipment we examined such as vital sign monitors, mobile computers and infusion pumps were visibly clean. We observed green 'I am clean' labels were in use to indicate when equipment was cleaned.
- We observed cleaning staff cleaning the department in a methodical and unobtrusive way. We spoke to the cleaning staff, who showed good understanding of separating different types of waste and the use of color-coding to dispose waste and colour code mops for different areas. Waste segregation and storage was in line with Department of Health 2011 Safe Management of Waste guidelines. The location of the waste storage

cupboard was on the unit risk register due to its proximity to the bed bays. However, the cupboard where unit waste was collected before disposal was not kept locked and did not comply with the Department of Health 2011 Safe Management of Waste guidelines. We highlighted these concerns to the unit manager and clinical lead and they assured us that this would be reviewed as a priority and cupboard would be kept locked in future.

- Disposable curtains around the cubicles were clean and stain free with a clear date of first use indicated on them. We inspected the linen storage areas and noted that there was sufficient clean linen available. However, we saw rips in three chairs used by staff at patient bedside; these rips could harbour germs and infectious organisms. The unit manager informed us that these chairs would be replaced soon.
- There was a programme of monthly infection control audits carried out for environment designed and managed effectively to minimise reservoirs for micro-organisms and reduce the risk of cross infection to patients, staff and visitors. The results for July and August 2016 showed 100% compliance with clean utility, bed space, toilet and linen management.
- The Intensive Care National Audit and Research Centre (ICNARC) data regarding infection prevention and control, for the period April 2015 –March 2016 showed no reported case of unit - acquired blood infection, which was better than other similar units that reported an average of 3.2 cases in the same reporting period.
- The unit had no MRSA (Methicillin-resistance Staphylococcus Aureus) bacteraemia and no C.difficile case in the last six months.

Environment and equipment

- The CCU was well organised throughout including storage rooms. The department was well spaced out. All areas within the department were well lit.
- Patients were protected from the risks associated with the unsafe use of equipment because staff maintained a reliable and documented programme of checks. The hospital had a robust equipment maintenance programme in place. There was a service level agreement with an external company to manage and monitor the equipment maintenance programme and there were formalised meetings to monitor the agreed key performance indicators (KPIs). Maintenance and servicing was planned and carried out in accordance with manufacturer guidance. Staff told us they had no problems in accessing equipment in a timely manner.
- We checked number of equipment, such as syringe pumps, ventilators, bed mattress and cardiac monitor had the required checks for electrical safety and found the checks had been completed and were in date. We saw one ventilation machine, which was out of order. The unit manager informed us that they were waiting for a part to be delivered from another country. They told us that this would not have an impact on capacity as the bed would be only used as a step down bed for patients in stable condition.
- We saw the hospital level results of the environment and equipment audit for quarter one (January 2016 – March 2016) which showed one recommendation for CCU related to waste segregation management and disposal and actions were taken to provide wheelie bins for CCU to better manage waste and for more frequent (twice a day) collection of waste by porters. During our visit, we saw porters collected the waste on two occasions during the day using wheelie bins.
- Nursing staff maintained the resuscitation and emergency equipment trolley on the unit with twice daily, documented checks. The trolleys were clean, secure, fully stocked. We reviewed the logbook for last four months, which showed that both trollies were checked and logged on a daily basis.
- The two doors for the negative airflow pressure room for isolation of infectious patient did not closed correctly. We highlighted this to the senior staff in the unit and were informed that the room was rarely utilised but doors were functioning correctly when checked last week. They informed that this would be reported to the estates team to be fixed as a priority.
- Bed spaces in the CCU complied with the Department of Health's (HBN) Health Building Note 00-09, which dictates a minimum standard of space for effective infection control.
- We saw the certificate of compliance with HBN 04-02 for Critical Care Services.

- Staff completed competency based equipment training during the probationary period of their employment and worked under supervision until successful completion of their first line assessment. We looked at three staff competency records, which confirmed this.

Medicines

- Medicines were stored safely and available for patients when they needed them, including controlled drugs. Staff we spoke with were aware of how to access medicines out of hours.
- A specialist critical care pharmacist spent time on the ward and was involved in decisions about patient care and medications. There was good clinical input by the pharmacy team, providing advice to staff and patients, and making clinical interventions with medicines to improve patient safety.
- Medicines were stored appropriately in a secure, temperature-controlled room, which staff checked and documented for safe temperature twice daily. A temperature checking system was in place for refrigerated medicines that complied with the Royal Pharmaceutical Society of Great Britain (2005) guidance. We checked the logbook of the last three months and observed checks were carried out daily and the temperatures were within recommended limits.
- Controlled Drugs (CDs) were stored in a locked cupboard, which the nurse in charge held keys for. The nurse in charge, along with a qualified nurse, checked drug stock daily and a spot check of the register confirmed levels were correct. We saw the CD storage audit report and between January 2016 to March 2016 the unit was 96% compliant with the standards.
- The medicine reconciliation audit showed unit compliance with the standards was 100%
- Fridges were locked to ensure safety and security of medicines. Staff checked and recorded current fridge temperature and records were kept of the minimum and maximum temperatures. We found these to be within acceptable limits.
- We reviewed four prescription charts and patient records contained appropriate documentation of medicines prescription and administration. Allergies were clearly documented and antibiotics were prescribed as per hospital guidelines.
- Medicines errors were reported via the incident reporting electronic system. The learning from these incidents was shared across staff via monthly medicines newsletter, learning grids and clinical governance meetings.
- Medicines policies were available on the intranet and easily assessable to all staff.

Records

- Patient records were created and stored using a paperless electronic system that was compliant with GMC Confidentiality (2009) guidance. We saw evidence of clear and comprehensive discharge summaries completed for patients leaving the unit. These included VTE risk assessments and VTE prophylaxis treatment the patient was currently receiving.
- In the 10 electronic patient records we reviewed, all the nursing and medical care plans and observation were completed fully. All ward round documentation were present, with clear plans communicated to the rest of the team.
- RMOs and nurses were able to view patient telemetry at the nurse's station and staff escalated concerns as appropriate.
- Staff demonstrated a good understanding of the need for confidentiality and we observed them using appropriate electronic password protection systems effectively. Paper records from the ward were stored in a locked cupboard within the nurse's station.

Safeguarding

- Safeguarding policies were up to date and readily available for staff on the unit, who knew where to access them.
- Staff had good knowledge of their responsibilities regarding the safeguarding of patients. However, they informed us that they had never made any referrals and never come across any case which raised safeguarding concerns.
- Staff completed annual safeguarding training as part of the mandatory training programme. Data submitted to us showed that 100% of CCU staff were compliant with safeguarding adult and children level one and level two training.

Good

Critical care

Mandatory training

- Mandatory and statutory training was delivered in line with provider policy and monitored through the appraisal system. We talked with members of staff of all grades, who confirmed they had received a range of mandatory training and training specific to their roles, for example, incident reporting, ethics, fire safety, health and safety and information governance.
- All staff we spoke with on the unit had up to date mandatory training. Data submitted to us showed that 100% staff were compliant with fire safety, health and safety, information security training and 94% staff were compliant with manual handling training.
- The unit manager with support from the provider lead clinical practice facilitator tracked the training needs of nurses in the unit and maintained comprehensive records. Unit manager told us that they had recently appointed a clinical practice facilitator for CCU starting in October, who will take over this role.
- All designated nurses in charge in ITU had completed advanced life support training and were available to support the resuscitation team and attend emergencies outside of the unit.
- All clinical fellows attended corporate and/or local induction on commencement of employment and received training specific to their role. Clinical fellow then attended annual updates either within their NHS trust or through the provider. Clinical Fellows receiving training via their NHS Trust were asked to provide evidence of completion and records were held centrally by the provider HR department.

Assessing and responding to patient risk

- The Princess Grace Hospital provided 24 hour seven days a week critical care outreach service to all inpatients outside of critical care environment who were considered to be at risk of clinical deterioration. Critical care outreach system consists of critical care consultant, critical care fellow, critical care outreach lead nurse and Duty Nurse Manager (DNM).
- We observed the outreach system guideline was available on intranet and was in date. We observed the daily outreach team safety huddle at 9:30 am that involved the DNM, RMO of oncology, medicine, surgery, outreach lead nurse, CCU consultant and clinical fellow. All members of the team were assigned roles for the day and all patients that could deteriorate were discussed. The team also discussed the possible step down patients that would be transferred from CCU to a ward. We observed that the team had a good understanding of all sick patients within the hospital.
- All members of the outreach team were trained in advanced life support (ALS) and were contactable by emergency bleeps. Between March 2015 and April 2016, the emergency team responded to 28 calls.
- The clinical fellow showed us the policy for the management of sepsis and that they were aware of this policy. However, specific training in the management of sepsis was not part of the hospital mandatory training programme.
- The staff used the electronic system based on national early warning system (NEWS), to monitor patients for signs of deterioration. Patients who triggered a review were seen by the outreach team or CCU Clinical Fellow and where required they were escalated to the Consultant Intensivist.
- Assessment tools were used for assessing and responding to patients risks. For example, the Malnutrition Universal Screening Tool (MUST), venous thromboembolism tool (VTE) and Safer Skin Care (SSKIN) were all in use. This information was utilised to manage and promote safe patient care.
- We reviewed 10 electronic patient notes, which confirmed that NEWS was documented in cases and all patients had their level of risk assessed for Venous Thromboembolism (VTE), falls and malnutrition, which was reviewed at regular intervals. VTE risk documentation was completed and in accordance with NICE Quality Statement 3.
- Advance life support (ALS) training was mandatory for all senior staff nurses and above, 77% of the total CCU staff group had ALS training. All staff below this grade had completed Basic Life support (BLS). All Clinical Fellow were trained in difficult airway management.

