Rivers 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?	Good
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an announced, comprehensive inspection visit of Rivers Hospital on the 21 and 22 June 2016 and an unannounced inspection on the 1 July 2016. Overall, the hospital was rated as requires improvement.

Our key findings were as follows:

Are services safe at this hospital?

- There was generally access to suitable equipment to provide safe care and treatment.
- Generally, systems were in place to ensure all areas complied with the service's infection control procedures.
- Staff were encouraged to report incidents and were aware of the duty of candour regulation. There was some evidence of learning from incidents and complaints and effective processes were in place to reduce risk.
- Most staff were up to date with mandatory training in the medical care and children's and young people service in line with the hospital's annual training plan
- Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice.
- The hospital carried out a range of medicines safety indicators to assess how they were performing, and to identify areas for improvement. However, not all medicines were stored appropriately at the time of the inspection.
- Staffing levels were generally appropriate to the needs and flexed according to the demands of the service, ensuring patients' needs were met at the time of the inspection.
- There were clear escalation processes in place, which included the use of the resident medical officer (RMO) and escalation to consultants.
- Systems to safeguard patients were in place and staff knew how to respond appropriately to safeguarding concerns.
- There was a system in place to recognise the deteriorating patient. Appropriate triggers were in place to ensure patients, who had deteriorated were treated according to their clinical needs.
- The risk register for medical care was not updated regularly and in a manner that reduced the risk of disruption to the service. The risk register did not identify risks to the delivery of safe care and treatment that we found during the inspection. These risks had not been recognised by the service.
- There were some potential risks to health and safety due to the administration of chemotherapy in some carpeted areas in patient bedrooms, which the hospital had assessed. The hospital took immediate action to provide four non-carpeted bedrooms immediately after we raised this issue.
- The rooms used for chemotherapy were often used for other services if needed. The hospital had well defined processes regarding the cleaning of these rooms before and after use and also checked patients were not immunocompromised before having treatment in these rooms.
- Not all consultant entries on medical records were legible.

Are services effective at this hospital?

- Policies were current, accessible to staff and reflected professional guidance**.**
- Care and treatment was given in line with evidence-based guidance.

Summary of findings

- The hospital offered intrathecal chemotherapy in line with the latest available guidance from the Department of Health (2008).
- Information about the outcomes of children and young people's care and treatment was not routinely collected and monitored. The service did not have a robust system for monitoring the outcomes for patients. We were not assured the service could therefore drive improvements due to lack of monitoring and performance information.
- The hospital had some audit programmes specific to children and young people's service, including documentation, environmental and pain audits. Feedback from patients and learning from incidents was also reviewed.
- Staff followed evidence-based practice, including guidance from the Royal College of Nursing, the Joint Advisory Group (JAG), and the National Chemotherapy Advisory Service
- There was participation in national audits in surgery, which showed outcomes within an expected range
- The medical advisory committee reviewed all new consultants before practising privileges were approved; this included their scope of practice. The hospital had an effective system in place to ensure that practising privileges were updated annually with the relevant information.
- An induction programme was provided to all new staff.
- There was a process in place for checking professional registration.
- Consultants were on call for 24 hours a day and seven days a week for their inpatients and day case patients. There was a RMO providing medical cover for patients and clinical support to staff.
- There were arrangement's to ensure staff were able to access all necessary information to provide effective care.
- Staff were aware of their role with to regards to the Mental Capacity Act and Deprivation of Liberty and had received training. However, patients' consent to chemotherapy was not clearly documented.

Are services caring at this hospital?

- Patients were overwhelmingly complimentary about the service they received at the hospital.
- The Friends and Family Test survey results for the period July to December 2015 had a varying response rate from 8 to 58%. The percentage of patients that would recommend the hospital was 100% for inpatients and 99 for outpatients. Results from Rivers patient satisfaction scores showed that from January to March 2016 above 93% of patients were satisfied with aspects of the care they received including cleanliness of the hospital, staff, admission procedures, physiotherapy, discharge procedures and care since discharge.

Are services responsive at this hospital?

- Services were generally planned and delivered in a way that met the needs of the local population.
- There was a lack of recognition of the children and young people's service as a separate, distinct service in the hospital.
- Information on complaints or how to raise a concern was available for patients. Complaints and concerns were always taken seriously and responded to in a timely manner. There was evidence of actions taken to address issues raised in complaints and staff were informed of changes required in response to complaints.
- Staff had awareness of dementia and had received training in caring for patients living with dementia. There was a lead nurse for dementia in the hospital.

Summary of findings

- The chemotherapy service demonstrated a positive relationship with commissioners and stakeholders in relation to service development.
- Access for disabled people was good throughout the departments.
- Interpreters could be booked when required for patients whose first language was not English.
- Staff made efforts to ask people for their views on the service and used these to make improvements where possible.

Are services well led at this hospital?

- There was a hospital risk register in place. However, the register lacked sufficient detail to provide adequate assurance about the appropriate identification and management of corporate risks, the mitigating actions, and the level of improvement or latest progress updates.
- Risks to children and young people using the service had not been recognised, assessed, or mitigated against before our inspection. However, the service took immediate action once we raised these concerns.
- There was limited assurance that improvements were being driven in the children and young people's service due to a lack of effective performance and outcomes measurements.
- There was good local leadership and an open culture where staff felt valued.
- The hospital had a clear corporate set of values. Staff knew the provider's vision and strategy, called 'The Ramsey Way'.
- The hospital had a clear governance structure and a clinical governance committee that met to discuss a range of hospital issues. However, some concerns found on inspection had not been recognised, assessed or mitigated against by the service.
- There were clear routes for cascading information to hospital staff.
- Senior management staff at the hospital were visible, supportive and approachable.
- Staff were generally proud to work at the hospital.
- Clinical leads had a shared purpose and motivated staff to deliver services and succeed
- There were robust recruitment procedures in place including checks on professional registration and those for the disclosure and barring service (DBS).

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

The provider must:

- Ensure effective quality assurance and performance measures are used to drive improvements in the children and young people's service.
- Ensure all risks in the medical care and children and young people services are recognised, assessed or mitigated against and that risk registers accurately reflect the level of risks and actions taken to minimise them.
- Ensure the legibility of medical records in the chemotherapy service.

The provider should:

- Monitor how consent to care and treatment is recorded before any procedure takes place. This may include implied consent or consent using non-verbal communication.

Summary of findings

- Monitor assessments and observations of care and treatment are accurately and routinely documented and that all records are legible.
- Monitor that effective systems are in place so all equipment in medical care is fit for use to meet needs of patients.
- Consider the risks and sustainability surrounding the paediatric nursing service, where it currently relies on two registered nurses (child branch) to cover all eventualities in relation to children and young people in the hospital.
- Consider having a dedicated paediatric nurse in the outpatients department.
- Enhance the environment of the hospital to make it more child-friendly.
- Review the requirement to make child friendly information available to children and young people.
- The provider should consider improving the environment in the outpatient and radiology departments as it is not suitable for providing dignified care to people who use the service
- Share results from infection control audits, including hand hygiene audits, consistently with staff using a method they can readily access.
- Review signage relating to the safe operation of fire doors so that it is up to date.
- Improve the security of patient records at all times when not being used by staff.
- Review the on-call nurse cover available in the chemotherapy service to ensure staff working hours are balanced and services are available to patients in line with their published standards.
- Review the arrangements in place so that staff at all levels are clear about patients' consent for surgery.
- Review the systems for ensuring all patients' requiring hydration monitored have the appropriate record to do this in place.
- Review the clinical hand washing facilities in the bedrooms in the wards.
- Monitor staff mandatory training is in line with the annual plan and with regard to helping patients living with a dementia.
- Monitor the process for documented patients' handover.
- Monitor the arrangements for medicines' storage in the pharmacy.

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
Medical care	Requires improvement 	Overall, we rated medical care as good for safe, caring and responsive. We rated effective and well-led as requires improvement. This was because: • The risk register for medical care was not updated regularly and in a manner that reduced the risk of disruption to the service. The risk register did not identify risks to the delivery of safe care and treatment that we found during the inspection. There were some potential risks to health and safety to the administration of chemotherapy in some carpeted areas in patient bedrooms, which the hospital had assessed. These risks had not been recognised by the service but the hospital took immediate action to provide four non-carpeted bedrooms immediately after we raised the issue. • In the pharmacy, cytotoxic drugs were not appropriately stored because they were stored in an unlocked refrigerator alongside other medicines. However, the hospital took immediate action to address this concern this during our inspection. However, we found that: • Consultant summaries in some chemotherapy patient records were sometimes illegible. • Patient's consent for chemotherapy was not clearly documented in all cases. • A robust incident reporting procedure was in place and staff said they received feedback after reporting incidents. This was used to share learning. • Staff demonstrated an understanding of safeguarding processes and established protocols were in place to protect people from abuse.

Summary of findings

- Generally, systems in place to ensure all areas complied with the service's infection control procedures.
- Medical staffing in medical care services was stable and consultant-led and out of hours cover was effective.
- Nurse staffing met patient needs during the inspection. We looked at rotas for the endoscopy unit for the six months prior to our inspection. All sessions had been staffed according to the establishment of a senior nurse, registered general nurse and healthcare assistant.
- Care and treatment were generally provided in line with national guidance including from the National Chemotherapy Advisory Group and the Royal College of Nursing. Clinical endoscopy staff used the World Health Organisation (WHO) surgical safety checklist for each procedure and audits showed checklists were completed accurately and used appropriately.
- Staff had acted to reduce delays in accessing endoscopy by introducing a new appointment system.
- Staff followed evidence-based practice, including guidance from the Royal College of Nursing, the Joint Advisory Group (JAG), and the National Chemotherapy Advisory Service.
- The hospital offered intrathecal chemotherapy in line with the latest available guidance from the Department of Health (2008).
- A small office was available for private and confidential conversation with patients and talking about consent but this was also used by clinical staff for completing paperwork.

Surgery

Good

Overall, we rated the surgery service to be good because:-

- Staff were caring and compassionate in all interactions with patients during the inspection.
- Patients spoke positively about staff and the information they received pre and post-surgery

Summary of findings

- Patients were pre-assessed prior to their admission for surgery, ensuring that any risks were identified and managed appropriately and comprehensive care records were being maintained.
- Effective systems were in place to report, record and learn from incidents and concerns
- Staff, at all levels, were skilled and experienced, and were supported via appraisal to undertake their roles effectively.
- Nurse staffing levels met patients' needs at the time of inspection and were reviewed throughout each day and staffing numbers were flexed to accommodate fluctuations in activity and the complexity of patients care.
- Medical staffing cover was appropriate and there was effective arrangements for out of hours and weekend cover.
- Theatre staff were using the Five Steps to Safer Surgery (World Health Organisation's checklist for surgery) and had instigated a pre-list 'huddle' to discuss the requirements of the surgical list and the patients who were to receive care.
- Departmental areas were visibly clean, tidy and well-ordered and robust systems were in place to minimise the risk of infections.
- A pharmacy was on site to provide access to medications and we found that medicines were being stored and managed safely throughout the department.
- Care and treatment was delivered based on evidence based care and national guidelines.
- The hospital monitored the Patient Reported Outcomes Score for procedures such as groin hernia repair, primary hip replacement and primary knee replacement. The hospital's patient outcomes were comparable to the national average.

- Staff were supported to maintain and further develop their professional skills and experience. Multi- disciplinary team working was effective.
- The service provided flexibility to provide appointments and admissions to meet patients' needs.

Summary of findings

- Access to the service was timely and appropriate discharge arrangements were in place.
- All patients were pre assessed prior to their admission and plans put in place to mitigate any risks identified.
- Individualised care planning was being undertaken based on procedure specific care pathways for all patients.
- Effective systems to record concerns and complaints raised within the service, to review these and take action to improve patients' experience were in place.
- Policies and procedures were in place to support staff in understanding the needs and managing the care of people with complex conditions.
- Senior managers worked effectively to manage risk, develop best practice and to communicate their vision to all areas of the service
- Heads of department were visible and approachable and staff told us that they felt able to approach the managers for advice or to discuss any areas of concern.
- Leadership was clear and focused the staff team on the drive for improvements. Regular departmental meetings took place during which service improvement plans were discussed and their progress reviewed.
- Staff engagement was positive and staff at all levels spoke highly about their leaders and the support they received.
- Effective risk assessment and risk management systems were in place across the service.

However, we found that:

- Whilst procedures were in place to ensure that patients were able to give informed consent to their care and treatment, we found that not all staff were clear about who would be able to give consent for the patient's surgery.