Nursing staffing

- Staffing levels in the critical care service were in line with relevant national guidelines. The unit had an

establishment of 24 full time nursing posts. There were 19 staff in post, including two ward sisters, nine senior staff nurses and seven staff nurses and one clinical practice facilitator starting in October 2016.

- The unit staffing levels were based on a set staff to patient ratio. The unit had a ratio of one registered nurse (RGN) to one patient for all level three patients and 1:2 for level two patients. We saw all patients received 1:1 registered nurse support. There was a designated supernumerary nurse in charge for every shift in line with the Standards for Intensive Care Services published by the Joint Standards Committee of the Faculty of Intensive Care Medicine and the Intensive Care Society (2013).
- We saw an adequate staff skill mix to enable patients to remain safe. We looked at previous rotas showing that these staffing levels were sustained over time. Relatives we spoke with said that there were enough staff to care for patients.
- The unit had five vacant post, one senior nurse was already appointed to start in October 2016. Bank and agency staff were used to fill remaining vacant posts.
- 72.2% of the nurses held a post-registration award in critical care nursing. This was above the minimum recommended requirements of the Royal College of Nursing.
- Nursing staff conducted handovers twice daily with the whole team, at 8am and 8pm. We observed two handovers and found those to be structured, detailed and with a focus on personalised care. Staff had good understanding of patient's individual needs and it was clear to us that compassion was very much a part of the handover process.
- During the handover, staffing and patient levels were discussed and it was confirmed that the staff to patient ratio met Royal College of Nursing guidelines. Availability of the outreach team and supernumerary staff role were allocated. After the detailed handover nurses handed over to each other at the patient bedside again using the electronic record to ensure all pertinent information was communicated.
- Bank and agency nurses were used when there was a nursing shortage, and they undertook a unit induction to ensure they were competent to care for patients. We saw the induction of one agency nurse who was on the shift for the first time. An induction checklist was used and we found the induction to be comprehensive.

Medical staffing

- At the time of our inspection six critical care consultants participated in the rota, which covered the critical care unit. All the consultants also held NHS contracts. The consultant we spoke with confirmed they had no other clinical commitments whilst on call. The consultant attended the unit as a minimum, once a day with frequent telephone contact with the clinical fellow on duty dependent on patient acuity. They were required to be able to reach the unit within 30 minutes and met the Intensive Care Society Standard.
- Consultants worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. The medical advisory committee (MAC) was responsible for approving practising privileges for medical staff, chief executive officer (CEO) had the oversight and this was reviewed centrally on annual basis. Consultants with practising privileges had their appraisals and revalidation undertaken by the medical director if they did not work at an NHS Trust. For RMOs who also worked in an NHS Trust, a copy of their appraisal and revalidation undertaken at the NHS Trust was provided to the HR department of the hospital.
- The unit had three full time equivalent resident medical officers (RMOs) working 12 hour shifts for example 8am to 8pm or 24 hours shift. One critical care clinical fellow (RMO) was always available 24 hours a day, seven days a week. The hospital also had a bank of RMOs who had NHS contracts and worked in the NHS. RMOs were interviewed by the lead consultant prior to employment and it was ensured that they had suitable previous experience in anaesthesia and in critical care setting. These arrangements met the Intensive Care Society guidelines for ensuring there was immediate access to a practitioner who had skills in advanced airway techniques.

Good

Critical care

- All CCU RMOs were trained to level ST6 or above or equivalent. They all had completed advanced life support training. This meant they met the standards of Faculty of intensive care medicine.
- There were structured handovers between the RMOs at shift changes at 8am and there was a daily consultant intensivist led ward round.
- We saw copies of the medical rota and staff we spoke with told us the level of cover meant there was always a doctor present on the unit in an emergency.

Major incident awareness and training

- All staff received fire safety training as part of their mandatory training programme; staff told us they had practised drills as part of their training days and we saw evidence of evacuation equipment available next to the stairs.
- We examined the provider's major incident and fire safety policy, which was available on the hospital intranet. All staff we spoke with were able to describe the process to follow in case of a major incident or fire and plans were in place for wide range of uses. For example, staff showed the fire exits and pathway to move patients out of the unit in case of an emergency. During our visit, there was a fire alarm and all staff showed good understanding of how to act in that situation and keeping visitors and patient safe.

Are critical care services effective?

Good

We rated effective as good because:

- There was good access to seven-day services and the unit had input from a multidisciplinary team. Staff managed pain relief effectively and monitored patients' nutrition and hydration needs closely.
- Staff at all levels had a good understanding of the need for consent and mental capacity assessment.
- An experienced team of consultants and nurses delivered care and treatment based on a range of best practice guidance. Medical staff received regular training as well as support from consultants.
- Patients were cared for by appropriately qualified nursing staff who had received an induction to the unit and achieved specific competencies before being able to care for patients independently.
- ICNARC data for the period, April 2015 to March 2016 showed no cases of unit-acquired infections in the blood. This was better than similar units.

However,

- There was poor compliance with DNACPR policy, but an action plan was in place to improve compliance.
- The unit did not meet all the standards of Intensive Care Society related to screening patients for delirium. Staff were developing a policy to meet this standard.
- There was no regular joint MDTs. The unit had put a plan in place to introduce this initiative.

Evidence-based care and treatment

- Policies and procedures were available on the hospital intranet. Clinical policies and procedures we reviewed all referenced relevant NICE and Royal College guidelines. We checked the review date of 10 policies and all were within their review date and staff told us that those that were near to the date when review was required were in the process of being updated.
- Appropriate care pathways and protocols were available for the management of complex surgical admissions and for the management of postoperative oncology patients. We observed these been used by staff.
- The Princess Grace Hospital participated in the provider level (HCA) Healthcare audit programme. Staff told us that they participate in all relevant audits regularly.
- We saw examples of clinical audit where actions been taken to improve patient care. For example, medicines reconciliation audit, blood transfusion audit, nursing records audit
- There were systems to identify high-risk surgical patients pre-operatively. Surgical pre-assessment processes were in place and patients were able to visit the unit prior to admission.
- All patients received daily physiotherapy as required by the NICE guidance and Intensive Care Society Standards. However, the unit did not meet all relevant standards of the Intensive Care Society. For example,

not all patients were screened for delirium. We saw the delirium policy developed by staff. They told us that once the policy is in place, staff training will commence and there will be a link nurse for this.

- Staff used Glasgow Coma Scale (GCS) and Richmond Agitation Sedation Scale (RASS) to assess patient's level of sedation. The RASS could be used in all hospitalised patients to describe their level of alertness or agitation. It was mostly used in mechanically ventilated patients in the intensive care unit in order to avoid over and under-sedation. Result of quarter one RASS audit in 2016 showed that unit was 100% with recording GCS scores and where applicable RASS was recorded correctly.
- Resuscitation audit to ensure compliance with DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) policy showed there were 10 DNACPR orders during January 2016 - March 2016. The data showed 50% compliance with the policy. There was lack of; consultant's signature, indicating reason for CPR, documented discussion with family. There was evidence that actions were taken to improve compliance with these standards including, developing a process for closer monitoring of each DNACPR from completed and to inform a nominated manager with spot checks made by the outreach nurse.
- Following a gap analysis of the NICE NG51 sepsis guidance, an action plan to address the main findings was developed by the hospital. We saw evidence of that action plan and staff told us that they were planning to implement the sepsis six care bundle from October 2016.

Pain relief

- Pain was assessed at hourly intervals or more frequently for patients with pain control issues. A scale specifically for patients unable to communicate their pain was used for unconscious patients.
- Patients could receive pain relief in various formats; patient controlled analgesia (PCA), epidural, intra-venous or orally. Staff told us pain relief medicines were reviewed frequently to ensure pain control was optimised and patients were weaned from analgesia when they were ready.
- Patient records showed that staff used a standardised scoring tool to assess patients' pain and recorded pain assessments in patients' notes. We saw that pain scores were documented hourly in electronic patient records by staff who demonstrated good understanding of how pain could be assessed. However, one relative we spoke with told us that the patient's pain could have been controlled better but they accepted it.
- As part of their remit, the critical care outreach team advised on patient with complex pain needs, including those requiring Patient Controlled Analgesia (PCA). In addition, there were two consultants who provided a pain service to the hospital via referral, and access to a palliative care service was provided by neighbouring hospital. The outreach lead nurse informed us that they were in the process of amending the outreach policy to include a flow chart regarding referrals for this service.

Nutrition and hydration

- Patients on CCU were referred to be reviewed by a dietitian from Monday to Friday. Out of hours, nursing staff were responsible for initiating enteral feeding if required. Staff highlighted the critical care enteral feeding policy on the intranet and explained how they would calculate feed doses from this policy
- Our review of clinical notes showed that staff used the Malnutrition Universal Scoring Tool (MUST) to identify those at risk of malnutrition. The unit was 100% compliant with the MUST audit in March 2016
- When it was known that patients would require total parenteral nutrition following their procedure this was organised by the dietitian prior to the operation so there was no delay in initiating nutrition. Pharmacists were also be involved with TPN (total parenteral nutrition) for patients as required.
- The dietitian told us that they only visit when CCU staff referred patients. Although this was in line with the hospital policy but there were plans to start daily visits to the unit in line with the HCA (provider) standards.

Patient outcomes

- The average length of stay on the unit for patients was 84 hours (3.5 days) which was lower than other similar units nationally (332 hours or 13.8 days)

- The unit contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. The latest ICNARC data available at the time of our inspection was for the period from April 2015 to 31 March 2016.
- ICNARC data for April 2015 to 31 March 2016 showed that the majority (70.9%) of patients were planned admissions to the CCU following elective surgery which was lower than similar units (75.7%), 5.3% admitted following urgent surgery, which was higher than similar unit (2.1%) and 19.2% were admissions from ward or intermediate care area, which was higher than similar unit (13.8%).
- ICNARC data for the period, April 2015 to March 2016 showed no cases of unit-acquired infections in the blood (0.0). This was better than similar units (2.7) were.
- Risk adjusted acute hospital mortality ratio was 1.32. This was slightly higher than similar units. Clinical lead informed us that they reviewed the ICNARC data and majority of the cases were complex oncology patients.

Competent staff

- There were systems to ensure clinical staff were competent to carry out their role. This included an induction programme that ensured new staff were familiar with local policies and procedures, particularly in relation to standards of patient assessment and record keeping.
- The unit nurse manager with support from the hospital lead clinical practice facilitator monitored nurse competencies on a rolling basis to ensure that nurses maintained competencies based on national benchmark standards. 72.2% of the core nursing staff on the unit held a critical care qualification. This was compliant with the national standards for nurse staffing in critical care which stipulates a minimum of 50%.
- Staff within the Critical Care Services had completed additional training in specialised equipment. For example, syringe drivers used in the unit, bladder scanners and enteral nutrition pumps.
- The unit nurse manager had developed excellent records of core competencies, equipment training and the national competency programme. We reviewed three competency documents that included the use of patient controlled analgesia, cardiac monitoring and insertion of catheters. The documents showed evidence of the completed assessments and competency checks. Staff told us they could approach senior staff for help and support and obtain dedicated time to develop their skills.
- Allocated link nurses were in place for a number of key themes within each critical care area such as tissue viability, infection control, safety risk assessment and blood transfusion. This allocation meant nurses on the units could seek guidance from their colleagues around specific issues. Staff told us this system worked well and they felt they asked for guidance more readily.
- The appraisal rate for staff across the unit was 100%. Staff told us they had completed appraisals within the last twelve months. This process was useful in identifying learning opportunities.
- Agency nurses completed an orientation checklist booklet on their first shift and worked under the supervision of senior unit staff. We saw an agency staff nurse who received an orientation by the unit manager on their first shift on the day of our inspection. The agency nurse was supervised by a senior nurse and told us that they felt supported by staff.
- The nurse in charge of each shift checked the skill mix and competencies of their team before allocating work at handover. We observed the unit manager and nurse in charge worked collaboratively to ensure sufficient staff were arranged for the next shift.
- Consultants with practising privileges had their appraisals and revalidation undertaken by the medical director if they did not work at an NHS trust. For Clinical Fellow who also worked in an NHS Trust, a copy of their appraisal and revalidation undertaken at the trust was provided to the HR department of the hospital.

Multidisciplinary working

- Doctors worked collaboratively with nursing and physiotherapy staff to plan and implement ventilator weaning programmes (when patients' reliability on breathing machines is reducing and they are able to do more breathing on their own).

Good

Critical care

- We observed good working relationships between all grades of staff and all professional disciplines. A pharmacist and physiotherapist visited the unit daily for their input.
- Therapists worked closely with ward staff in liaising rehabilitation exercises around other care plans, such as investigations and ventilator weaning. We observed nursing staff and therapists working together to complete patient care tasks and rehabilitation.
- There were no joint regular MDTs with pharmacy, dietitian, physiotherapy and other multidisciplinary professionals. The clinical Lead informed us that unit had recently initiated a weekly MDT for patient staying over 72 hours, which took place on an ad hoc basis currently as they didn't have many long term patients.
- Staff had a thorough understanding of external MDT relationships for patients who would be transferred to the ward, such as the need for active liaison with the ward staff and patients requiring input from specialist teams in other hospitals.
- We looked at 10 sets of patient records and all of them showed evidence of MDT input.
- The CCU was part of the corporate provider's critical care delivery group and we saw the monthly quality newsletter used to share practice and learning.

Seven-day services

- The Princess Grace Hospital provided 24 hour seven days a week critical care outreach service to all inpatients. A dedicated critical care outreach lead nurse was available from 8am to 5pm Monday to Friday to assess and provide support for deteriorating patients on the wards. Outside of these times including all day at weekends, the duty manager would hold the critical care outreach bleep and coordinate the critical care outreach calls.
- Medical and nursing staff provided cover for 24 hours a day, seven days a week. A consultant intensivist was available 24 hours a day, seven days a week and was available to attend the unit within 30 minutes. There were twice daily consultant led ward rounds.
- A dietitian was available for five days per week, 9am – 5pm. However, there was no on call access for out of hours.
- Physiotherapy service was available seven days a week. 24 hours a day, seven days a week and on –call access for out of hours.
- Speech and language therapy (SALT) was available from neighbouring hospital. Staff told us that the team was easily accessible and approachable.
- Pharmacy services were available Monday to Friday between 9am and 5pm. There was an on-call pharmacist for out of hours support.
- Imaging service was available 9am to 5pm Monday to Friday and out of hours cover was via on-call system.
- All planned discharges from the unit were identified to the outreach team at daily safety huddle and were reviewed at discharge and followed by the team on the ward.

Access to information

- Patient admission details, including past medical history, operation notes and a social history, were recorded on the electronic patient record. Paper medical notes were available for some patients depending upon the admission pathway. Electronic records could be accessed via a staff log in on any computer, which had the relevant software installed. This meant staff could access the information from anywhere within the hospital and this was useful when discussing individual patient cases away from the unit. All agency and bank staff were issued with temporary log in details to enable them to access the information easily.
- Nurses told us that policies were available on the hospital intranet and demonstrated how to access these. Computers were available at the end of each bay. There were adequate computers on trolleys forward rounds and medicine rounds.
- Patient investigation results, including blood tests and diagnostic imaging, were available electronically and could be directly uploaded to the patient's record.

Consent and Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us it was necessary to obtain consent from patients before performing care tasks, investigations or giving medicines. Where consent could not be obtained, for example unconscious patients, staff explained care

would be provided in the patient's best interests. We observed staff seeking consent from patients throughout critical care, including explaining the rationale behind the procedure being performed.

- We reviewed two consent forms in patient notes and all were completed correctly.
- Staff had access to best practice guidance and local mental capacity policies on the unit. Staff routinely re-assessed capacity whenever a person's condition improved, in line with the guidance of the Mental Capacity Act (2005).
- Staff knowledge of Deprivation of Liberty Safeguards (DoLs) was variable across critical care. Some staff were able to fully describe principles behind DoLs but were unclear how this was applicable to the critical care setting.

Are critical care services caring?

Good

We rated caring as good because:

- Staff treated patients with respect and we saw staff interacting in a friendly and professional way with patients and their families.
- The CCU provided compassionate care and staff ensured patients were treated with dignity and respect at all times. Staff demonstrated a clear focus on getting to know relatives who came to the unit. Patients spoke positively about the care they received and the attitude of motivated and considerate staff and were satisfied with the care they received.
- Patients and their relatives and families were kept informed of on-going plans and treatment. They told us that they felt involved in the decision making process and were given clear information about their treatment.

Compassionate care

- Nurses and doctors introduced themselves to patients. Interactions between staff and patients were positive across the unit.
- Staff demonstrated a tireless and on-going dedication to treating patients and their relatives with dignity and respect.
- Staff had a caring, compassionate and sensitive manner. We observed staff speaking to patients and their relatives in a caring manner. They reassured patients and answered questions about their care. They made sure that patients and their relatives were informed about the daily care plan.
- We observed staff ensured patients' privacy and dignity was maintained at all times by closing doors and blinds. Curtains were drawn around bed bays when providing personal care. We observed the nurses and doctors were very courteous towards the patient and the privacy and dignity of each patient was preserved. At medical ward round patients who were able to communicate were asked for consent before the handover process was commenced.
- During our visit, both sisters were on leave and senior staff nurse was the nurse in charge (NIC), who informed us that NIC and unit manager visited all patients and relatives on the unit daily to assess if they had any concerns with their stay in the CCU.
- Staff in the unit encouraged patients and their relatives to complete the recently introduced CCU questionnaire. The Unit Manager had plans to review the feedback and utilise this to improve the service. One relative told us that they were not aware of how to give any feedback
- All of the patients and relatives we spoke with told us they were very happy with the care provided. They said nurses and doctors were always visible and easy to speak with. One patient said they had received good care from nurses and doctors.
- We noted thank you cards received from patients praising the care they had received throughout critical care.

Understanding and involvement of patients and those close to them

- Staff introduced themselves and their role to patients and relatives throughout critical care. Relatives told us this was needed because it could be difficult to tell who was who due to all staff wearing the same colour uniforms on the unit.

Good

Critical care

- Relatives told us they were included in the care of their loved one and staff provided thorough explanations about what had happened and what the on-going care plan was. They said "Staff have been helpful and courteous, attend to the night telephone call made by the daughter and was treated with kindness". One relative said, "Communication has been excellent so far. The RMO was very helpful on admission and spoke to family at length"
- Staff demonstrated a clear focus on getting to know relatives who came to the unit. This included understanding their worries and fears, involving them where appropriate in decision-making and making sure they looked after their own wellbeing.
- Discussions with patients and families were evident in all of the notes that we examined, including discharge planning, decisions to transfer to the ward and obtaining consent. Family involvement was also discussed in the handovers we attended.

Emotional support

- We observed nursing staff providing emotional support to patients as they completed care tasks, for example reassuring a patient when doing observations.
- The CCU did not have specific assessment proforma available to assess for anxiety or depression in their patients. Nurses told us that assessing patient care was part of their daily assessment and they would document any concerns on daily assessment plans within the electronic records.
- Staff provided emotional support to patients and their relatives. Senior staff nurse told us that most of the time patients would have their own faith Chaplain or Imam and staff will ensure to accommodate patient wishes. Staff told us that there was chaplaincy service available and patients could access that any time of the day. They showed us the patient information booklet, which detailed the service and how to contact the chaplaincy coordinator.
- Staff were aware of the procedures to follow in the event of a bereavement of a patient. Support was offered from the bereavement team who would come to the unit if needed. An information booklet for relatives and friends relating to the death of a patient at the HCA hospital was available.
- The clinical lead told us that the patient's primary consultant provided the follow up and the critical care outreach nurse if required followed up patients discharged from the unit on the ward. The majority of the patients would have had the opportunity to visit the unit prior to their admission or during their in-patient stay on the ward after being discharged from the unit.