Summary of findings

- Whilst patient's case notes generally provided clear and comprehensive information about their care and treatment, we found that not all case notes included fluid balance charts where they were required to do so.
- Whilst most staff were aware of how to support people living with dementia and some had had specific training in order to understand the condition, not all staff were clear of how to be able to help patients living with a dementia.

Services for children and young people

Requires improvement 

Overall, we rated the children and young people's service to be requires improvement. We rated the service as good for safe and caring and requires improvement for effective, responsive and well led. This was because:

- Risks to children and young people using the service had not been recognised, assessed, or mitigated against before our inspection. However, the service took immediate action once we raised these concerns.
- Whilst there was some evidence that the service was scrutinised and discussed at a local level, there was a lack of recognition of the service as separate from adult services provided.
- Information about the outcomes of children and young people's care and treatment was not routinely collected and monitored. The service did not have a robust system for monitoring the outcomes for patients. We were not assured the service could therefore drive improvements due to lack of monitoring and performance information.
- The hospital was a predominantly adult environment, with few adjustments made for children and young people. There was little security and access was not enhanced to offer robust protection to children. There was no play specialist to support children and young people during their visit to hospital. There was no dedicated paediatric nurse in the

Summary of findings

outpatient department. All hospital staff had access to the paediatric nurses rota and paediatric appointments were planned in line with this.

- The hospital had some audit programmes specific to children and young people's service, including documentation, environmental and pain audits. Feedback from patients and learning from incidents was also reviewed.
- Safeguarding systems were in place and staff knew how to respond to safeguarding concerns. All staff that came into contact with children and young people had the appropriate level of safeguarding training. Children who attended the hospital for day case surgery were cared for by registered sick children's nurses (RSCNs).
- All staff had access to the electronic incident recording system and outcomes of any resulting investigations were shared with staff. All areas we visited were visibly clean and equipment checks were in place and up to date.
- There was a culture of openness promoted by the senior leadership team, with transparency around incidents and the outcome of investigations shared with staff.

Outpatients and diagnostic imaging

Good

Overall, we rated outpatients and diagnostic imaging as good. This was because:

- Incidents were well managed and staff understood their responsibilities regarding the reporting of incidents and concerns.
- There were good infection control processes and the departments were clean and tidy and equipment was well-maintained.
- There were enough suitably qualified and experienced staff to provide a good service to patients. Staff absence rates and vacancy levels were low.
- Staff were aware of and followed policies and procedures and national guidelines for effective treatment.

Summary of findings

- Staff competency was regularly assessed and monitored. Staff had the skill, qualifications and experience to carry out their roles and some staff had received specialist training to improve services for patients.
- Access to appointments was good and referral to treatment times were in line with the national average.
- Staff sought and acted on the views of patients to improve services. Information about how to complain was available to patients and complaints were responded to and used to improve services.
- Staff were clear about the vision and values for the service and were committed and highly engaged.
- Leadership was strong and there was a culture of supporting staff.
- The environment was not suitable in all areas for the work being undertaken because some parts of the department, such as reception and waiting areas, were too small.
- Some areas did not comply with the Health Building Notes for hand wash basins in a clinical area.
- Some risks in the departments had not been identified and adequately assessed and managed.

Summary of findings

Contents

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Rivers Hospital

Services we looked at
Medical care; Surgery; Services for children and young people and Outpatients and diagnostic imaging;

Summary of this inspection

Background to Rivers Hospital

Rivers Hospital is a private hospital in Sawbridgeworth, Hertfordshire. It has 57 registered beds. The hospital opened in 1992. The hospital is managed by Ramsay Healthcare UK Operations Ltd part of a network of over 30 hospitals and day surgery facilities and two neurological rehabilitation homes, across England. In addition they own and run hospitals in Australia, Indonesia and France.

The hospital provides care for private patients who are ether paid for by their insurance companies or are self-funding. Patients funded by the NHS, mostly through the NHS referral system can also be treated at Rivers Hospital.

The registered manager has been in post for over five years.

The hospital provides outpatient consultations to both adults and children. The outpatient department comprises 17 consulting rooms together with three treatment rooms which are used for minor procedures. The hospital offers imaging and physiotherapy services in addition to a pharmacy department providing services for both inpatients and outpatients

All wards and departments are situated on the ground floor of the hospital.

The operating facilities include four theatres and an endoscopy suite. All of the theatres have laminar flow. At the time of our inspection plans were in progress to build a fifth theatre which was anticipated to be completed by June 2017.

The hospital undertakes a range of surgical procedures and treats adults and children.

Our inspection team

Our inspection team was led by:

Lead Inspection Manager: Louise Hagger, Care Quality Commission.

Inspection Manager: Phil Terry, Care Quality Commission.

The team of 14 included six CQC inspectors and six clinical specialists including a theatre nurse, consultant surgeon, and a governance specialist.

How we carried out this inspection

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 21 and 22 June 2016 and an unannounced inspection on 1 July 2016. We spoke with a range of staff in the hospital, including nurses, allied health professionals, support staff and consultants. During our inspection we reviewed services provided by Rivers Hospital in the ward, operating theatre, outpatients, pharmacy and imaging departments.

During our inspection we spoke with patients and staff, including consultants, who are not directly employed by the hospital. In addition, we spoke with six family members/carers from all areas of the hospital, including the wards, operating theatre and the outpatient department. We observed how people were being cared for and reviewed personal care or treatment records of patients. We also carried out formal interviews with senior clinicians and leaders, including the resident medical officer and the chair of the medical advisory committee.

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?

Summary of this inspection

- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Information about Rivers Hospital

The hospital has 57 beds, all with en-suite facilities. There are four operating theatres, all with laminar flow, 17 consultation rooms and an endoscopy unit with nine bays.

Rivers provides an inpatient and outpatient service for various specialties to both private and NHS patients. This includes, but is not limited to, orthopaedics, gynaecology, general surgery, diagnostic imaging and urology. There were 14,278 inpatient spells between January 2015 to December 2015. 11,860 were day cases and 2,418 stayed one or more nights in hospital. In total, there were 16,118 procedures carried out between January 2015 and December 2015.

Between January 2015 and December 2015, 61,904 people were seen in outpatients. 22,153 of these appointments were under NHS funded care opposed to 39,751 which were self-funding or for patients paid for by their insurance companies. In the same period, 8,698 patients received inpatient care under NHS funding whilst 5,580 did so via other means.

The individual activity of the 222 doctors that have practicing privileges was monitored. In addition, there was 223 whole time equivalent employed staff.

Rivers has Joint Advisory Group (JAG) accreditation.

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

The hospital accountable officer for Controlled Drugs (CDs) is the matron.

Rivers Hospital was previously inspected by the Care Quality Commission in 2013 and was found to be fully compliant against seven standards of care. These included: respecting and involving people who use services, care and welfare of people who use services, meeting nutritional needs, cleanliness and infection control, management of medicines, requirements relating to workers and complaints.

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?

Good

- There was generally access to suitable equipment to provide safe care and treatment.
- Generally, systems were in place to ensure all areas complied with the service's infection control procedures.
- Staff were encouraged to report incidents and were aware of the duty of candour regulation. There was some evidence of learning from incidents and complaints and effective processes were in place to reduce risk.
- Most staff were up to date with mandatory training in the medical care and children's and young people service in line with the hospital's annual training plan
- Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice.
- The hospital carried out a range of medicines safety indicators to assess how they were performing, and to identify areas for improvement. However, not all medicines were stored appropriately at the time of the inspection.
- Staffing levels were generally appropriate to the needs and flexed according to the demands of the service, ensuring patients' needs were met at the time of the inspection.
- There were clear escalation processes in place, which included the use of the resident medical officer (RMO) and escalation to consultants.
- Systems to safeguard patients were in place and staff knew how to respond appropriately to safeguarding concerns.
- There was a system in place to recognise the deteriorating patient. Appropriate triggers were in place to ensure patients, who had deteriorated were treated according to their clinical needs.
- The risk register for medical care was not updated regularly and in a manner that reduced the risk of disruption to the service. The risk register did not identify risks to the delivery of safe care and treatment that we found during the inspection. These risks had not been recognised by the service.
- There were some potential risks to health and safety due to the administration of chemotherapy in some carpeted areas in patient bedrooms, which the hospital had assessed. The hospital took immediate action to provide four non-carpeted bedrooms immediately after we raised this issue.

Summary of this inspection

- The rooms used for chemotherapy, were often used for other services if needed. The hospital had well defined processes regarding the cleaning of these rooms before and after use and also checked patients were not immunocompromised before having treatment in these rooms.
- Not all entries in medical records were legible.

Are services effective?

Requires improvement

- Information about the outcomes of children and young people's care and treatment was not routinely collected and monitored. The service did not have a robust system for monitoring the outcomes for patients. We were not assured the service could therefore drive improvements due to lack of monitoring and performance information.
- The hospital had some audit programmes specific to children and young people's service, including documentation, environmental and pain audits. Feedback from patients and learning from incidents was also reviewed.
- Staff were aware of their role with to regards to the Mental Capacity Act and Deprivation of Liberty and had received training. However, patients' consent to chemotherapy was not clearly documented in all cases.
- Policies were current, accessible to staff and reflected professional guidance.
- Care and treatment was given in line with evidence-based guidance.
- The hospital offered intrathecal chemotherapy in line with the latest available guidance from the Department of Health (2008).
- Staff followed evidence-based practice, including guidance from the Royal College of Nursing, the Joint Advisory Group (JAG), and the National Chemotherapy Advisory Service
- There was participation in national audits in surgery, which showed outcomes within an expected range
- The medical advisory clinic reviewed all new consultants before practising privileges were approved; this included their scope of practice. The hospital had an effective system in place to ensure that practising privileges were updated annually with the relevant information.
- An induction programme was provided to all new staff.
- There was a process in place for checking professional registration.
- Consultants were on call for 24 hours a day and seven days a week for their inpatients and day case patients. There was a RMO providing medical cover for patients and clinical support to staff.

Summary of this inspection

- There were arrangement's to ensure staff were able to access all necessary information to provide effective care.

Are services caring?

Good

- Patients were overwhelmingly complimentary about the service they received at the hospital.
- The Friends and Family Test survey results for the period July to December 2015 had a varying response rate from 8 to 58%. The percentage of patients that would recommend the hospital was 100% for inpatients and 99 for outpatients. Results from Rivers patient satisfaction scores showed that from January to March 2016 above 93% of patients were satisfied with aspects of the care they received including cleanliness of the hospital, staff, admission procedures, physiotherapy, discharge procedures and care since discharge.

Are services responsive?

Good

- Services were generally planned and delivered in a way that met the needs of the local population.
- There was a lack of recognition of the children and young people's service as a separate, distinct service in the hospital.
- Information on complaints or how to raise a concern was available for patients. Complaints and concerns were always taken seriously and responded to in a timely manner. There was evidence of actions taken to address issues raised in complaints and staff were informed of changes required in response to complaints.
- Staff had awareness of dementia and had received training in caring for patients living with dementia. There was a lead nurse for dementia in the hospital.
- The chemotherapy service demonstrated a positive relationship with commissioners and stakeholders in relation to service development.
- Access for disabled people was good throughout the departments.
- Interpreters could be booked when required for patients whose first language was not English.
- Staff made efforts to ask people for their views on the service and used these to make improvements where possible.

Summary of this inspection

Are services well-led?

Requires improvement

- There was a hospital risk register in place. However, the register lacked sufficient detail to provide adequate assurance about the appropriate identification and management of corporate risks, the mitigating actions, and the level of improvement or latest progress updates.
- Risks to children and young people using the service had not been recognised, assessed, or mitigated against before our inspection. However, the service took immediate action once we raised these concerns.
- There was limited assurance that improvements were being driven in the children and young people's service due to a lack of effective performance and outcomes measurements.
- There was good local leadership and an open culture where staff felt valued.
- The hospital had a clear corporate set of values. Staff knew the provider's vision and strategy, called 'The Ramsey Way'.
- The hospital had a clear governance structure and a clinical governance committee that met to discuss a range of hospital issues. However, some concerns found on inspection had not been recognised, assessed or mitigated against by the service.
- There were clear routes for cascading information to hospital staff.
- Senior management staff at the hospital were visible, supportive and approachable.
- Staff were generally proud to work at the hospital.
- Clinical leads had a shared purpose and motivated staff to deliver services and succeed
- There were robust recruitment procedures in place including checks on professional registration and those for the disclosure and barring service (DBS).

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

1. We inspect but do not rate effectiveness for outpatient and diagnostic screening services, as we are not confident we have sufficient, robust information which answer the KLOE's and reflect the prompts.

Requires improvement

Medical care

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

Information about the service

Medical care services at Rivers Hospital consists primarily of a chemotherapy service and an endoscopy day unit service. The hospital is also able to provide haematology, rheumatology and cardiology care. A nurse clinical lead has oversight of chemotherapy services and a consultant and senior sister lead the endoscopy unit. Medical inpatients can be cared for on one of two surgical wards although this is rare and at the time of our inspection, there were no medical inpatients.

Between January 2015 and December 2015, the hospital conducted 370 medical oncology procedures and saw 262 haematology patients, six cardiology inpatients, two nephrology inpatients, one rheumatology inpatient and one general medicine inpatient.

Chemotherapy is provided for up to 10 patients per day during two days per week. In addition to the clinical lead, a senior sister and two specialist nurses support this service.

The endoscopy unit provides up to 21 procedures per day during nine clinical sessions per week, Monday to Friday. A senior sister and healthcare assistant support the team of consultants who are accredited by a medical advisory committee. This unit has been accredited by the global Joint Advisory Group on gastrointestinal endoscopy and is rated the maximum 'A' rating for all four quality domains used to assess the service.

We spoke with 17 members of staff including consultants, theatre staff, nurses, healthcare assistants and administrators and spoke with nine patients. We looked at 36 patients' records and associated documents in order to come to our judgement.

Summary of findings

Overall, we rated medical care at the Rivers Hospital as requires improvement because:

- The risk register for medical care was not updated regularly and in a manner that reduced the risk of disruption to the service. The risk register did not identify risks to the delivery of safe care and treatment that we found during the inspection. There were some potential risks to health and safety to the administration of chemotherapy in some carpeted areas in patient bedrooms, which the hospital had assessed. These risks had not been recognised by the service but the hospital took immediate action to provide four non-carpeted bedrooms immediately after we raised the issue.
- In the pharmacy, cytotoxic drugs were not appropriately stored because they were stored in an unlocked refrigerator alongside other medicines. However, the hospital took immediate action to address this concern during our inspection.
- Medical summaries in some chemotherapy patient records were sometimes illegible but the hospital had assurance that, as this was a consultant led service with one named consultant for each patient, any concerns or queries could be raised directly with the patient's named consultant who would be contactable at all times. Nurses and the RMO would have been informed at the time of all aspects of the patient's care and treatment as per the hospital's protocols. Typed notes of the consultation formed part of the letter to patients' GPs.

Requires improvement

Medical care

- Patient records in the endoscopy unit were not always stored securely.
- Patients' consent for chemotherapy was not clearly documented in all cases.

However, we also found that:

- A robust incident reporting procedure was in place and staff said they received feedback after reporting incidents. This was used to share learning.
- Staff demonstrated an understanding of safeguarding processes and established protocols were in place to protect people from abuse.
- A small office was available for private and confidential conversation with patients and talking about consent but this was also used by clinical staff for completing paperwork.
- Medical staffing in medical care services was stable and consultant-led and out of hours cover was effective.
- Nurse staffing met patient needs during the inspection. We looked at rotas for the endoscopy unit for the six months prior to our inspection. All sessions had been staffed according to the establishment of a senior nurse, registered general nurse and healthcare assistant.
- Individual patient risk assessments were consistently completed and acted upon.
- Care and treatment was generally provided in line with national guidance including from the National Chemotherapy Advisory Group and the Royal College of Nursing. Completion rates for endoscopic procedures were better than national averages.
- Staff followed evidence-based practice, including guidance from the Royal College of Nursing, the Joint Advisory Group (JAG), and the National Chemotherapy Advisory Service.
- Clinical endoscopy staff used the World Health Organisation (WHO) surgical safety checklist for each procedure and audits showed checklists were completed accurately and used appropriately.
- The hospital offered intrathecal chemotherapy in line with the latest available guidance from the Department of Health (2008).
- Pain relief was monitored and recorded in line with Faculty of Pain Medicine (2015) Core Standards for Pain Management Services.
- Patients had an assessment of nutritional care needs during pre-assessment, which staff used to provide nutritional support using an established pathway.
- The endoscopy unit had Joint Advisory Group accreditation to level A.
- Staff were given regular supervisions and annual appraisals.
- Multidisciplinary working was effective in the service.
- Staff reported positive working relationships in an environment that encouraged professional development.
- Patients and their relatives reported a caring and compassionate service.

Requires improvement

Medical care

Are medical care services safe?

Good

Overall, we rated medical care services at the Rivers Hospital as good for safe because:

- A robust incident reporting procedure was in place and staff said they received feedback after reporting incidents. This was used to share learning such as in the administration of pain relief
- Levels of mandatory training were good and actively monitored. All chemotherapy staff had up-to-date mandatory training and 87% of endoscopy staff and nurses who could work with medical patients had up to date training.
- Staff demonstrated an understanding of safeguarding processes and established protocols were in place to protect people from abuse.
- Medical staffing in medical care services was stable and consultant-led.
- Nurse staffing met patient needs during the inspection. We looked at rotas for the endoscopy unit for the six months prior to our inspection. All sessions had been staffed according to the establishment of a senior nurse, registered general nurse and healthcare assistant.
- Planned medical cover was consistent and appropriate to meet patient needs according to scheduled rotas.
- Individual patient risk assessments were consistently completed and acted upon.

However, we also found that:

- There were some potential risks to health and safety due to the administration of chemotherapy in some carpeted areas in patient bedrooms, which the hospital had assessed. The hospital took immediate action to provide four non carpeted bedrooms immediately after we raised this issue.
- In the pharmacy, cytotoxic drugs were not appropriately stored because they were stored in an unlocked refrigerator alongside other medicines. However, the hospital took immediate action to address this concern this during our inspection.
- Medical summaries in some chemotherapy patient records were sometimes illegible but the hospital had assurance that, as this was a consultant led service with one named consultant for each patient, any concerns or queries could be raised directly with the patient's named consultant who would be contactable at all times. Nurses and the RMO would have been informed at the time of all aspects of the patient's care and treatment as per the hospital's protocols. Typed notes of the consultation formed part of the letter to patients' GPs.
- Patient records in the endoscopy unit were not always stored securely. Some medical records were not legible in the chemotherapy service.

Incidents

- Staff used an electronic incident reporting system to submit incident reports. All of the staff we spoke with said they had been trained and were confident in the use of this system.
- There had been no never events reported for this service in the past year. A never event is described as wholly preventable incident, where 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.
- Between May 2015 and May 2016, 14 incidents were reported in the endoscopy unit. Ten incidents related to patient management including four cases of equipment malfunction. Risks associated with a malfunction of the endoscopy washer had been addressed with the introduction of a second washer. This had been provided after staff escalated the risk to the senior team.
- Between May 2015 and May 2016, 31 incidents reported related to chemotherapy services. Incidents relating to the safety and quality of patients care and treatment accounted for 20 of the total number. This included incidents of appropriate emergency transfers to accident and emergency departments when patients presented inappropriately or deteriorated on site. Of these 31 incidents, there was no evidence of patient harm.
- There had been one drug error in chemotherapy services in the year prior to our inspection and

appropriate measures had been taken to prevent a similar occurrence. For example, staff implemented stronger systems to ensure chemotherapy errors were avoided.

- There was evidence of learning from previous incidents. For example, following the mislabelling of patient specimens in endoscopy, a new double-checking process had been implemented. Senior and clinical staff monitored trends in incidents and shared learning through meetings, clinical supervision and communication with individual staff. Incidents were discussed and minuted in clinical governance and clinical leads meetings. However, it was not always clear how robust incident investigations were. For example, in some cases staff had written incidents were "reviewed and discussed" but the outcomes were not clearly documented in all cases.
- Clinical leads included a review of morbidity and mortality (M&M) in quarterly clinical governance meetings. We looked at details of these for the three quarters prior to our inspection. Staff at the appropriate level recorded discussions of expected and unexpected deaths although this was often brief and did not indicate any learning or changes to practice as a result.
- The matron was developing the terms of reference for a dedicated M&M Committee. This would enable the service to provide a dedicated multidisciplinary review of deaths and adverse events in a more focused setting than could be achieved in quarterly clinical governance meetings.
- Providers are required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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. Staff documented use of the duty of candour in incident reports and understood their responsibilities during our conversations. This included speaking with people affected when something went wrong, giving an apology and informing them of action taken as a result.

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

- Data equivalent to the NHS safety thermometer was on display in medical care areas, including the endoscopy unit. The hospital monitored equivalent information, including instances of pressure ulcers, falls, venous thromboembolism (VTE) acquired on admission and catheter-related urinary tract infections acquired during admission. Staff used care pathways to prevent avoidable pressure ulcers and falls, which included risk assessments and monitoring based on individual patient need.
- Between January 2015 and April 2016, four cases of hospital-acquired VTE were recorded. In this period, staff met or exceeded the provider's target of 95% compliance with VTE risk assessment standards using a monthly audit. The most recent data available was from June 2016 and indicated 97% compliance with provider policies. Two areas were found to need improvement. These were the completion of a VTE risk assessment for all patients and a review of VTE prophylaxis after a procedure. Action plans were in place to address this and a monthly quality and safety scorecard monitoring system was in place to track progress.

Cleanliness, infection control and hygiene

- Generally, systems were in place to ensure all areas complied with the service's infection control procedures.
- Most elements of the endoscopy unit were visibly clean. However, we found an air vent in the 'dirty' side of the washer room was coated in a thick layer of dust. The latest available infection control and environmental audit was from June 2016. This audit identified all furnishings in the endoscopy unit as visibly clean and in a good state of repair.
- Disposable curtains in the endoscopy recovery area were changed in accordance to the hospital's policy.
- Infection control was part of the hospital's mandatory training programme for all staff and 80% of staff were up to date with this against a target of 95% in the training year (which ran from January to December).
- During our inspection we observed staff wash their hands between patient contact and use alcohol hand gel appropriately.
- Standards of cleanliness and hygiene were monitored using monthly audits and feedback from performance

visits from other organisations, such as the clinical commissioning group (CCG) and regional decontamination lead. Where shortfalls were found in infection control practices, staff implemented procedures to improve them.

- All patients were tested on admission for MRSA and C. difficile. Between January 2015 and April 2016, there were no instances of either infection.
- Antibacterial hand gel was available in each bed space in the endoscopy unit and at one entrance/exit. One entrance/exit in the unit did not have hand gel in the vicinity and there were no notices on display to request visitors to wash their hands. However, there were numerous points at which patients and visitors had access to hand gel on their journey to and from the unit and there were also numerous gel dispensers within the unit including one at each patient bay.
- The hospital had a lead nurse for infection control who conducted audits on clinical practice, including hand hygiene. Hand hygiene audits for July 2015 and December 2015 demonstrated 100% compliance with hospital standards. There had been a slight decrease in standards in April 2016, where staff had not always followed the bare below the elbow policy, resulting in 94% audit compliance.
- Infection control audit results were not always shared consistently with staff. For example, a clinical member of staff we spoke with said they had not received feedback from hand hygiene audits and did not know the latest results. Another member of staff said they were aware of the results only because of an information display in the ward area. Senior managers told us that audit results were shared at mandatory training days, they were also accessible on the intranet and were included in departmental meetings' discussions and at infection prevention and control meetings
- Trained decontamination staff documented appropriate checks on endoscopy equipment. This included a weekly final rinse water test, daily drying cabinet checks and weekly decontamination of flexible endoscopes. We checked decontamination records for the six months prior to our inspection and found no gaps.
- The decontamination lead for an external regional endoscopy group conducted an annual audit of all documentation related to cleaning and infection control audits in endoscopy. The last audit had been conducted in October 2015 and the unit was found to be 92% compliant. Areas of best practice included a preventive maintenance programme and procedures for equipment. Areas for improvement included management and practice, personnel and training and transportation of instruments and equipment. The department had an action plan to address this, which staff monitored monthly.
- The endoscopy unit was compliant with Department of Health Technical Memorandum 01-06 relating to the management and decontamination of flexible endoscopes.
- Scopes used in the endoscopy treatment room were cleaned with an enzymatic cleanser after each procedure.
- An infection control nurse reviewed practices in the chemotherapy service. They reported a low rate of infection associated with peripherally inserted central catheters and implanted venous access devices, or 'portacath.' Both are common procedures for patients receiving chemotherapy.
- A microbiologist and pharmacist conducted a quarterly audit of clinical equipment used in the delivery of chemotherapy for bacteria growth. We looked at the most recent three audits and found them to be robust and evidence of good infection prevention and control.
- The rooms used for chemotherapy, were often used for other services if needed. The hospital had well defined processes regarding the cleaning of these rooms before and after use and also checked patients were not immunocompromised before having treatment in these rooms.