Are critical care services responsive?

Good

We rated responsive as good because:

- There were clear admission pathways for patients to access critical care . A low occupancy rate meant most patients were admitted within the hour of the decision to admit being made. There was consistently one critical care bed staffed and kept free to ensure an emergency admission could be accommodated.
- Access and flow was a particular focus for staff. There was no out of hours discharge and one non-clinical transfer.
- There was an effective complaints process, with evidence of appropriate investigations and there was culture of learning from complaints across all areas. Formal complaints in the unit were rare and issues arising from formal and informal complaints led to changes in working practice.
- ICNARC (Intensive Care National Audit and Research Centre) data for April 2015 to March 2016 showed that the unit had mixed results compared to similar units in other independent hospitals.

However, we also found;

- There was no multi faith room to meet the spiritual needs of patients and their relatives.
- Patient information leaflets regarding complaints procedure were not readily available on the unit.

Service planning and delivery to meet the needs of local people

- The unit provided care and treatment primarily to complex elective surgical, oncology and medical patients. The unit did not take emergency admissions

from other hospitals or critical care units, however the unit did accommodate patients from other wards in the hospital if their condition deteriorated or unexpected complications occurred following planned surgery.

- The service provided by the unit was planned in advance with the surgeons and the admissions office. New admissions were reviewed daily on the unit to ensure there was sufficient capacity to meet patient needs. In the event of an unplanned admission, the unit was given some advance notice from theatre and were usually able accommodate the patients making suitable staffing arrangements.
- The corporate provider's overseas offices managed all aspects of care of patients from aboard. they oversaw the full referral process from pre-admission to follow-up care.
- Staff were equipped to provide a service that met patient needs outside of the clinical treatment plan. Staff had access to the provider counselling service and chaplaincy service to help them to provide care that met the needs of individuals.

Meeting people's individual needs

- Relatives told us that they felt safe to leave their loved ones on the units. Two patients told us that they had adequate pain relief in a timely manner.
- The visiting hours were flexible and relatives said that they have been kept informed while they wait in the waiting area.
- Staff told us that although they get a mix of patients, a significant number of patients were from overseas and English was not their first language. Interpreters were used where necessary and staff were aware of how to access an interpreter and a telephone translation service was also available.
- All staff we spoke with had good understanding of meeting the needs of patient living with dementia or learning disabilities. However, they had never come across those patients in CCU.
- There was a dedicated waiting room for relatives of patients admitted in CCU. Relatives we spoke with said that they were aware of the relative's room for their use and that staff were very good at offering them refreshments. The facilities in the relatives and visitors waiting area were well maintained with clean chairs, a TV, hot beverages machine and water cooler was available for them. However, the décor was bland and basic and some relatives using the room told us that the facilities were very basic and could be improved.
- Patients who were able to eat and drink had a choice of food from a menu, which included vegetarian, gluten free, halal, 'easy to eat' and pureed options. Staff could order hot meals on demand from the hospital kitchen. We observed that drinks were placed within patient's reach.
- However, there was no prayer or multi faith room to meet the spiritual needs of patients and their relatives. One relative told us "there is no place for Muslims to pray".

Access and flow

- The CCU cared for 457 patients between April 2015 and March 2016. There were 14 deaths in critical care during that period.
- There were 3,294 level three critical care bed days available in the hospital during April 2015 to March 2016. 141 level three critical care bed days were used, giving an occupancy rate of 4%, three beds could be used flexibly for level two patients and 958 bed days were used. There were clear admission pathways for patients to access critical care and a low occupancy rate meant almost all patients were admitted within an hour of the decision to admit being made. There was consistently one critical care bed staffed and kept free to ensure an emergency admission could be accommodated.
- ICNARC (Intensive Care National Audit and Research Centre) data for April 2015 to March 2016 showed there had been zero bed days of care post eight hour delayed discharges. This was better than similar units nationally which had 0.1% post eight hour delayed discharges.
- There was one occurrence of non-clinical transfers out of the unit to a critical care unit in another hospital in the same period. This was nominally higher than similar units nationally.
- There was no patient discharged out of hours to a ward. (These were discharges occurring during the hours of 10pm and 6:59am which are not delayed.) ICNARC data analysis showed that this was better than similar units, which had 0.4% out of hour discharges.

Good

Critical care

- There were five (1.3%) unplanned re-admissions to the critical care unit within 48 hours between April 2015 to March 2016. This was slightly higher than similar units, which had 1% unplanned re-admissions.
- There were arrangements in place to admit patients to the unit from the wards in an emergency. The decision to transfer was made on medical grounds and involved the consultant intensivist, ward RMO, CCU RMO and the nurse in charge of the unit in consultation with the patient's lead consultant.
- We asked the leadership team if there was a business continuity or contingency plan to manage full capacity. Senior staff told us that there was never a capacity issue and they rarely had all nine beds in use, hence this gave them the flexibility to accommodate any unplanned admissions as well.

Learning from complaints and concerns

- The chief executive officer (CEO) was responsible for complaints management with the chief nursing officer (CNO) taking responsibility for the day-to-day administration of patient complaints. Complaints were investigated in collaboration with the governance team. The CCU manager was responsible for disseminating learning from complaints to staff in the unit.
- Most concerns raised by relatives were dealt with informally on the unit by nursing staff and unit manager.
- Formal complaints on the unit were rare and staff were confident in speaking with relatives who had minor concerns or issues. There had been five complaints relating to critical care during April 2015 and March 2016. We noted the hospital dealt with the majority of the complaints within the agreed timescale. We saw evidence that improvements were identified following investigation of these complaints. Examples of improvements made included, development of a staff education programme reinforcing the importance of patient nutrition and hydration, the revision of a CCU policy referencing access for family and visitors to stay at the bedside and how information regarding carers assisting in patient care was handed over between shifts to ensure consistency of care.
- We did not see any patient information leaflets available on the unit regarding the complaints procedure and relatives we spoke with were not aware of how to make a complaint, but they said the leaflets were not needed as they were happy with the care received and staff were always there to resolve any concerns.

Are critical care services well-led?

Good

We rated well-led as good because:

- There were good governance structure within the hospital and interlinked with critical care unit.
- We saw good local leadership within the unit and staff reflected this in their conversations with us. Staff said the culture on the unit was supportive and any member of staff could approach the leadership team with any issues or new ideas.
- The management team had oversight of the risks within the services and mitigating plans were in place.

Leadership / Culture within the service

- There was an established leadership team, led by the clinical director/ lead consultant intensivist and deputy chief nurse, with support from unit manager, sisters and a team of RMO and nurses.
- All staff we spoke with told us that the CEO and other leadership team did regular walk rounds and were very approachable. Staff felt they could talk to the CEO.
- We observed good leadership skills during nursing handovers. There was clear communication with staff regarding their role and responsibilities for the shift.
- Lines of accountability and responsibility in the unit were coherent and staff were clear of their roles and how to escalate problems. The nurses and RMO we spoke with were clear about their lines of accountability. Staff told us that were supported by senior sisters, unit manager and consultants. The clinical leadership within the unit was very prominent and all permanent staff told us that they were all approachable and responsive to communication.
- Across all staff groups we found there was a strong commitment to the provider combined with delivering the highest quality care for patients.

Good

Critical care

- We saw that the medical team worked well together, with consultants being available for RMOs to discuss patients and to give advice and RMOs felt very well supported in their supervision. There was collaborative working between CCU, outreach team, pharmacy and dietitian teams.
- We observed good team working among unit staff and clinical staff from other departments. Nurses, unit manager and clinical leads were committed to support their staff.
- Senior Staff nurses told us that the culture in the department was one of being open, stability and mutual support. Staff commented that there was a culture of 'no blame'. Everyone was encouraged to learn from incidents and staff said the individual feedback they received after any incident was constructive and helpful.
- During interviews with staff and discussions at focus groups many staff told us, they were proud to work for the provider and felt valued.
- All staff we spoke with were passionate about providing empathetic care. Staff told us they enjoyed working in the department and that there was good team spirit. Staff including nurse, doctors, managers and cleaners, worked supportively to meet the needs of patients.

Vision and strategy for this core service

- There was a provider level vision and strategy, which incorporated all service areas; hence, the provider informed us that there was no separate strategy for the critical care service. Staff were aware of the role the CCU played in meeting the overall hospital vision. The leadership team told us that there was no separate strategy for the unit as "they plan to grow in what they were good at". Over past few years, the CCU had evolved to meet the demands and the leadership team felt proud that they had managed to respond to patient needs well.
- Staff within the critical care unit were mainly aware of the goals of the service and told us the aim was to continue providing high quality critical care to patients admitted to the unit. The leadership team were aware of the future business direction of the provider.
- Staff knew how their work contributed to the wider vision of the hospital and were aware of the hospital values.