Environment and equipment

- Appropriate equipment was used to keep people safe. However, a lack of consistency in the frequency of checks of maintenance of some equipment meant there was room for improvement in how equipment was checked and monitored.
- The environment was generally well maintained but it was not always suitable for the all types of care and treatment being provided.

- Chemotherapy was administered to patients in individual patient rooms on the ward, with preparation materials stored on an unsecured trolley in a corridor. Trollies were sometimes shared with staff who conducted lumbar punctures, which meant there was an increased risk of staff confusing or cross-contaminating equipment. There were some potential risks to health and safety due to the administration of chemotherapy in some carpeted areas in patient bedrooms, which the hospital had assessed. Spillage kits were available for staff to use. The hospital took immediate action to provide four non carpeted bedrooms immediately after we raised this issue.
- A resuscitation trolley with emergency medicine, oxygen and an anaphylaxis kit was located in the endoscopy unit. Staff documented daily safety checks on this. An anaphylaxis kit contains emergency medicine used to treat potentially life-threatening allergic reactions. Staff documented daily checks of the equipment and action taken when needed, such as to replace an expired pocket mask. The resuscitation trolley did not include an emergency hypoglycaemic kit although the unit routinely treated patients with diabetes. The matron had completed a risk assessment that highlighted mitigating actions for this risk. This included the availability of glucogel in the unit as well as 10% dextrose in the trolley. There were also sugary drinks and sweet snacks available in the unit. This adequately addressed the risk and the matron had ordered a hypoglycaemic kit and was awaiting delivery. On our unannounced inspection, we found that the hospital had taken appropriate action to address this issue.
- Staff were trained in the use of resuscitation equipment and resuscitation techniques and had their competency and abilities checked annually.
- Arrangements and policies were in place for managing waste and clinical specimens including storage, handling and disposal. We saw staff followed these in practice.
- Emergency spill kits were available for cytotoxic drugs. Staff documented regular checks to make sure they were ready for use. Blood spill kits were also available. However, we found one blood spill kit had expired in 2011. We spoke with a senior nurse about this who removed the kit and replaced it with a new one immediately. A chemical spill kit was located in the endoscopy procedure room.
- Endoscopy equipment was subject to an annual traceability check in line with JAG guidance. This meant the use of equipment could be traced to each individual procedure in the event of an infection control risk or complication.
- We checked 12 items of equipment and found them to have up to date electrical safety checks. We did also find two mobile phone chargers in this area, which staff said had been left by patients. These were removed by staff.
- The ward areas used for medical inpatients were compliant with Department of Health Building Notes 04-01 relating to adult in-patient facilities, including the provision of patient support spaces, utility spaces and staff areas.
- Staff received training in the use of equipment and this was monitored annually through practical competency checks. Changes to best practice use of equipment or to policies relating to them were communicated to staff.
- In the endoscopy unit, a small administration office was located at the rear of the waiting room. This office had no ventilation and was overcrowded with equipment, which meant the door could not be fully opened. There was no process in place for this member of staff to obtain rapid help in the event of an emergency or aggressive patient or visitor. Unit staff had escalated this issue to the senior team in the six months prior to our inspection but had not received a response. This was not on the hospital's risk register. Senior managers told us that this room was originally used to store documentation and not be used by staff, and over time it was used by staff to do paperwork or make calls. Once this issue was highlighted during the inspection, it was taken out of use. The hospital then converted a patient room into an office space for staff to have private conversations with patients over the telephone.
- Although individual members of staff demonstrated a proactive approach to ensuring privacy, the environment in some areas was not conducive to this. For example, space in the endoscopy unit was restricted and staff did not have access to dedicated office or desk space for booking patients in. A small office was

available for private and confidential conversation with patients and talking about consent but this was also used by clinical staff for completing paperwork. This meant staff often found it difficult to book patients in with privacy and when the unit was busy, there was insufficient space for each member of staff to work effectively. The senior sister in charge of the unit did not have dedicated private space for meetings, completing records or speaking with staff and patients. Senior staff in the unit had escalated concerns about this to the senior leadership team in the hospital. The Joint Advisory Group (JAG) recommended more dedicated space in the unit be provided to help staff to deliver a more efficient service. However, no action had been taken and this was not reflected in the service risk register.

- During the inspection, the hospital was undertaking a refurbishment of the phlebotomy rooms that was scheduled to last three weeks. There was a temporary arrangement whereby the phlebotomy office was placed with the endoscopy unit.

Medicines

- Arrangements for prescribing, handling, dispensing, administration, and disposal of medicines kept people safe. However, there was room for improvement in how medicines were recorded and stored, including chemotherapy drugs.
- We looked at eight drug charts and found them to be completed appropriately.
- Most medication was stored securely in line with the provider's guidance. Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use.
- In the pharmacy, cytotoxic drugs were not appropriately stored because they were stored in an unlocked refrigerator alongside other medicines. Cytotoxic drugs (sometimes known as antineoplastics) describe a group of medicines that contain chemicals, which are toxic to cells, preventing their replication or growth, and so are used to treat cancer. However, the hospital took immediate action to address this concern during our inspection. This meant cytotoxic drugs were not stored according to Department of Health (2008) requirements. The provider's 2013 guidance for the handling and administration of cytotoxic drugs did not adhere to Department of Health requirements. This was raised with senior staff, who took immediate action to address this by storing these drugs appropriately on the day of the inspection.
- The hospital did maintain a record of intrathecal chemotherapy drugs as required by the Department of Health. Drugs delivered using an intrathecal process are administered directly to fluid surrounding the spinal cord.
- Cytotoxic drugs are subject to safety restrictions issued by the Health and Safety Executive (HSE) under the control of substances hazardous to health. The hospital met HSE regulations with the use of a risk assessment for the control and handling of such drugs that covered the handling and exposure of drugs, the use of personal protective equipment and policies and training to deal with spillages.
- Pharmacy staff followed the provider's 2013 guidance for the handling and administration of cytotoxic drugs but this was not in line with Department of Health (2008) guidance regarding the separate storage of such drugs.
- Controlled drugs were stored in the endoscopy treatment room in a locked cupboard and recorded in accordance with the hospital's documentation. A member of staff checked the drugs at the beginning and at the end of each clinical list.
- Staff used a designated chemotherapy prescription chart that was signed by a consultant at each new cycle. The hospital did not have an electronic prescribing system for chemotherapy and an electronic system planned for introduction in November 2016 was not yet equipped for chemotherapy.
- An oncology pharmacist managed risks to new chemotherapy patients through the preparation of a medication chart that was then stored electronically. This was an electronic data storage system and not an electronic prescribing system. Sheets and labels for subsequent appointments were prepared in advance. Where a pharmacy technician prepared medicine labels, the lead pharmacist checked the batch number, expiry date, patient name and the volume and dose of the drug. This system protected patients against the risks associated with incorrect doses of drugs. Regular

- Two drug errors in chemotherapy services were recorded in the 12 months prior to our inspection. Both incidents involved the incorrect timing of medication due to errors in records. There was no harm to the patient in either case and a review of documentation was undertaken to identify how the mistakes happened and to prevent them happening again. We saw evidence this was shared with all ward nurses.
- Staff recorded drug allergies when a patient was admitted and patients who were cared for in chemotherapy services wore a red wristband to indicate to staff they were allergic to a medicine. Staff in the endoscopy unit recorded allergies on the register in the treatment room.
- Sedation in the endoscopy unit was given according to national guidance based on individual needs and the patient's age. This was clearly and consistently documented.
- The patient was prescribed the medication, it was prepared immediately and brought to the ward and checked with the consultant, the pharmacist and the patient.

Records

- Patient's individual care records were not always written and managed in a way that kept them safe.
- We looked at the records of six patients who were under the care of medical chemotherapy services. In three records, the written medical summary was illegible.
- Each patient who received treatment in the endoscopy unit had a care plan for their procedure. This included a document used to identify other conditions or health issues. In the five records we looked at, this document was blank. A nurse told us this was because they were aware of other conditions on first admission to the hospital, not the individual unit. However, there was no documented evidence staff in the endoscopy unit were aware of this from patient records.
- The endoscopy unit was unsecured and visitors to the hospital could enter this without being monitored. On one day of our inspection, we found eleven patient records unattended on the reception desk of the unit. There were no clinics in session and no staff present. We spoke with a member of staff about this. They said a locked filing cabinet was available but notes were usually left out for consultants to collect before each clinic. This meant patient records were not routinely protected or stored appropriately.

Safeguarding

- Staff followed a centralised hospital safeguarding policy, including for children who might be visitors in the hospital. Safeguarding was part of the provider's mandatory training programme for staff, which was based on guidance from the safeguarding intercollegiate standards.
- The hospital established the level of safeguarding training needed for staff based on their job role and type of contact they had with patients. All staff in the hospital were required to have level one safeguarding training for both adults and children. All clinical staff were required to undertake level two training and all clinical staff who had responsibilities of care for children and young people were required to undertake level three training. A lead consultant and lead nurse were required to undertake level four training. Medical services staff did not treat children but this training was provided because children may be present on site.
- Safeguarding training and staff understanding of this was comprehensive and included how to identify and act on signs of abuse such as unexplained bruising and female genital mutilation.
- The hospital implemented an action plan in April 2016 to address a decrease in the compliance rate of staff with safeguarding training. This occurred due to a system problem with electronic learning equipment. The problem had been resolved and the action plan was due to be completed in July 2016, when all staff groups would meet or exceed the hospital target of 95% safeguarding. In June 2016, compliance with level one training was 93%, compliance with level two training was 99% and compliance with level three and level four training was 100%. The data relating to levels of safeguarding training are for adults and children combined.
- All of the staff we spoke with were able to explain the escalation procedure to us and this was available in clinical and administration areas for staff to refer to.

- Incident reports showed staff were able to liaise quickly with relevant services when they had an urgent safeguarding concern, including with social services crisis teams and the police.
- Resident medical officers (RMOs) received accredited training in child protection from the National Society for the Prevention of Cruelty to Children.

Mandatory training

- Human resources coordinated and planned mandatory training. Staff received most of their training updates during a scheduled annual refresher day, which was protected time.
- All staff had basic life support training. Registered general nurses and sisters had intermediate life support training, including paediatric intermediate life support.
- The hospital's mandatory training programme included 27 areas, including infection control, informed consent, basic life support and manual handling.
- Nurses in the chemotherapy service had 100% compliance with mandatory training. This included in blood transfusion procedures and equipment. Access to blood transfusion products was controlled electronically with a barcode that expired automatically if mandatory training was not successfully updated.
- Staff who worked in the endoscopy unit were also assigned to the surgical inpatient wards. Amongst this staff group, 87% had up to date mandatory training. This was below the hospital target of 95%.
- Equality and human rights was included in mandatory training for all staff. This further helped to ensure staff avoided discrimination. In July 2016, 95% of staff had had up to date training.
- The organisation that supplied RMOs to the hospital ensured they maintained 100% compliance with mandatory training. This included fire safety, infection control, safer prescribing and safeguarding.

Assessing and responding to patient risk

- An admission policy was in place that set out the safe and agreed criteria for the admission of medical patients. This included the level of care that could be provided and staffing resources needed.
- Staff completed risk assessments as part of the admissions process to ensure risks were monitored and managed continually.
- Protocols were in place to ensure patients who arrived as an urgent or un-planned admission were seen and assessed by a relevant consultant within 12 hours of admission. This process ensured the RMO assessed patients within 30 minutes of arrival. We saw documented evidence the protocol worked in practice.
- Patient risk was managed in the endoscopy treatment room by the allocation of trained staff. For example, a standard procedure team was made up of two decontamination staff, a consultant, a doctor's assistant and a nurse trained in head care for the patient. There was not a formal competency framework in place for qualified nurses undertaking endoscopic procedures.
- Where a patient needed sedation in the endoscopy unit, staff administered this only if they could confirm the patient had a suitable escort to take them home afterwards.
- Staff used the national early warning scores (NEWS) system to monitor patients in case of deterioration and this was recorded consistently in the records of endoscopy patients we looked at.
- We looked at four NEWS charts and found all were completed correctly and there was evidence of escalation when required.
- A procedure was in place in the event a patient experienced bleeding after an endoscopy procedure. This included on-site access to emergency scanners and a minor surgery unit.
- A protocol for the treatment of patients with diabetes was available in the endoscopy unit and staff used this to minimise risks to patients. For example, patients with uncontrolled diabetes were scheduled into morning clinics.
- In all of the patient records we looked at, a member of staff had completed a risk assessment for venous thromboembolism.
- Policies and procedures were in place to monitor and manage the risk of neutropenic sepsis for chemotherapy patients. The hospital had a policy for recognising and management of the deteriorating patient which

included guidance and treatment pathways for other types of sepsis, such as Sepsis Six guidance. Neutropenic sepsis is a potentially fatal complication of anticancer treatment (particularly chemotherapy).

- A service level agreement was in place for the urgent transfer of critically ill patients if their condition deteriorated and they could be better cared for at another hospital. A standard operating procedure was in place that ensured patients were followed up afterwards and learning from transfers was shared amongst the clinical team.
- Where patients became ill between chemotherapy appointments, arrangements were in place to provide urgent care. This included rapid access to treatment at the hospital where possible or referral to a nearby acute hospital if care could be provided there more quickly.
- Doctors responded appropriately to changing risks, including deteriorating health and wellbeing, medical emergencies or behaviour that challenges. This included the use of emergency transfer protocols, escalation procedures with the RMO and access to urgent mental health support.

Nursing staffing

- A clinical lead, senior sister and two specialist nurses led the chemotherapy service. This team had an appropriate competency and skill mix to ensure the service was safe. Numbers of available staff met patient need during our inspection, and was flexed appropriately depending on the number of patients being treated.
- The latest available staff data was from January 2016 and indicated there were no nurse vacancies.
- The safe clinical staffing level established by the hospital for the endoscopy day unit included a senior sister, a registered nurse and a healthcare assistant. A dedicated senior sister and a healthcare assistant formed the permanent team for the endoscopy unit. A registered general nurse (RGN) and another healthcare assistant from one of the two surgical wards provided additional support at all times the unit was open. This was an informal agreement but an RGN we spoke with told us it worked well in practice and enabled staff to maintain a good skill mix by working in the endoscopy unit and on the wards. However, it did mean there was no formal structure in place to guarantee staffing.
- We looked at rotas for the endoscopy unit for the six months before our inspection. All sessions had been staffed according to the establishment of a senior nurse, registered general nurse and healthcare assistant.
- Some staff described challenges in restricting the number of patients accepted to endoscopy treatment lists when they felt the service would be unsafe due to not enough staff to manage the level of work given the rate of procedures performed. This did not reflect a shortage of established staffing levels per shift but the overall workload associated with the number of patients and speed of procedures.
- The senior sister in endoscopy led a caseload meeting with unit staff at the beginning of each shift. This helped to plan the management of the waiting room and recovery area.
- Clinical staff conducted a bedside handover in recovery after each endoscopy procedure. This included a review of their sedation and medication and a check of the documentary monitoring the nurse needed to make.
- Chemotherapy nursing staff reviewed the caseload and the allocation of patients at the beginning of each shift.
- There were no medical inpatients in the wards at the time of our inspection. Staff told us nursing and medical handovers took place twice daily when medical patients were being cared for in the wards. This ensured information regarding treatment and discharge planning was shared between shifts and different staff groups.
- Healthcare assistants provided a clinical support service, including taking blood pressure and removing cannulas. We saw documented evidence they were appropriately trained to perform such duties safely.
- Two senior sisters and two specialist nurses provided chemotherapy care, all of whom were appropriately skilled from specialist oncology courses at recognised clinical training centres. The clinical lead for chemotherapy was on call during weekdays and out-of-hours, patients were advised to contact the ward or their consultant directly.
- In endoscopy, bank nurses and healthcare assistants were available when needed and had a minimum standard of skills and knowledge. A robust, documented induction process was in place that ensured staff were competent to work in the service. The chemotherapy service did not use bank nurses and agency nurses were not used there or in the endoscopy unit.

Requires improvement

Medical care

- An orientation and induction checklist was used for agency staff new to the hospital. This included a competency check of their administration of medicines. Endoscopy and chemotherapy services did not use agency staff. However, medical inpatients were occasionally cared for on the wards, where agency staff were sometimes used.
- The two surgical wards could provide care and treatment for medical inpatients. This happened rarely and on only two occasions in the 12 months prior to our inspection.

Medical staffing

- The RMO was available on site at all times. RMOs typically worked six to eight hours per day on a two week rota within a robust, clearly defined definition of skills and accountability. RMOs were provided by an agency and the hospital has robust systems in place regarding the competency of RMOs working in the service.
- When medical inpatients were cared for on the wards, the consultant was available to attend the unit within 30 minutes. This was planned for elective admissions and there was not a formal on call rota. The hospital provided medical care on an elective admissions basis. This meant staffing levels and skill mix were planned to ensure patients received safe care and treatment at all times. This was planned by the patient's consultant based on their individual need.
- Consultants were accredited to work in the hospital through a process that ensured their skills and experience matched patient need and hospital resources.
- Nine consultants provided a range of seven treatments in the endoscopy unit according to their specialist training and practising privileges. A lead consultant for endoscopy was in post. The hospital ensured only consultants with practicing privileges performed procedures and delivered treatment. Consultant cover plans minimised the risk procedures would be cancelled if one individual was unavailable.
- Consultants based their hours on the number of clinics per week, with variations between three hours and 18 hours.
- Medical staff worked within a peer support group that helped them to discuss and share practice.
- Consultants in the endoscopy unit were validated through a medical advisory committee and were included in the JAG accreditation.
- Patients who received chemotherapy were cared for by consultants who also worked in NHS hospitals. This team included a range of experience and specialties.

Major incident awareness and training

- A business continuity plan was in place to manage potential risks associated with adverse weather and disruption to staffing. This plan was reviewed on an annual basis and included guidance for staff to ensure clinical services were provided without interruption.
- The hospital had a centralised emergency evacuation process, with fire wardens assigned to specific areas of the hospital. Staff in the endoscopy unit had defined processes to follow in the event of an emergency, including protecting patients who were sedated.
- Endoscopy washers had independent power supplies. This meant that if one washer failed, patient treatment could continue.
- Emergency and evacuation processes were tested annually and fire drills were carried out quarterly. All of the staff we spoke with were aware of the process to follow and actions to take if they heard the fire alarm.
- Local and emergency fire safety was part of the hospital's mandatory training programme for all staff. In July 2016, 79% of staff were up to date with this training. This was below the hospital's target of 90%.

Are medical care services effective?

Requires improvement

Overall, we rated medical care services at the Rivers Hospital as requires improvement for effective because:

- There was an inconsistent approach to obtaining and documenting consent from patients being treated for chemotherapy. Staff showed us the steps they were taking to improve this.

- Competency checks for pharmacists working in chemotherapy services were not always documented although a dedicated oncology pharmacist provided support.

However, we also found that:

- Care and treatment were generally provided in line with national guidance including from the National Chemotherapy Advisory Group, Royal College of Radiologists and the Royal College of Nursing.
- The hospital offered intrathecal chemotherapy in line with the latest available guidance from the Department of Health (2008). The hospital stopped this service after our inspection.
- A new audit programme was implemented in July 2016. This included 18 areas for audit activity, including consent, various areas of infection control and the completion of pre admission and discharge documentation.
- Clinical endoscopy staff used the World Health Organisation (WHO) surgical safety checklist for each procedure and audits showed checklists were completed accurately and used appropriately.
- Pain relief was monitored and recorded in line with Faculty of Pain Medicine (2015) Core Standards for Pain Management Services.
- Patients had an assessment of nutritional care needs during pre-assessment, which staff used to provide nutritional support using an established pathway.
- Patients cared for by the chemotherapy service had access to food and drink in line with Department of Health recommendations.
- The endoscopy unit had Joint Advisory Group accreditation to level A.
- Staff were given regular supervisions and annual appraisals.
- Multidisciplinary working was effective in the service.

Evidence-based care and treatment

- The hospital generally used relevant and current evidence-based guidance, standards, best practice and legislation to audit and monitor services for quality and outcomes. This included the National Institute of Health and Care Excellence, the Nursing and Midwifery Council, the Joint Advisory Group, the Royal College of Radiologists and the Royal College of Paediatrics and Child Health. Guidance was used to monitor compliance with standards of risk assessments, standards of safeguarding and specialist clinical care.
- Staff used defined pathways based on national guidance to ensure treatment and care was delivered based on the needs of each individual. For example, patients who received chemotherapy were cared for using an individualised patient-specific pathway.

  The hospital offered intrathecal chemotherapy in line with the latest available guidance from the Department of Health (2008). To maintain standards of safety, intrathecal chemotherapy was offered on a different day to intravenous chemotherapy. This meant clinical staff were able to focus on one type of complex procedure at a time. Two patients had received treatment between 2014 to 2016. The staff were able to access the DOH Guidelines via the computer on the ward and in pharmacy to ensure that the guidance used was current and up to date, This was a consultant led service with the lead from a local acute NHS trust delivering the treatment. The hospital did not use a hard copy of the DOH guidelines as there was a due to the infrequent use of this that the policy may have been out of date by the time the next patient was treated. The hospital took the decision to cease intrathecal chemotherapy during our inspection pending a full review of this aspect of care and treatment provided by the hospital.
- Equality and human rights was included in mandatory training for all staff to further help to ensure staff avoided discrimination.
- Clinical endoscopy staff used the World Health Organisation (WHO) surgical safety checklist for each procedure. This meant patients received consistent care and treatment to established standards, including the NHS five steps to safer surgery. We looked at five sets of patient records and found staff had fully completed the WHO checklist in each and had used it correctly. The Clinical Commissioning Group monitored the use of the WHO checklist. The latest available audit was from August 2015, which found the WHO checklist to be robust and used appropriately.

- Staff used a checklist for chemotherapy pre-assessment and conducted an annual audit to monitor compliance with blood safety and quality regulations. This met national guidance from NHS England.
- Chemotherapy was provided in line with national guidance. This included the 2009 guidelines of the National Chemotherapy Advisory Group and the Royal College of Nursing standards for infusion.
- The lead pharmacist for oncology and a pharmacy technician conducted a quarterly aseptic audit for chemotherapy services using microbiology protocols. This helped to ensure patients were treated in a safe environment. At the time of our inspection, audits indicated practice adhered to the hospital's best practice policies.
- The chemotherapy clinical lead conducted an annual audit of the stroke prevention in atrial fibrillation risk (SPARC) tool. A care pathway for stroke was in place. At the time of our inspection there were no medical inpatients and so we did not see this in use.
- Staff completed a monthly audit of compliance with the urinary catheter care bundle. In June 2016, overall compliance was 95%. This included 100% compliance with insertion and on-going care standards and 88% compliance with adherence to policy. Three areas within policy compliance required improvement. This included a record of why the patient needed a catheter insertion, a record of the reason for on-going catheter use and the use of a fluid balance chart.
- A new audit programme had been implemented in July 2016. This included 18 areas for audit activity, including consent, various areas of infection control and the completion of pre admission and discharge documentation.

Pain relief

- The hospital met the Faculty of Pain Medicine (2015) Core Standards for Pain Management Services. This was because patients with acute pain had an individualised analgesic plan and staff conducted regular pain assessments using appropriate tools.
- Staff monitored each patient's pain score during and after an endoscopy procedure. They were able to offer non-pharmacological relief for discomfort after a procedure such as peppermint water and herbal tea. This was in addition to prescribed pain medication and anticipatory pain relief.
- Staff who worked in chemotherapy services had access to 'compassionate reason' drugs, which provided pain relief and comfort to patients who had reached their ceiling of care. This meant patients who were not expected to recover were assessed for pain relief to help maximise their levels of comfort.
- Patients we spoke with told us their pain had been managed effectively and staff asked them regularly about this. This was recorded consistently in patient records.
- Staff had completed a pain relief and management audit in January 2016. This assessed prescribing and monitoring standards against national guidance from the British National Formulary, the Nursing and Midwifery Council and the General Medical Council. This audit found 99% compliance with policies and included an action plan to improve this. This included documentation of the discontinuation of medication.

Nutrition and hydration

- Patients had an assessment of nutritional care needs during pre-assessment, which staff used to provide nutritional support using an established pathway. This included the identification of malnutrition risks due to illness, co-morbidities and special dietary requirements.
- Staff had access to a dietician who provided support with nutritional planning and nutritional intervention. This meant patients had dietary support in line with guidance from the National Institute of Health and Care Excellence (2006) nutritional support in adults. Staff provided nutritional advice and information to patients in line with national best practice guidance from the National Patient Safety Agency (2009).
- Patients with diabetes who were treated in the endoscopy unit had blood sugar checks before and after each procedure. This meant risks relating to blood sugar levels were managed appropriately.
- Staff used the Malnutrition Universal Scoring Tool, food intake charts and fluid intake charts to monitor patient nutritional needs and risks.