Governance, risk management and quality measurement for this core service

- There was a defined governance and risk management structure from corporate provider level to hospital and department level. There was also a designated reporting structure for quality and risk management. A number of localised committees including, blood transfusion, mortality review meeting, infection prevention and control and resuscitation reported to the hospital clinical governance committee. The hospital clinical governance committee, standards progression board, health and safety, complaints meeting and senior leadership team, reported to the hospital's executive team and Medical Advisory Committee (MAC).
- The critical care unit performance indicators and quality indicators were discussed monthly at unit meetings. We noted from the minutes of these meetings that complaints, incidents and emerging risk were discussed, evaluated, and monitored.
- The unit was part of the provider critical care delivery network. We saw evidence of collaboration with other units in relation to shared learning from incidents. We saw the network newsletters, which demonstrated reviews of serious incidents across the network and dissemination of learning point. For example, there was a reminder for staff about second checker for control drugs.
- Unit manager informed us that there was shared training programme with other units and nursing staff were also rotated to other hospitals within the provider network to maintain competencies.
- The unit did not meet all the core standards of intensive care units. Senior staff told us that non- compliance were highlighted and specific actions been taken to achieve full compliance, for example, unit recently appointed a clinical practice facilitator and were developing a delirium policy to ensure systems and tools are in place to assess those patients.
- There was a CCU risk register in place. The register recorded the level of risk and the target level of risk. The risk register documented three risks, such as equipment storage, patient handling and infection control. For example, the register recorded that ITU dirty utility was close to patient area and might cause disturbance to the patient and an infection control risk. We noted that

actions were taken to minimise this risk by reminding staff that the room should be closed, bins were covered at all times and porter collect clinical waste twice a day. The aim was to move the dirty utility away from the patient area. However, we noted that the utility room was not kept locked which was not complaint with the Department of Health 2011 Safe Management of Waste guidelines. Staff were not aware that the room should be kept locked and this was not identified as a potential risk.

- The unit manager maintained the unit risk register. Senior clinical staff we spoke with were aware of the risks relevant to their specific areas. We saw that actions were updated regularly with tasks evidenced. For example, assessments were done to ensure that staff were aware of how to store equipment in the main CCU corridor as there was lack of space for equipment storage and what actions to take if staff observe any unsafe equipment stored in the unit.

Public and staff engagement

- Staff received communications in a variety of ways such as newsletters, emails, briefing documents learning grids and meetings. Staff told us that they were able to provide feedback and input into the running of the service. However, staff were not familiar with the challenges facing the provider outside of their own service area.
- The Princess Grace hospital was committed to developing staff, encouraging and empowering them to make improvements. It also provided them with the skills and support to make improvements. We were informed that hospital provided for a nurse to complete their master's degree.
- The hospital participates in the provider patient survey and data was not available at core service level. The unit identified this gap and in July 2016, the unit introduced a feedback questionnaire and patients and relatives were asked to complete this about their experience in the CCU. However, the results were not yet available. Relatives told us that they had been kept up to date with the care their loved one received.
- There was an on call room for the RMOs on a different floor and a well-equipped staff room with in the unit. We observed staff using this for their breaks.

Innovation, improvement and sustainability

- Critical care had plans to initiate various quality and safety improvement projects, including implementation of quality rounds to optimise patient safety, management of delirium in CCU, optimise safe management of airway and to improve learning and optimise care through safe practice.
- Unit manager informed that quality rounding was focused on tissue viability, ventilator and urinary catheter care bundles, CVP audits and ITU environment.
- They unit also planned to introduce and display quality and safety outcomes board and we saw the pilot template which was under consultation and awaiting approval.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

The outpatient and diagnostic imaging department at The Princess Grace Hospital (PGH) provide services to private UK patients and those from overseas. Outpatients and diagnostic imaging services includes all areas where patients undergo diagnostic testing, receive diagnostic test results, are given advice or provided care and treatment without being admitted as an inpatient.

PGH provided a service to a total of 42,807 patients in the reporting period of April 2015 to March 2016. PGH outpatient department holds clinics for a range of different specialities including but not limited to orthopaedics, gastroenterology, gynaecology, general surgery, neurosciences, breast care and oncology. The diagnostic and imaging services offer Computerised Tomography (CT), Magnetic Resonance Imaging (MRI), X-Ray, Interventional radiology, Digital Mammography, Ultrasound and irreversible electroporation treatment to a range of different tumours.

The outpatient services were provided from three locations including the main hospital, the 47 Nottingham Place outpatient building (due to be moved to a new building in 2017) and the 30 Devonshire Street building. The diagnostic imaging department was split over the main hospital and the Devonshire Street building. As part of this inspection we visited all outpatient locations and diagnostic areas. We spoke with 19 patients and their relatives, 25 staff and departmental managers. We observed care and treatment and looked at care records. Information provided by the hospital before the inspection was also reviewed.

The outpatient service only served adult patients and did not see any children.

Summary of findings

We rated the service good because:

- There were quarterly staff forums where senior management and all staff could engage regarding the goals and strategy of the hospital.
- Staff felt encouraged and supported to innovate and implement new ideas.
- The CEO and other executive team members had an open door policy encouraging staff to engage with them. All staff we spoke with confirmed that the executive team was approachable.
- Outpatient and diagnostic services were delivered by caring, committed and compassionate staff and care was planned that took account of patients' needs and wishes.
- An electronic patient record (EPR) was used to ensure constant availability of medical records.
- All radiological reporting was conducted within 24 hours and all diagnostic results were available with minimal delay.
- We observed minimal waiting times for appointments, all patients we spoke with confirmed that they were seen on time and were kept informed on the rare occasion where they had to wait.
- We observed that staff were very accommodating to patients individual needs.
- Managers and clinical leads were visible and approachable and had a good knowledge of performance in their areas of responsibility.
- There was an open and honest culture within the service, morale was good and we were provided with evidence of continuous improvement and development of staff.

Good

Outpatients and diagnostic imaging

However,

- Part-carpeted flooring in most outpatient clinic rooms did not meet national standards which require any clinical area where spillage of bodily fluids is likely to be non-carpeted, but we were shown an action plan to resolve the situation by quarter 1 of 2017.

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good because:

- Policies and procedures were in place and successfully implemented for the prevention and control of infection and maintenance contracts were in place to make sure specialist equipment was serviced regularly.
- No controlled drugs were stored in the outpatients or imaging departments and prescription pads were stored securely and usage tracked.
- Incidents were discussed at monthly divisional governance meetings and information and lessons learnt were shared with staff. Staff knew how to report incidents.
- An electronic patient record (EPR) was used which ensured availability of medical records for outpatients clinic.
- Both outpatients and radiology staff had 100% completion for safeguarding training in adults and children.

However;

- Flooring in most outpatient clinic rooms did not meet national standards, but we were shown an action plan to resolve the situation by quarter 1 of 2017.

Incidents

- There were no serious incidents reported during April 2015 to March 2016 specific to outpatients and diagnostics.
- There were 119 clinical incidents reported in the period of April 2015 to March 2016. The department had a rate of 0.2-0.3 incidents per 100 outpatient attendances; this rate was lower than the average rate of other independent acute hospitals during the reporting period of April 2015 to March 2016.
- There were 56 non-clinical incidents reported in the period of April 2015 to March 2016. The department had

a rate of less than one incident per 100 outpatient attendances; this rate was higher than the average rate of other independent acute hospitals during the reporting period of April 2015 to March 2016.

- There were no never events reported in the last 12 months. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- Incidents were reported using an electronic reporting system. Staff could describe how to report incidents and told us the reporter always received feedback.
- Incidents were discussed at monthly governance meetings and information and lessons learnt were disseminated to staff via a learning grid discussed at staff meetings. Staff we spoke with could describe examples of previous incidents and the learning from those incidents.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- All staff we spoke to were aware of duty of candour and could describe circumstances when it would be exercised. We were shown example incident records of when the duty of candour was applied.

Cleanliness, infection control and hygiene

- All of the clinical and waiting areas we visited were visibly clean and tidy.
- We observed that most outpatient consulting rooms were part-carpeted with a non-carpeted treatment area and there was one fully carpeted room. These areas were refurbished before the 2013 standards were released and as such did not meet current national standards which require any clinical area where spillage of bodily fluids is likely to be non-carpeted. We were provided with an action plan to change the flooring by quarter 1 of 2017 and we were reassured that adequate cleaning procedures were in place.
- Completed cleaning checklists for the period of January 2016 to June 2016 were observed in outpatients and radiology.
- Policies and protocols for the prevention and control of infection were in place and all staff attending clinical areas adhered to "bare below the elbow" guidelines. All staff we spoke with were aware of the procedure to decontaminate clinic areas after infectious patients.
- Stickers were placed on equipment to inform staff when equipment was last cleaned and we saw evidence of this being used across all departments we visited.
- Arrangements were in place for the handling, storage and disposal of clinical waste. Sharps bins were noted to have been signed and dated when assembled and were disposed of immediately when full.
- There were sufficient hand washing facilities including basins, hand wash, hand gels and moisturiser and we observed staff being compliant with the recommended hand hygiene practices.
- Hand hygiene audit data showed that the outpatient and radiology department did not achieve the 95% compliance target for all months in the reporting period of January – July 2016, achieving an average of 88% compliance. The Devonshire street building outpatient department achieved an average of 76% compliance in the reporting period. The radiology department had an average compliance rate of 93% during the reporting period.
- There were disposable curtains in all the treatment and consulting rooms with a date on when they were put up and when they were due to be changed.

Environment and equipment

- The outpatients and diagnostic imaging department were adequate and well maintained. Patient waiting areas were clean with sufficient seating for patients and relatives. All clinical areas seen in the outpatients and diagnostic imaging departments were visibly clean and tidy.

Good

Outpatients and diagnostic imaging

- Maintenance contracts were in place to ensure specialist equipment was serviced regularly and faults repaired and we saw evidence of quality assurance for diagnostic equipment.
- Portable appliance testing (PAT) for equipment was in use across outpatients and diagnostics and the equipment we reviewed had stickers that indicated testing had been completed and was in date.
- Clear signage and safety warning lights were in place in the radiology departments to warn people about potential radiation exposure.
- Monthly quality assurance logs were provided for the X-ray units, MRI and CT scanners for the period of July 2015 to July 2016. We were assured that procedures were in place for the safety testing of all diagnostic imaging machines on a daily, monthly and annual basis.
- All clinical staff we observed in the radiology departments had valid in-date radiation monitoring badges.
- Personal protective equipment was available in all clinical areas we observed.
- Emergency resuscitation equipment was in place in all areas of the outpatients and imaging departments and followed national resuscitation council guidelines. Trolleys we reviewed were checked on a daily and weekly schedule and had their seals intact; trolleys that were asked to be opened had all the required equipment and medication valid in-date.
- Due to the limited resources available in the Devonshire Street building, the use of basic life support bags was in place and only one defibrillator was available for the entire building. There was no crash team available for this building and the hospital policy stated to call '999' for emergencies. All staff we spoke with confirmed that they were aware of this policy.
- There were working emergency call bells in every clinic room and toilet. We observed the weekly checking process and reviewed the testing logs for July 2016 in the outpatients department.