- Staff used the Department of Health intrathecal chemotherapy guidelines to ensure patients received adequate nutrition and hydration.

Patient outcomes

- Limited information was collected and audited about the outcome of patient's care and treatment.
- The service did not collect information regarding outcomes for patients who received chemotherapy.
- The hospital was accredited as the maximum grade A by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG). This meant the endoscopy unit and its staff was assessed and monitored for quality performance and clinical safety against established international benchmarks. JAG accreditation was monitored through quality checks annually. For example, completion rates of endoscopy procedures were collected and audited regarding patient outcomes.
- Patients who received treatment in the endoscopy unit were cared for using a procedure-specific pathway. The endoscopy procedure list could include up to 21 procedures in one day. The length of procedures was variable and in some cases very quick, such as between two and five minutes. The turnaround time was reduced as the service had five staff assigned to the procedure room and the hospital had the latest equipment which increased efficiency and reduced turnaround time. 21 procedures in a day complied with JAG recommendations.
- Staff monitored the risk of neutropenic sepsis in chemotherapy patients and patients and their carers were aware of the symptoms. Doctors gave intravenous antibiotics before taking blood cultures if they were concerned. We were told the hospital did not conduct audits in this area which was an area for improvement.
- The lead consultant for endoscopy recorded polypectomies (a polypectomy is the removal of intestinal polyps in order to prevent them from turning cancerous) with the global rating score. The unit's polypectomy rate was 24% and the completion rate for colonoscopies of 94% was better than the national average of 90%.This meant the service performed better than the national average at removing colonic polyps. The re-admission and return rates were low.
- There were no unplanned readmissions following an endoscopic procedure in the 12 months prior to our inspection.
- Staff monitored patient transfers to other hospitals for safety through incident reporting and clinical governance systems. For example, between June 2015 and June 2016 there were 14 medical transfers. Staff reviewed the cause and outcome of each transfer to ensure transfers were only initiated when clinically appropriate.

Competent staff

- Recruitment processes were in place that ensured staff had the right qualifications, skills, knowledge, and experience to do their job when they started their employment. Staff were encouraged to take on new responsibilities and contribute to the development of the service.
- Staff identified their learning needs in a number of ways. This included through annual appraisals and investigations of incidents and complaints.
- All of the staff we spoke with said they felt they had access to appropriate training and development. They said they could approach senior staff at any time to discuss new courses and identify these during team meetings and appraisals.
- Resident medical officer's (RMO's) had sufficient training to meet the requirements of the patients they covered, including out of hours. This included advanced life support training for adults and children.
- The hospital ensured consultants working under practising privileges only carried out treatments or procedures they were assessed as skilled, competent and experienced to perform. This was ensured by a robust facility rules protocol. The general manager held responsibility for this process, including gathering evidence of credentials and communication with the consultant's main NHS trust of employment. On completion of this process, the hospital granted practising privileges to the consultant through annual accreditation. The general manager conducted an annual review to ensure accreditation remained appropriate.
- Resident medical officers (RMOs) completed an induction at an NHS hospital prior to a period of shadowing at this hospital. This ensured they practiced according to national standards and guidance.

- All staff who worked in endoscopy and chemotherapy services had an annual appraisal from a senior member of staff. Compliance with this was 100% at the time of our inspection and all staff we spoke with said the appraisal process enabled them to focus on professional development.
- Nurses who worked in endoscopy had their skills and competencies checked by senior clinicians.
- Staff who worked on the endoscopy unit from the wards did so based on the skills and competence they had shown in the unit and did not undergo a formal competency check. However, according to the JAG accreditation report, there were 15 nursing staff assigned to work in the unit. This list had been prepared in 2013 when the unit was first accredited and had not been maintained. We asked senior clinical staff about this. They said because the unit was doctor-led, nurses were given necessary training in infection control and patient care but did not have formal specific endoscopy training.
- An oncology pharmacist provided medicines support to the chemotherapy service. This member of staff maintained annual competency updates by attending conferences certified by the General Pharmaceutical Council. Other pharmacists and pharmacy technicians who supported chemotherapy services received annual training in aseptic practices but did not have documented competency checks. However, the lead oncology pharmacist conducted an annual appraisal with each member of the team during which training needs were identified.
- Healthcare assistants who worked on the surgical wards and in the endoscopy unit had achieved an appropriate National Vocational Qualification to level three.
- Decontamination staff undertook an annual study day to maintain their skills in addition to annual training with the manufacturers of key equipment.
- The hospital was part of a regional network chemotherapy group, which ensured nurses remained up to date with annual competency training and checks within the provider's own competency framework. This was achieved through practical competency checks from accredited trainers and attendance at chemotherapy group training days. We looked at the training records of chemotherapy nurses and found they were up to date. The competency check tool was based on national best practice guidance and monitored by an appropriate person.
- Catering staff followed Department of Health nutrition guidelines for patients receiving chemotherapy although the hospital did not use a competency checklist to assess them. The manager responsible for catering used annual training updates to ensure catering staff followed best practice guidance.
- A ward manager completed annual performance development reviews (PDRs) with lead nurses. The lead nurses for chemotherapy and endoscopy conducted PDRs with their core staff including staff who rotated into services from the inpatient wards. We looked at eight PDRs. We found them to be robust and fit for purpose with a focus on professional competence, recognition of good service and future development.
- Staff in chemotherapy services said they could ask the senior team for access to specialist training courses and these were usually provided.
- The hospital conducted quarterly reviews on the quality of work of each RMO as well as an annual appraisal and General Medical Council revalidation.
- Senior nurses were responsible for providing clinical supervision to nurses. This was provided on an as-needed basis in clinical areas and as part of mandatory training.

Multidisciplinary working (in relation to this core service)

- Internal service level agreements between different clinical departments were used to ensure they worked together to meet clinical guidance for report turnaround times for diagnostic imaging and endoscopy reports.
- Care was provided by multidisciplinary staff from well co-ordinated teams. This included when patients were referred from outside of the hospital and when teams worked together to assess, plan and deliver care and treatment.
- There was evidence there were multidisciplinary meetings for patients with complex needs that included social services or local authority best interests staff where necessary. The hospital provided

multidisciplinary care in line with the London Quality Standards. This meant patients with complex needs had a multidisciplinary assessment within 14 hours of admission and a consultant-led treatment plan in place within 24 hours.

- Staff used multidisciplinary meetings to discuss the care and treatment of chemotherapy patients such as to provide the most appropriate individual care and ensuring work between doctors, nurses and pharmacists met each patient's individual needs.
- Consultants who provided chemotherapy conducted meetings with the hospital's resident medical officer where patients were at risk of neutropenic sepsis. This process was used to manage risk and to ensure treatment was individualised.
- Consultants held weekly multidisciplinary meetings of their patients at a local hospital with appropriate specialists. This was used to coordinate care for patients with co-morbidities and who were under the care of more than one health professional. Although this represented good practice because it helped to make sure care was individualised and doctors were aware of other treatment pathways, it was not part of a formal relationship with a specialist cancer centre. Staff told us they would welcome this.
- Oncology pharmacists worked with consultants and ward staff to ensure chemotherapy prescribing times met patient needs based on blood test results. This meant patients received the most appropriate medication dose at the time it would be most beneficial.
- Nurses and pharmacy staff met pharmaceutical professionals during lunchtime learning sessions to discuss how new drugs entering the market could benefit patients.
- The discharge process ensured all members of the multidisciplinary team had input into the package of care or discharge and follow up plan.

Seven-day services

- RMOs provide a continuous seven day service.
- Pharmacy services were available every day except Sunday, when an on-call pharmacist was available. A pharmacy top-up service was available in all medical areas. This meant medicine stocks were maintained consistently because staff could obtain extra medicines at any time on demand.
- A haematologist was available on-call 24-hours, seven days a week.

  The clinical lead for chemotherapy was on call during weekdays, and for out of hours and weekends, patients were advised to contact the ward or their consultant directly.

Access to information

- Staff used well-organised pre-admission processes that ensured they had all the information needed to deliver effective care and treatment. This included care plans, medical history and test results.
- Staff shared information between appropriate care teams when patients were referred, discharged or transferred. This took place within robust confidentiality and information governance protocols.
- Where accredited consultants with practising privileges generated medical records, these were shared with other services treating the patient as part of the treatment and discharge plan.
- Staff communicated with referring GPs where a patient had an existing prescription for a medicine that could cause problems during an endoscopic procedure. For example, where a patient was referred who was prescribed warfarin; a nurse contacted the GP to confirm the patient had their prescription stopped.
- Staff routinely sent discharge letters to each patient's GP as part of the discharge pathway.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Nurses in the endoscopy day unit obtained consent from each patient prior to their procedure. This process was completed by a member of staff with appropriate training and in a private office where patients were given time to ask questions. Adapted consent procedures were in place for patients who lacked mental capacity.
- We looked at the records of five patients who had been cared for in the endoscopy service. In each case, the patient had provided signed consent.

Requires improvement

Medical care

- All hospital staff undertook training in the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS). In June 2016, 98% of staff had up to date training, which was better than the hospital's minimum standard of 95%. All of the staff we spoke with demonstrated a good understanding of their responsibilities in relation to this.
- There was an inconsistent approach to obtaining and documenting consent in the chemotherapy service. For example, we found some patients gave consent to treatment off-site, in the referring hospital. This was not always documented in current patient records and staff said they encouraged patients to bring their letter of consent with them. Staff said they checked this but we did not always see documented confirmation of consent. Patient consent was documented in only two of the six sets of patient records we looked at. One set of records included a consent form completed by staff but without a patient signature and date.
- The clinical lead for chemotherapy was aware of the inconsistencies with patient consent forms. To improve this, they had issued a new instruction to consultant secretaries to ensure consent forms were sent to patients directly. Staff told us this had resulted in a steady improvement of consent forms received and we saw further evidence of a drive to improve this from the records of local clinical governance meetings. However, this was not reflected in the records we looked at on the day of our inspection.
- Senior managers told us that chemotherapy patients had verified consent in clinic with the consultants however, they were filed in the consultant's notes and not always copied in clinic and filed in the patient's notes. They agreed that whilst this was not correct, the patients had consented and changes had been made to the process immediately following our feedback. The hospital took actions to implement new systems to monitor and audit records for consent after the inspection.
- Endoscopy patients reported satisfaction with the consent process in the April 2016 JAG quality of patient experience survey.
- Care of patients living with dementia formed part of the mandatory training programme for most staff although substantive staff in the endoscopy unit were not required to take this.Staff were required to undertake training in caring for patients subject to a Deprivation of Liberty Safeguards authorisation. This included using modified pathways of care and treatment and working with carers to ensure patients were comfortable. In June 2016, 98% of staff had completed this training. This was better than the hospital's minimum target of 95%.
- Pre-admission checks required staff to complete a dementia assessment on all patients over the age of 75. The minimum target for this was 98%. In all four quarters of 2015/16, this target was met on only one occasion, in the final quarter. Compliance in the other quarters was between 89% and 90%.
- Staff discussed treatment plans and options with patients as part of the pre-admission process. This included providing support to patients to make decisions where different treatment options were available.
- When people lacked mental capacity to make a decision, staff made 'best interests' decisions in accordance with legislation and with guidance from the safeguarding lead.
- Staff discussed the side effects of chemotherapy with patients as part of the pre-admission process and throughout treatment. This included the provision of printed information and signposting to community support services.

Are medical care services caring?

Good

Overall, we rated medical care services at the hospital as good for caring because:

- We saw that on all interactions with patients, staff were kind, caring and respectful.
- Medical services performed consistently well in the Friends and Family and Joint Advisory Group quality of patient experience questionnaire for privacy and dignity.
- Patients told us they felt cared for, safe and secure.
- Patients reported they felt involved in decisions about their care.

- Counselling, bereavement and psychology services were available.