Medicines

- Staff we spoke with were aware of medicine management policies and the systems in place to monitor stock control and report medication errors.
- All medicines in outpatients were found to be in date and stored securely in locked cupboards as appropriate, and in line with legislation. The keys were kept in a secure area with a keypad lock.
- No drugs requiring temperature control were stored in the outpatients or diagnostic departments.
- Contrast media used within the diagnostic imaging department was stored securely in a locked cupboard, which the CT lead radiographer had keys to access.
- No controlled drugs (CD) were stored in the outpatients department.
- A record was maintained regarding administered drugs recording the relevant patient details, signed by two nurses.
- Prescription pads were stored securely and usage tracked.

Records

- The hospital used an electronic patient record (EPR) which ensured availability of medical records for outpatient's clinic. New patients arrived with all relevant records from their referring clinicians and if on occasion this is not available administrative staff will contact the clinicians to source the required details. We were assured patients were not seen without relevant records.
- Service managers told us that there were not any plans to mitigate the risk in case of disruption of the EPR. We were also told that there has never been a time where the EPR was unavailable for clinics. We did note that the hospital business continuity policy stated a strategy in case of electricity loss which covered the loss of the EPR, it outlined that staff could use another HCA facility to print medical records if needed, we also noted that there were paper forms to request diagnostics as a back-up.
- We reviewed 5 sets of patient records in the outpatients department. All contained details of past medical history, allergies, infection control, medicines and discharge planning. Evidence of consent was also observed as appropriate.
- Records could be viewed off site in any HCA hospital due to the EPR. In such cases where physical records need to

be moved off site for continuity of patient care then copies were made and the notes were tracked. Medical record bags were available for transport and staff were not permitted to remove original records off site.

Safeguarding

- Safeguarding policies and procedures were in place. These were available electronically for staff to refer to. Staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately.
- Hospital data showed that 100% of staff in both outpatients and radiology completed safeguarding level 1 & 2 training for adults and children.
- Safeguarding flow charts to help staff escalate concerns correctly were on display in the outpatients and radiology departments.
- There was a chaperone policy and we saw signs throughout the outpatient clinic and diagnostic imaging department advising patient how to access a chaperone should they wish to do so.
- Nursing staff told us they had received training on female genital mutilation (FGM) awareness. Nursing staff in the OPD were aware to be vigilant in this area of safeguarding due to the high number of overseas women and children seen in the department. Staff demonstrated they had an understanding of the procedures to follow which included informing the safeguarding lead and raising an immediate safeguarding alert.

Assessing and responding to patient risk

- Clear signs were in place informing patients and staff about areas where radiation exposure took place.
- The three point identification check was used in radiology as required by the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)(2000). In addition we saw staff check patients a by asking which side they needed the procedure for and also what procedure they were there for.
- Staff told us they checked female patient's pregnancy status in the radiology department before initialising any imaging procedure. They gave recent examples of when patients were not permitted for a procedure due to lack of clarity regarding pregnancy status.
- A radiation protection supervisor was appointed for both the main imaging department and the Devonshire street site. Further support was noted in the department's local rules.
- Adapted World Health Organisation (WHO) checklists were in place and followed to ensure the right patient received the correct radiological scan at the right time. Staff showed us examples of checklists that had been completed and these were audited regularly.
- Staff were able to describe the procedure if a patient was suspected of suffering from a cardiac arrest or anaphylaxis. All staff knew the hospital internal crash team number.
- Due to the limited resources available in the Devonshire Street building there was no crash team available for this building and the policy stated to call '999' for emergencies. All staff we spoke with confirmed that they were aware of this policy.

Nursing staffing

- The outpatient department had a ratio of six qualified nurses to one health care assistant.
- The radiology manager supervised six clinical specialist radiographers, 11 radiographers and five radiology assistants.
- The outpatients department manager told us that the outpatients department did not use agency nursing staff and instead relied on permanent or bank staff. Staffing data provided to us supported this.
- The rate of use of bank staff for nurses working in the outpatients department was low when compared to the average of other independent acute hospitals during the reporting period of April 2015 to March 2016; however the department employed 6 bank staff with variable full time and part time shifts.
- Data showed that there were 18 full time equivalent (FTE) nurses and 3 FTE health care assistants employed as of April 2016. Data provided also showed that there were no nursing and 2 health care assistant vacancies as of August 2016.
- Outpatient departments do not have set guidelines to follow on the number of nurses required. Senior nursing staff told us staffing was flexible depending on activity and that bank staff were booked when required.

Good

Outpatients and diagnostic imaging

- The outpatient's sister told us there were adequate staffing levels to enable the clinics to run effectively. Nursing staff told us any staff shortage due to sickness and annual leave were covered by bank staff.

Medical staffing

- There were approximately 698 consultants with practising privileges attending the hospital, however not all of them regularly saw patients in outpatient clinics. Hospital data showed that between April 2015 and March 2016 a total of 82 consultants held practice privileges in the outpatients department and a total of 76 radiologists held privileges in the radiology department.
- There was a process in place for granting practising privileges, via the medical advisory committee (MAC). This process included interviewing, obtaining references and DBS checks on all applicants
- The hospital employed 12 Resident medical officers (RMO's). RMO's are doctors of varying experience that are full time hospital employees. The RMO's provided medical cover in case of patients requiring to be seen urgently or in need of prescriptions if their consultant was unavailable.
- Staff told us that clinics were rarely cancelled, but if consultants were on annual leave they would ask a colleague to see their patients. This was confirmed by patients we spoke with.

Major incident awareness and training

- The hospital had a business continuity management plan which had been approved by the management team. The plan established a strategic and operational framework to ensure the hospital was resilient to a disruption, interruption or loss of services.
- The hospital major incident plan covered major incidents such as loss of electricity, loss of frontline system for patient information, loss of information technology systems and internet access, loss of staffing, loss of water supply and terrorist attack.
- Senior Mangers explained that staff members would be contacted by their line managers in regards to attending work following a major incident. Each department had their own major incident plan detailing actions to take.
- Staff in the outpatients and imaging departments told us they could identify the designated fire marshals in their own departments.

Are outpatients and diagnostic imaging services effective?

We inspected the service but did not rate it, the following is a summary:

- Patients attending outpatients and diagnostic imaging departments received care and treatment that was evidence based and followed national guidance.
- Staff worked together in a multi-disciplinary environment to meet patients' needs.
- Staff were competent to perform their roles and took part in shared learning schemes.
- All diagnostic images were reported on within 24 hours.
- There were procedures in place to deal with patients requiring urgent pain relief.

Evidence-based care and treatment

- Care and treatment within the outpatient and diagnostic imaging department was delivered in line with evidence-based practice. Policies and procedures followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE).
- Professional guidelines were discussed in the monthly governance committee meeting which was attended by service managers, matrons, consultants and sisters. The clinical governance lead disseminated guidelines information to the relevant service leads who then discussed and implemented the relevant guidelines within their own departments.
- Radiology dose reference level audit results were available for staff to read, the department's 2015 results complied with the national dose level however the results were within the upper tolerance limit. We were told by the CT radiographers that the imaging machine manufacturer has been contacted to resolve the issue and the department is also altering their scanning protocols to help reduce unnecessary dose to the patient.

- Audits of compliance with IR(ME)R 2000 were completed and Radiation Safety Committee meetings were held every six months to monitor radiation safety throughout the hospital.
- Staff told us they participated in local audits. We saw evidence that when audits identified areas for improvement action was taken; an example was given where radiology nurses conducted a WHO safer surgery checklist audit for invasive diagnostic and therapeutic procedures.
- The outpatients department conducted monthly environmental inspection audits as in line with HCA policy.
- A weekly departmental teaching session regarding new treatment techniques was held in physiotherapy and we also saw evidence of outpatient and inpatient nurses co-learning sessions.
- Safety alerts were received by the outpatient and diagnostic imaging managers and all relevant alerts were cascaded to staff via email, displayed in the staff office and discussed at team meetings.

Pain relief

- RMO's could be used to assess the patient and prescribe relevant medication in cases requiring urgent attention. If the patient's consultant is available then they would assess the patient.

Patient outcomes

- The hospital in collaboration with other HCA hospitals has published the Breast Quality Framework Report; this report contains outcome data collected as a retrospective audit of breast cancer patients treated in the period of 2010 to 2014. The hospital is working collaboratively with Public Health England to collate and publish patient survival rates.
- The chief operations officer told us that the hospital is looking at participation in the Imaging Services Accreditation Scheme (ISAS), however due to staffing changes it has been postponed to quarter 1 of 2017.
- All diagnostic images were reported within 24 hours unless the referrer requested earlier, this is compliant with the national guidelines for radiological reporting. This included all images being quality checked by radiographers before the patient left the department.
- The breast institute is accredited by Caspe Healthcare Knowledge Systems (CHKS) for ISO 9001:2015 quality management system.
- Both the breast institute and MRI scanner unit were BUPA accredited.

Competent staff

- Managers and staff told us performance and practice was continually assessed during their mid-year reviews and end of year appraisal. Staff we spoke with confirmed they received regular appraisals. Data we were provided supported this.
- Nursing and allied health professional staff we spoke with confirmed they were encouraged to undertake continual professional development and were given opportunities to develop their skills and knowledge through training relevant to their role. This included completing competency frameworks for areas of development and they were also supported to undertake specialist courses.
- Evidence was provided to show all staff in the outpatients and radiology departments had CPD and competency records for their specific role.
- Medical consultants with practising privileges had their appraisals and revalidation undertaken by the consultant liaison team if they did not work at an NHS trust. For those working in a NHS Trust a copy of their appraisal and revalidation undertaken at the trust was provided to the hospital.
- Managers told us they had procedures in place for the induction of new staff and all staff, including bank staff completed hospital and departmental induction before commencing their role. We saw evidence that attendance at these induction sessions.

Multidisciplinary working

- Multidisciplinary working was evident throughout the outpatients and imaging departments.
- Regular consultant led multidisciplinary team (MDT) meetings were held to discuss patients based on their treatment area. We were told by service managers that nursing staff, allied health professionals and managers were encouraged to attend.

Good

Outpatients and diagnostic imaging

- Nursing staff we spoke with explained internal MDT meetings took place for differing core services and example of the breast institute was given where different allied health professionals, nursing staff and consultants would discuss on going patient issues.

Seven-day services

- Seven day a week outpatient services were not provided. The outpatient service was provided Monday to Friday 8am to 9pm. The hospital provided information to show that the outpatient service did provide ad-hoc weekend clinics to meet patient needs.
- The radiology department also did not provide a seven day service. The service was available Monday to Friday 8am to 10pm except MRI which finished at 6pm.
- The radiology department provided 24 hours on-call services including weekends for inpatients only except MRI which only provided a Saturday on-call service during 8am to 6pm.

Access to information

- All staff had access to policies, procedures, NICE guidance and e-learning on the hospital's intranet.
- The radiology department used a nationally recognised system to report and store patient images. The system was used across the hospital and allowed local and regional access to images.
- All clinic rooms had computer terminals enabling staff to access patient information such as x-rays, blood results, medical records and physiotherapy records via the EPR.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with were aware of the Mental Capacity Act 2005 and its implications for their practice. All staff we spoke with confirmed that level one adult safeguarding training included elements of the Mental Capacity Act 2005.
- Staff told us they were aware of the hospital's consent policy. Consent was sought from patients prior to the delivery of care and treatment. In the diagnostic imaging department, radiographers obtained written consent from all patients before commencing any procedure.
- Consent forms for patients lacking capacity were available in outpatients and diagnostic imaging departments.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good because:

- Outpatient and diagnostic services were delivered by caring, committed and compassionate staff.
- We observed staff assisting patients and their relatives during their time in the hospital.
- The patients we spoke with were positive about the way staff looked after them. Care was planned with respect to patients' needs and wishes.
- Patients' views and feedback were collected and the hospital was looking at ways to expand this.
- Psychological and emotional support was available for patients.

Compassionate care

- We observed staff assisting patients in the department, approaching them rather than waiting for requests for assistance. For example, asking them if they needed help and pointing people in the right direction.
- Patients' privacy was respected and they were addressed and treated respectfully by all staff. Staff were observed to knock on consulting room doors before entering. Curtains were drawn and doors closed when patients were having their consultation or treatment.
- The environment and the consulting rooms in the outpatients department allowed for confidential conversations.
- Patients consistently gave very positive accounts of their experiences with staff and the hospital.
- Complimentary therapies including massage and aromatherapy were available to oncology outpatients free of charge.

Understanding and involvement of patients and those close to them

Good

Outpatients and diagnostic imaging

- We saw staff spent time with patients, explaining care pathways and treatment plans. All patients we spoke with told us they fully understood why they were attending the hospital and had been involved in discussions about their care and treatment.
- Patients told us they were given time to make decisions and staff made sure they understood the treatment options available to them.
- The outpatients and radiology department collected patient views using a patient satisfaction questionnaire and there was an action plan in place to address issues and requests raised by patients.
- The 19 patients we spoke with were satisfied with the overall experience of visiting the outpatients, breast institute and diagnostic departments. Patients had positive feedback to share with us regarding the all staff that they saw while in the hospital. All patients we spoke with told us they felt they were given ample time for their consultations and were wholly involved in making decisions regarding their care.
- All patients we spoke with confirmed that they had received previous correspondence between their consultant and GP. Patients that had previous diagnostic procedures confirmed that they had received the results or imaging report along with a copy of the scan if they requested. This was in line with hospital policy.
- All patients we spoke with explained they felt confident in contacting their consultant or the outpatient department regarding further questions or concerns.

Emotional support

- Nursing staff provided practical and emotional support to patients in all of the clinics. Staff told us how they supported patients who had been given bad news about their condition, and offered them sufficient time and space to come to terms with the information they were given.
- Patients reported that if they had any concerns, they were given the time to ask questions. Staff made sure that patients understood any information given to them before they left the clinic.
- Psychological and counselling services were available for patients and their relatives.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good because:

- The hospital had a dedicated international patient centre (IPC) to assist the large demographic of international patients attending the hospital, additionally the IPC facilitated patient needs by organising appointments, translation and liaising with embassies and insurance companies.
- All waiting areas were furnished to a high standard provided free refreshments and were well stocked in the latest newspapers and magazines.
- We observed that there were minimal waiting times for outpatient clinics and diagnostic imaging. Patients we spoke with confirmed this.
- An in house interpreter was available for Arabic. A telephone hotline was also in place for over the phone translation in any language.
- Diagnostic appointment slots were available to accommodate patients needing tests or images conducted on the same day.
- Complaints were rare but were dealt with in a timely and appropriate manner.

Service planning and delivery to meet the needs of local people

- The hospital had a dedicated IPC staffed by liaison officers. This service was designed to meet the needs of the large demographic of international patients the hospital received. The centre arranged assisted and escorted patients through their hospital journey, liaising with insurance companies and embassies if required, the centre also provided translation, accommodation booking and travel booking.
- The London Breast Institute offered a complete and state of the art service for patients, including consultation and diagnostics during one appointment in one clinical area.

Good

Outpatients and diagnostic imaging

- We observed that there was adequate signposting in the outpatients and imaging departments. All signs were written in English and international patients were escorted around the hospital by IPC or reception staff.
- Patients told us they received instructions over the telephone when booking the appointments for outpatient or diagnostic appointments.
- The waiting room amenities were designed around the needs and expectations of self-funding patients. All waiting areas seen within the hospital were clean and contained adequate comfortable seating with access to toilets, selection of free hot beverages and refreshments, water dispenser and selection of current newspapers and magazines.

Access and flow

- Consultant secretaries provided appointment times to the outpatient reception team. Consultants directly referred to diagnostic imaging and the booking team gave the patient appointment time choices.
- Patients we spoke with said they were informed of how to book an appointment at the clinic and they knew how to access to other services such as blood test and diagnostic imaging.
- Service managers and reception staff told us waiting time delays were rare, and if there were any delays, these were minimal and that patients were always informed. This was confirmed by all the patients we spoke with.
- Patients had access to same day diagnostics after consultation, appointment slots were allocated for same day referrals and results were available within 24 to 48 hours.
- Monitoring cancer patient waiting time data is not a requirement for independent health, however the hospital did benchmark it self against national targets in the HCA breast quality framework report published in 2014. Senior managers said that patients did not follow their entire cancer pathway at the hospital and may present after their first definitive treatment or they may choose to have treatment at another hospital and therefore waiting time data was not audited. We were also told that once patients cases were decided at the MDT meeting that patients had surgery within one week.
- Consultants provided direct referral patients and post-operative follow up appointments within hours or days for most outpatient appointments and radiological diagnostics. All patients we spoke to confirmed this and also told us they had timely access to diagnostic investigations and minor treatment within a few days of their appointment at the hospital.

Meeting people's individual needs

- Staff told us the provisions they would make for patients living with learning difficulties or dementia such as a special needs assessment and fast track service, however staff said that these types of patients are rare. All staff we spoke with confirmed they received dementia training.
- In house interpreters were available for Arabic only and a language line telephone number was available for all other languages.
- There was no specific provision made for bariatric patients as they were a very rare type of patient for the department. Staff told us that arrangements could be made for patients with individual requirements, such as the consultant seeing the patients on the ground floor, being seen in a large consulting room and specialist equipment could be ordered.
- Within the outpatient, breast institute and diagnostic imaging main waiting areas there was a range of information leaflets and literature available for patients to read about a variety of conditions and support services available. The information we observed was only given in English, nursing staff we spoke with reassured us that all information is able to be received in any print size, language, braille and audio loops.
- The diagnostic imaging department has slots available to fit in patients that require imaging the same day in order to meet their individual needs.

Learning from complaints and concerns

- In the period of December 2015 to May 2016 there were three formal complaints regarding the outpatients department, two regarding the imaging services, and one regarding the breast institute. We saw evidence that all formal complaints were logged and action was taken appropriately in a timely manner.

Good

Outpatients and diagnostic imaging

- Initial complaints were dealt with by staff in the outpatients and diagnostics departments in an attempt to resolve issues locally; however if this was unsuccessful staff escalate it to the department manager who then starts the complaints process.
- Patients told us they knew how to make a complaint if needed.
- Details of complaints were discussed with staff in monthly team meetings. We saw minutes of meetings to demonstrate that learning from complaints had taken place; there was evidence to show that action had taken place to address the issues in a timely manner.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good because:

- There were quarterly staff forums where senior management and all staff could engage regarding the goals and strategy of the hospital.
- Staff felt encouraged and supported to innovate and implement new ideas.
- The CEO and other executive team members had an open door policy encouraging staff to engage with them. All staff we spoke with confirmed that the executive team was approachable.
- The outpatient and radiology departments actively sought the feedback of patients and there were plans to increase questionnaire rate of return.
- The data from a staff feedback audit showed 97% of staff was 'committed to doing their best for HCA'.