Compassionate care

- Staff demonstrated an understanding and respect of patient's personal, cultural, social and religious needs during their pre-admission assessment and treatment.
- Staff took the time to interact with patients and their relatives in a respectful and considerate manner and with a sensitive and supportive attitude.
- We spoke with two patients who were cared for on the endoscopy unit. Both patients told us they were happy with the care shown by staff. One patient said, "I like the quiet environment. I feel safe here and think everyone is very accessible."
- A patient under the care of the chemotherapy service described nurses as "great, fabulous".
- Staff in the endoscopy unit collected feedback from NHS patients using the national Friends and Family test. The latest available results were from May 2016 and showed 100% of patients would recommend the unit although day case survey response rates were typically below 12% in day case services.
- As part of its Joint Advisory Group (JAG) accreditation, the endoscopy unit performed a monthly assessment of the quality of patient experience. The latest available results were from April 2016 and were displayed in the unit. All patients in this survey reported satisfaction with how staff maintained their respect and dignity.
- Privacy and dignity were part of the hospital's strategy and core values. We saw staff followed this in practice. For example, staff closed curtains when performing checks on patients in the endoscopy recovery area. Following endoscopic procedures, patients often experienced pain from a build-up of gas. Staff demonstrated compassion with patients who found this embarrassing and ensured they understood this was an expected side effect.
- Clinical endoscopy staff described consultants as "very caring". For example, a nurse told us consultants talked to patients throughout their procedure, explained what was happening and asked them about pain regularly.

Understanding and involvement of patients and those close to them

- Staff demonstrated attention to detail when explaining care and treatment to patients to help them understand this.
- Staff recognised where patients needed extra support and guidance during their time in the hospital and provided this, such as help with mobility or taking the time to talk to them.
- An admission process was in place in the endoscopy unit that meant patients and anyone with them were informed of their planned procedure, introduced to the clinical team and given the opportunity to ask any questions.
- The oncology pharmacist acted as a direct point of contact for patients on discharge and they could call him at any time for support and advice on their medicine.
- A patient in the endoscopy unit told us they had been involved in their care. They said, "I feel in charge of what's going on. The doctor and I agree the next procedure in advance."
- All patients who took part in a JAG quality of patient experience survey in April 2016 reported they were happy with how they had been involved in their care.
- Staff gave detailed information to patients on their care and treatment plan during the pre-admission process. This was confirmed again at the point of admission. Clinicians explained what they were doing and why during procedures and during recovery time.

Emotional support

- Patients had timely access to counselling and psychology services on site. These were offered by staff who understood the impact that treatment or a patient's condition could have on their emotional state and social life.
- Staff were trained in providing emotional support to patients, including holding difficult conversations and supporting patients to make challenging decisions. This included signposting them to appropriate specialist and community organisations.
- Staff empowered patients to support and manager their own health and wellbeing through opportunistic health promotion and by taking the time to discuss their broader health and lifestyle with them.

Requires improvement

Medical care

- The hospital followed national best practice guidance from the National Institute for Health and Care Excellence about regularly assessing their physical and psychological needs. For example, staff made sure needs relating to pain relief, personal hygiene and anxiety were managed.

Are medical care services responsive?

Good

Overall, we rated medical care services at the Rivers Hospital as good for responsive because:

- The referral to treatment time for chemotherapy services was under seven days. There was no waiting list.
- Pre-assessment services were consistently delivered and staffed appropriately.
- The service demonstrated a positive relationship with commissioners and stakeholders in relation to service development.
- Chemotherapy nurses demonstrated an excellent understanding of their patients and planned services around them.
- Staff in the chemotherapy service planned to set up a patient user group of local people to inform the development of a dedicated cancer centre.
- The endoscopy service treated up to 21 patients per day split into two daily clinics. There was no waiting list.
- The discharge protocol ensured GPs received communication decisions in writing within 24 hours.
- The provider had made reasonable adjustments to the environment to improve access for patients and visitors.

However, we also found that:

- The endoscopy unit was very busy and staff told us most informal complaints related to waiting times. The unit performed worse than the national average in the Joint Advisory Group quality of patient experience survey from April 2016 in relation to access and appointments.
- Endoscopy services staff reported an increasing number of procedure cancellations due to consultant availability.
- Staff told us they very rarely cared for patients with dementia and there were no dedicated resources to help them communicate or provide support.
- The endoscopy unit did not have private space for booking patients in and there was very limited space for staff to conduct private telephone calls with patients.

Service planning and delivery to meet the needs of local people

- The service worked with commissioners and stakeholders to ensure services and resources were appropriate based on existing providers or gaps in service in the local area.
- The clinical lead for chemotherapy planned to form a user group of local people who would help to plan the services of a new cancer centre. This would help to ensure services met the needs of the local population. This approach would improve the scope of the service to plan for the local population as feedback and information had not routinely been gathered on this in the past. The clinical lead was new in post and described this as a plan to implement within the next six months.
- The waiting room for endoscopy services included chairs suitable for bariatric patients, which had been provided because of patient and visitor feedback.
- The service demonstrated a positive relationship with commissioners and stakeholders in relation to service development. For example, the hospital was transparent in relation to incidents and complaints and discussed these in terms of service improvement.
- Clinical facilities and treatment areas were appropriate for the purpose they were used for. This included treatment rooms and recovery rooms. There was a lack of space for private conversations and for administration staff.
- Staff maintained relationships with local authority social services to ensure patients with safeguarding needs had access to appropriate and timely services.

- Food and drink was available for relatives 24-hours, seven days a week. Relatives were able to stay overnight in patient bedrooms and beds were provided for them.

Access and flow

- Between January 2015 and December 2015, the service performed 370 chemotherapy procedures. This was delivered based on patient need and the four nurses who delivered this service worked flexibly to provide it. The chemotherapy service did not have a waiting list.
- The time from referral to treatment time for chemotherapy patients was under seven days.
- Chemotherapy nurses demonstrated an excellent understanding of their patients and planned services around them. For example, they were able to visit patients at home to conduct blood tests if needed.
- A nurse-led chemotherapy pre-assessment service was offered, which included blood tests and port flushing the day before treatment. This meant venous access ports were maintained to avoid blockages. An interventional radiologist provided a port and peripherally inserted central catheter service under local anaesthetic.
- An oncology pharmacist prepared individual chemotherapy medicine in advance to reduce patient waiting times when they arrived.
- The endoscopy service treated up to 21 patients per day split into two daily clinics. There was no waiting list. Endoscopy services were typically available between 8.30am and 5pm Monday to Friday.
- Patients were admitted to one of the two inpatient wards by their admitting consultant. Both wards were equipped for medical inpatients and consultants were available in cardiology, gastroenterology, general medicine, nephrology, neurology, oncology and rheumatology.
- Patients were scheduled into the endoscopy unit on a 'staggered' basis throughout morning and afternoon clinic times. This helped to reduce the amount of time each patient spent waiting although staff we spoke with told us waiting times were often excessive due to the number of procedures booked in. There were no formal complaints recorded regarding this and staff told us patients usually discussed this with them at the time.
- Staff documented each procedure in the endoscopy unit. We looked at a sample of five dates in the six months prior to our inspection and found clinic lists were busy. For example, on one morning between 8.30am and 10.30am, a consultant performed 13 procedures. On another date, eight gastroscopy procedures were performed between 9am and 10am. Consultants documented the start and finish time of each procedure. We looked at a sample of times and found some procedures were completed very quickly. For example, we saw a patient had a colonoscopy with sedation and the procedure last nine minutes. During this clinic, the time between patients was a maximum of five minutes.We spoke with clinical staff about this, including the lead consultant. The consultants told us list sizes felt manageable and they did not believe patient safety was compromised. There were no recorded incidents or complaints relating to this.
- The endoscopy unit performed worse than the national average in the April 2016 Joint Advisory Group (JAG) quality of patient experience survey for access and booking. In this survey, the national average was the maximum 'A' grade. This unit scored a lower 'D' grade. An action plan to improve this was not available at the time of our inspection. Senior managers told us after the inspection that, in April 2016, when the hospital submitted its data return to the JAG, it had answered 'no' to having a central booking system and that was why the unit had scored 'D'. Action plans had now been implemented to rectify this score and this would be reflected in an improved rating when the unit receives its new JAG certificate.
- Between January 2016 and June 2016, 3% of endoscopy procedures were cancelled. This represented a low proportion of procedures overall (63 out of 2,133 scheduled) but staff recognised it as an area for improvement. The notice period given to patients was variable with the least notice given two days before the procedure. Procedures were most often cancelled due to the cancellation of a whole clinic or due to consultant annual leave. A dedicated administrator contacted each patient to reschedule as soon as the procedure cancellation was made.
- The local clinical governance committee reviewed endoscopy cancellations and the service had an action in place regarding this. Senior managers told us that any

patient considered urgent, or where there would be a delay in a diagnosis, would be routinely added to the next available list or added to another consultants list to minimise the delay with an explanation to the patient.

- Staff monitored rebooking compliance against hospital governance standards, which required a firm date to be scheduled based on patient need within either five days or 28 days of the cancellation. Between March 2015 and April 2016, all endoscopy cancelled procedures were rescheduled according to these standards.
- Staff used a discharge pathway to ensure each patient had an individualised discharge plan that began at pre-admission. This included consideration of the aftercare they would need as well as recovery time from treatment. Although the policy took account of the principles of effective discharge, it did not include guidance for staff on out of hours discharges.
- The discharge protocol ensured GPs received communication decisions in writing within 24 hours.
- Where the service received an inappropriate referral, the senior clinician in the relevant area liaised with the referring service to ensure patient needs were met and other services understood admissions criteria.
- In the event cancer was identified from an endoscopic procedure, scanning was available the same day. This meant patients had access to rapid assessment and treatment.

Meeting people's individual needs

- All hospital policies and protocols were ratified to take into account the needs of different people on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation. Staff conducted an assessment during the development, review and ratification of policies to ensure it did not adversely affect or disadvantage any groups of people.
- Staff sought to meet individual needs by assessing patients' condition and likely treatment plan during the pre-assessment process. This was on an elective case basis and not based on broad local population needs.
- Where it was identified patient needs were not met, staff took action appropriately to rectify this. This included where patients asked for improvements in catering, car parking and the timeliness of clinics.
- There were no environmental modifications to help patients with dementia. This included a lack of large-print or pictorial signage. Staff training in caring for patients with dementia was also low staff said but records were not available regarding training figures.
- Each recovery bed in the endoscopy unit had a nurse call bell. As patients could be confused after sedation, a nurse explained what the call bell was for and made sure the patient understood this before leaving them.
- Three unisex toilets with disabled access were available in the endoscopy unit as well as an office for private discussions and difficult conversations. This office was shared and was not dedicated to patient discussions.
- The hospital had a range of rooms available for private conversations with patients and relatives.
- The endoscopy unit did not have private space for booking patients in and there was very limited space for staff to conduct private telephone calls with patients.
- All patients receiving chemotherapy were advised to have someone drive them to the hospital as they could not drive home afterwards and they could be dropped off at the front of the hospital.
- Staff sent printed information to patients who were scheduled to attend the endoscopy clinic to help them prepare for their visit as part of the pre-assessment process. This included information on bowel preparation and blood glucose checks for patients with diabetes.
- Staff had access to translation services using a telephone service and through interpreters who could be booked to visit the site with a patient. Services were available on a pre-booked and on-demand service.
- Sign language services were available on-demand at all times. This included British, American, Irish, Farsi and International Sign Language.
- The provider had made reasonable adjustments to the environment to improve access for patients and visitors. For example, hearing loops were installed in reception areas and staff had access to communication resources for patients with learning disabilities. Toilets and showers that could be accessed by people who used a wheelchair were available.

Requires improvement

Medical care

- Staff had access to translation services and communication support for patients with learning difficulties.
- Complex discharges were supported by the multidisciplinary team who liaised with other services where needed, including social services.

Learning from complaints and concerns

- The hospital had a centralised complaints procedure. This was displayed in medical areas and waiting rooms. All of the staff we spoke with understood their responsibilities in relation to complaints and there was a clear escalation policy in place.
- Patients we spoke with said they had not needed to make a complaint but had been made aware of the process.
- There was evidence of learning from informal complaints. For example, a new process in endoscopy ensured staff checked each patient's teeth before they were discharged.
- Between December 2015 and May 2016, there were no recorded complaints attributed to the endoscopy unit.
- Between January 2016 and June 2016, the chemotherapy service received two complaints. Staff followed the provider's complaints procedure in both cases and resolved them both, with the outcomes shared with staff for future learning. This included learning outside of the clinical chemotherapy team, such as with billing administration. In the same period there were no formal complaints received in the endoscopy unit.
- Senior staff maintained a tracker of complaints received. In all cases, the person who received the complaint acknowledged it the same day if this was a working day or the next working day. Where a complaint was not resolved by the initial planned date, staff communicated with the complainant to keep them up to date.
- Senior staff discussed complaints as part of monthly governance meetings. Documentation related to this showed us a multidisciplinary approach was taken to investigating and resolving complaints.
- Staff shared compliments from patients and relatives to identify areas of the service that worked well. For example, one relative wrote to the chemotherapy team to describe their care and kindness as "exemplary".