Leadership and culture of service

- Managers had a sound knowledge of performance in their areas of responsibility and they understood the risks and challenges to the service. It was evident from talking to staff and from our observations that managers in all departments we visited had good rapport with staff.
- It was clear from our conversations and the information we reviewed that staff felt supported and valued in their role. They told us they felt supported and valued by colleagues, line managers and the executive team. Staff told us that they were happy to escalate matters to the executive team and felt that they would be listened to.
- All staff we spoke with told us that the CEO and other executive members did walk rounds and were very approachable. Staff we spoke with also told us the executive team should visit all areas equally as some departments felt overlooked.
- All staff we spoke with were full of praise for their local managers and the chief operations officer who took responsibility as interim radiology manager whilst the role was vacant.
- All department quality and performance indicators were reported bi-monthly to medical advisory committee (MAC). The MAC provided advice to service managers in relation to clinical incidents and approval of new practices.
- The MAC was responsible for reviewing consultants practicing privileges renewals and acceptance of applications for new clinicians. Minutes of the MAC reviewed for 23 February 2016 and 26 April 2016 confirmed this was a standard agenda item at the MAC meetings.

Vision and strategy for this core service

- All staff we spoke to could tell us the corporate provider's vision and values which included being the provider of choice to staff, patients and consultants and also delivering safe delivery of complex care. Staff stated quality was a key priority for the hospital.
- The chief operating officer explained the radiology department was preparing for ISAS accreditation as a joint venture with all other HCA radiology departments, this was scheduled to be initiated in quarter 1 of 2017. The medium term goals for the department were to consolidate the roles of new members of staff including the new service manager, MRI radiographers and senior II radiographers. The department was recently refurbished and imaging equipment replaced, so there were no current plans of physical expansion.
- The outpatients service manager told us about the departments expansion plans. The current main outpatient facilities were due to be closed and a new

centre was being opened in early 2017. The department was currently working towards a swift and smooth transition of service, with the outpatients staff actively involved and consulted in the design of the new facility.

- All staff told us the hospital was constantly improving and spoke passionately about the service they provided. Staff told us that they felt current facilities hindered the hospitals growth, but senior managers were aware of this and a new outpatients building was due to be open in 2017.
- Quarterly staff forums were conducted that were designed to communicate the hospitals progress in regards to the goals and strategy. Staff were encouraged to engage and participate in these events.

Governance, risk management and quality measurement for this core service

- There were monthly clinical governance meetings attended by senior staff members, service leads and service managers. Minutes of the clinical governance meeting confirmed audit results and quality improvement programs were discussed at clinical governance and quality meetings. Additionally the meetings looked at comments, compliments and complaints by patients and staff.
- There were regular team meetings to discuss issues, concerns and complaints. Staff were given feedback at these meetings about incidents and lessons learnt by their line managers.
- Radiation Safety Committee meetings were held every 6 months to ensure that clinical radiation procedures and supporting activities in the outpatients and radiology departments were undertaken in compliance with IR(ME)R 2000 legislation.
- We saw evidence of regular outpatients and diagnostic services meetings. The meeting minutes confirmed that these meetings were designed to facilitate open and frank discussion on how to implement best practice.
- The radiology, breast institute and outpatients department recorded risks on the clinical services risk register. We were shown the risk registers which did not contain any major risk apart from general hospital associated risks.
- We saw evidence to confirm that outpatients and radiology departments had active quality control measures and audit programmes that were regularly discussed and reviewed in meetings designed to incorporate all staff at differing seniority levels.

Public engagement

- The views of patients were actively sought within outpatients and diagnostic imaging; patients were given a department specific feedback questionnaire.
- Data provided to us showed that 85% of patients viewed the outpatients department as excellent in July 2016 .We were not provided with data regarding how outpatients viewed the radiology department. Data given to us did show that 89% of inpatients regarded the imaging department as excellent in July 2016.
- The outpatients and radiology staff told us that previously feedback questionnaire return rates were low, so the questionnaire was re-designed and re-launched in July 2016. Data provided showed that outpatients received 28 questionnaires and radiology received 31 in the period of July 2016 to August 2016. Senior managers explained that a patient experience committee was being formed to initiate strategies to increase the rate of return.

Staff engagement

- Staff told us they could approach and talk to the CEO or other executive members any time.
- The hospital manager, chief nursing officer and chief operations officer had an open door policy allowing any member of staff to approach them; this was confirmed by all staff we spoke with.
- Data provided to us showed that 97% of hospital staff are 'committed to doing their best for HCA' and 86% say they are 'proud to work for HCA'.
- We saw evidence of quarterly staff forums, where senior management would present to staff regarding the hospital's goals and progress also allocating time for an informal engagement session. We were shown an example of where staff had made a suggestion regarding storage and how this was then implemented.
- Staff told us that they felt encouraged to introduce new ideas and new ways of working that it only took 'a few weeks' to implement change.

Good

Outpatients and diagnostic imaging

- We saw evidence of a mentoring programme within the outpatients department with regular meetings between staff and mentors.
- All staff spoken with were aware of the hospital's whistleblowing policy. They told us that they would feel happy using this policy to raise concerns if necessary.

Innovation, improvement and sustainability

- All staff we spoke with confirmed they were encouraged to implement new ideas and working practices. Shared learning and researched was also facilitated. We were told that it was 'easy' and 'very quick' to implement new treatment techniques an example of the irreversible electroporation pancreatic treatment modality used in radiology was given.

Outstanding practice and areas for improvement

Outstanding practice

The London Breast Institute offered a complete and state of the art service for patients, including consultation and diagnostics during one appointment in one clinical area.

Areas for improvement

Action the provider MUST take to improve

- The Urgent Care Centre must have a formal system to prioritise patients by acuity or severity of their condition during the triage process.
- Staff in the Urgent Care Centre must follow the hospital's policy to use National Early Warning Score (NEWS) system to monitor and detect deterioration in patients.
- The theatre department must implement an infection control policy which reflects best practice guidelines to ensure infection prevention control procedures are fully embedded in practice to protect patients from the risk of infections.
- The surgical services must ensure all staff are "bare below the elbows" when in wards and clinical areas.
- The hospital must ensure patient records are fit for purpose in that there is a full contemporaneous record of patient care and treatment. In addition, ensure the person making an entry is identified, they are legible, include an accurate record of all decisions and make reference to discussions with people who use the service and their wishes.

Action the provider SHOULD take to improve

Outstanding practice and areas for improvement

Urgent Care Centre

- The Urgent Care Centre should ensure that all staff partake in safeguarding training.
- The Urgent Care Centre should improve documentation of pain scores in patient notes.
- The hospital should ensure doctors in the Urgent Care Centre receive mental capacity act training.
- The Urgent Care Centre should update policies to include author and date.
- The Urgent Care Centre should produce formalised patient pathways with agreement from the medical advisory committee (MAC).
- The Urgent Care centre should collect data on patient waiting times.
- The Urgent Care Centre should have processes in place to assist patients with complex needs, dementia or learning disabilities.
- The Urgent Care Centre should have a formalised way to review and manage the opinions of patients

Medicine

- The hospital should ensure there is full compliance with the Deprivation of Liberty Safeguards (DoLS) and ensure records provide documentary evidence of mental capacity assessments and best interest decision making when patients are not able to make specific decisions about their care and treatment.
- The hospital should ensure all staff are "bare below the elbows" when in wards and clinical areas.
- The hospital should take a consistent approach to the identification and management of patients with pain to ensure the timeliness and effectiveness of interventions.
- The hospital should improve the coordination and delivery of services for people living with dementia and those with a learning disability.
- The hospital should develop and implement a strategy for End of Life Care to reflect current guidance.
- The hospital should develop a governance framework for End of Life Care to monitor implementation of the strategy and best practice guidance.

Surgery

- The service should ensure all staff are up to date with mandatory and statutory training.
- The theatre department should ensure all equipment is easy to access and clearly labelled to ensure agency, bank or new staff would know where to find essential equipment.
- The ward areas should ensure all medicines are administered in line with the corporate policy.
- The surgical services should take a consistent approach to the identification and management of patients with pain to ensure the timeliness and effectiveness of interventions.
- The surgical services should ensure all staff have access to professional development and career progression

Critical Care

- The critical care unit should ensure there is wider learning from incidents across all staff level.
- The unit should introduce stringent processes in place to ensure full compliance with all applicable standards of the Intensive Care Society.
- The unit should as a priority review the storage room where unit waste was collected before disposal and to be kept locked at all times with provision for staff to access it when required, in line with the Department of Health 2011 Safe Management of Waste guidelines.
- The unit should improve compliance with DNACPR policy.
- The unit should ensure patient information leaflets about complaints process are available in the unit. Steps to be taken to raise awareness among patients and relatives.
- The unit should ensure systematic processes are in place for joint MDTs with pharmacy, dietitian, physiotherapy and any other relevant professionals.

Outstanding practice and areas for improvement

- The hospital should review its provision facilities for patients and relative regarding quiet or prayer room within the hospital.
- The hospital should review the provision for daily visits to critical care unit by a dietician to assess all relevant patients.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(2)(a)(b) How the regulation was not being met: There was no formal system to prioritise patients by acuity or severity of their condition during the triage process in the UCC Staff did not consistently follow the hospital's policy to use National Early Warning Score (NEWS) system to monitor and detect deterioration in patients. Patient risk assessments were not always completed in a timely manner Staffing in the theatre department did not always meet the AfPP guidelines There were low rates of basic life support training for theatre staff

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Regulation 12 (1)(2)(h) How the regulation was not being met: Monitoring and procedures were not in place for assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(1) (2) (c)** **How the regulation was not being met:** **Clinical and operational risks were not always identified on risk registers.** **Patient records were not maintained in an accurate, complete and contemporaneous way.**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13(1) (2)** **How the regulation was not being met:** **The UCC did not have sufficient numbers of staff trained to meet the intercollegiate guidance for safeguarding children.**