Are medical care services well-led?

Requires improvement

Overall, we rated medical care services at Rivers Hospital as requires improvement for well led because:

- The risk register for medical care was not updated regularly and in a manner that reduced the risk of disruption to the service. The risk register did not identify risks to the delivery of safe care and treatment that we found during the inspection. These risks to the safety and quality of care and treatment of patients had not been recognised by the service.
- Recorded risks on the corporate risk register had not been monitored and reviewed regularly and there was a lack of clear actions to reduce these risks in place.
- The illegibility of medical records in the chemotherapy service had not been recognised by the service prior to the inspection.
- The lack of documented consent in all patients' chemotherapy records had not been recognised as a risk prior to the inspection. The hospital took actions to implement new systems to address this after the inspection.
- Whilst there was a governance system in place, there was not a robust system to for learning from all incidents and complaints to improve services.
- Medical care services did not have a well-defined vision and strategy, although staff understood the provider's broader strategy and development plans.
- Some staff did not feel confident in raising concerns about staffing levels to senior managers.

However, we also found that:

- Clinical staff said they felt supported on a day-to-day basis and felt the working culture was positive.
- There was a focus on improving patient outcomes.

Vision and strategy for this this core service

- The hospital promoted the provider's values base, called 'The Ramsay Way'. This was designed to ensure staff worked positively in a supportive environment to provide high standards of care and treatment. All of the staff we spoke with understood this and could explain how they applied this to their work, including the recognition of safety as their top priority.
- Chemotherapy and endoscopy staff worked within the vision and strategy of the hospital and corporate body.
- Future plans for the chemotherapy service were based on the need for a specialist, dedicated cancer treatment centre. Staff in the endoscopy service focused on securing more space and staff for their increasing patient numbers. These plans were localised and individual senior staff, or small teams of staff, were leading them. Plans included the reconfiguration of car parking facilities.

Governance, risk management and quality measurement for this core service

- The risk register for medical care was not updated regularly and in a manner that reduced the risk of disruption to the service. The risk register did not identify risks to the delivery of safe care and treatment that we found during the inspection. These risks to the safety and quality of care and treatment of patients had not been recognised by the service. As clinical risks were included on the broad corporate risk register, there was a lack of evidence that appropriate clinical staff and managers worked together to resolve issues.
- There were significant risks to health and safety due to the administration of chemotherapy in carpeted areas. The hospital had not recognised this as a risk before our inspection.
- There was not a local hospital policy for providing intrathecal chemotherapy on site at the time of the inspection: senior managers told us that the national guidance was being followed. The hospital had not recognised this as a risk, however, once we had raised this as a concern, the hospital ceased to provide intrathecal chemotherapy.
- The senior governance team maintained a corporate risk register for the hospital, including medical services. Senior staff did not always act upon risks in a timely manner. For example, an oncology pharmacist had escalated the prescribing risks relating to the lack of an electronic chemotherapy in 2006 but no action had been taken. Although this was reviewed regularly, no change in the risk had taken place. A new electronic prescribing system due to be introduced in November 2016 did not have the capability to include chemotherapy. A process was in place to mitigate the risks associated with this but staff we spoke with did not consider this a long-term solution.
- Clinical governance and risk management was led by hospital-wide governance structure and a system of risk committees. The matron had oversight of clinical risk in medical areas.
- We looked at the minutes of the latest clinical and management meeting for the endoscopy unit. Limited space in the waiting room and overheating were both noted as concerns. There were no action plans or timelines to address these. In addition, there was no documented learning from audits or feedback. This meant clinical governance processes were not focused on ensuring learning from problems was embedded in practice.
- A service level agreement was in place with a nearby NHS hospital to transfer deteriorating patients for emergency or critical care. This policy had been ratified by the appropriate team and reviewed annually.
- The general manager monitored the accreditation of consultants with practising privileges. This included ensuring they underwent a documented annual appraisal at their home trust.
- Staff monitored compliance with the duty of candour as part of monthly governance scoring. This included sharing information with appropriate people and providing written evidence of investigations into incidents and mistakes. Between January 2015 and April 2016, the hospital followed provider requirements in the duty of candour in all cases. As part of the accreditation process, the general manager ensured consultants had appropriate and valid indemnity insurance in accordance with the Health Care and Associated Professions (Indemnity Arrangements) Order 2014.
- Staff in the chemotherapy service planned to introduce treatment-specific audits, including for the use of ports. This would ensure standards of safety and infection control were monitored and controlled.

- For example, not all clinical staff in chemotherapy services had a current job description or protected time for the development of leadership practice and policies.
- Not all clinical staff in endoscopy services had specialised endoscopy training and there was evidence of a lack of support from the senior hospital team. For example, the risks associated with a lack of private space in the unit had not been acted upon by the leadership team.
- Staff in the endoscopy unit said their most significant challenge was managing a very high volume of patients in a small unit with limited staffing. One member of staff said they had to stop consultants taking extra patients when they felt safety could be compromised. They said they felt confident to do this but there was often pressure to "rush patients through". Another member of staff said they did not feel confident in this and said, "I wish we could say no sometimes, especially when [consultants] push more patients onto their list than we can cope with." There were no incident reports to suggest safety had been compromised and the impact of this was on staff morale, fatigue and their concern about the potential for mistakes. This was not reflected on the service risk register.
- Some medical records were not legible in the chemotherapy service. Whilst senior managers stated that the hospital had assurance that, as this was a consultant led service with one named consultant for each patient, any concerns or queries could be raised directly with the patient's named consultant who would be contactable at all times, the risk that illegible records posed had not been recognised by the service. Senior managers stated that nurses and the RMO would have been informed at the time of all aspects of the patient's care and treatment as per the hospital's protocols. The consultant wrote their notes and any updates were then later typed in letter format updating the GP and filed in the patients' notes. All patients had their consultant details on the front of their file on the patient ID label.
- The risk that consent was not fully documented in chemotherapy patient records and staff had proceeded with treatment was not identified as a risk on the risk register or through governance action plans. There was a potential risk that as there was no record of discussions; patients may not have fully understood the treatment and potential risks involved. Senior managers took steps to address this following the inspection.

Leadership and culture of service

- The medical care service was led by the matron and general manager for the hospital. Both endoscopy and chemotherapy services had a senior sister to lead the service.
- Nursing staff in charge of services did not always have appropriate, structured support from the senior team.
- Clinical staff in the endoscopy unit described a positive working environment that was responsive to their needs. For example, a nurse who sometimes worked in the unit said the senior sister was approachable and would always listen when they raised an issue. This unit did not have a permanent team of nurses and instead nurses rotated from the surgical wards. Although this process was informal, staff told us the "unique, small-team" approach worked well to ensure continuity of care.
- Clinical staff we spoke with described the matron and general manager as "visible and very supportive" and said they hoped to see an improvement in how quickly their concerns about space and workload were addressed.
- A system was in place to ensure people using the service were provided with a statement that included terms and conditions of the services being provided and the amount and method of payment of fees. This took place as part of the pre-admission process.
- Staff avoided discrimination including on grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation when making care and treatment decisions. Hospital policies and staff guidance included consideration of such factors and the process of ratification included documented confirmation of equitable access and administration.

Public and staff engagement

- Staff in the endoscopy unit collected patient and visitor feedback using a questionnaire and acted on feedback. For example, they provided a water cooler in the waiting room and maintained a service of tea and toast post-procedure. Staggered appointment times had been introduced following patient feedback and staff explained to each patient the difference between admission time and procedure time to help manage expectations.

Requires improvement

Medical care

- A noticeboard in the endoscopy unit displayed clear, easy-to-understand information from the patient questionnaire and showed patients and visitors what had been changed as a result.
- The hospital conducted a staff survey across the site, although this was not defined by individual service. In the latest survey results, 93% of staff recommended the hospital as a place to work.
- Staff from a cancer network group from four of the provider's hospitals contributed to the planning of a new cancer centre. This included consideration of how the service would be accredited and plans to establish a patient user group.

Innovation, improvement and sustainability

- Staff strived to improve their knowledge and practice through engagement with training in addition to that required to do their role effectively. For example, nurses and healthcare assistants had taken training in ear care, immunisation and occupational health. Senior staff supported healthcare assistants to complete a Diploma in Health and Social Care Level 3. A chemotherapy specialist module was available as part of this.

Good

Surgery

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

Information about the service

Rivers Hospital delivers surgical services from 57 inpatient beds over two wards. Patients from other core services provided at the hospital could also be accommodated in these wards at times. The focus of this core service report is on the care and treatment of surgical patients in these wards and using the service during the inspection. The hospital has four operating theatres, all with laminar flow; laminar low is an airflow system that provides clean air to the operating theatre environment. The wards and theatres are set out in close proximity on the ground floor.

Orchard ward accommodates patients undergoing major surgery with Meadow ward accommodating minor and day case patients. There is a two bedded 'Close Monitoring' unit which can accommodate patients who require closer nursing and medical monitoring.

Patients are admitted under the care of a named consultant, and medical care is supported over 24 hours by an onsite doctor, the resident medical officer (RMO). Patient care is provided by a team of trained nurses, and allied health professionals such as physiotherapists and pharmacists, all employed by the hospital.

The majority of the hospital's work is adult elective surgery. In the reporting period from October 2014 to September 2015, there were 8,579 visits to the operating theatre, and 3671 day case procedures (including endoscopy) undertaken. The majority of the surgical procedures (55%) were NHS funded, with private practice making up the remainder (45%). Orthopaedic and general surgery had the highest activity across both NHS and private work.

We carried out announced and unannounced onsite inspections of Rivers Hospital. The unannounced inspection took place on the 1 July 2016. We visited the inpatient wards, pre-admission clinic, and the operating theatre department. We talked with four patients and four visitors. We interviewed 23 staff including nursing staff, RMO, consultants, and managers, observed care and treatment and reviewed 11 patient records and associated documents. Prior to, and after the inspection, we reviewed performance about the hospital.

Good

Surgery

Summary of findings

Overall, we rated the surgery service to be good because:-

- Staff were caring and compassionate in all interactions with patients during the inspection.
- Patients spoke positively about staff and the information they received pre and post-surgery
- Patients were pre-assessed prior to their admission for surgery, ensuring that any risks were identified and managed appropriately and comprehensive care records were being maintained.
- Effective systems were in place to report, record and learn from incidents and concerns
- Staff, at all levels, were skilled and experienced, and were supported via appraisal to undertake their roles effectively.
- Nurse staffing levels met patients' needs at the time of inspection and were reviewed throughout each day and staffing numbers were flexed to accommodate fluctuations in activity and the complexity of patients care.
- Medical staffing cover was appropriate and there were effective arrangements for out of hours and weekend cover.
- Theatre staff were using the 5 Steps to Safer Surgery (World Health Organisation's checklist for surgery) and had instigated a pre-list 'huddle' to discuss the requirements of the surgical list and the patients who were to receive care.
- Departmental areas were visibly clean, tidy and well-ordered and robust systems were in place to minimise the risk of infections.
- A pharmacy was on site to provide access to medications and we found that medicines were being stored and managed safely throughout the department.
- Care and treatment was delivered based on evidence based care and national guidelines.
- The hospital monitored the Patient Reported Outcomes Score for procedures such as groin hernia repair, primary hip replacement and primary knee replacement. The hospital's patient outcomes were comparable to the national average.
- Staff were supported to maintain and further develop their professional skills and experience. Multi-disciplinary team working was effective.
- The service provided flexibility to provide appointments and admissions to meet patients' needs.
- Access to the service was timely and appropriate discharge arrangements were in place.
- All patients were pre assessed prior to their admission and plans put in place to mitigate any risks identified.
- Individualised care planning was being undertaken based on procedure specific care pathways for all patients.
- Effective systems to record concerns and complaints raised within the service, to review these and take action to improve patients' experience were in place.
- Policies and procedures were in place to support staff in understanding the needs and managing the care of people with complex conditions.
- Senior managers worked effectively to manage risk, develop best practice and to communicate their vision to all areas of the service
- Heads of department were visible and approachable and staff told us that they felt able to approach the managers for advice or to discuss any areas of concern.
- Leadership was clear and focused the staff team on the drive for improvements. Regular departmental meetings took place during which service improvement plans were discussed and their progress reviewed.
- Staff engagement was positive and staff at all levels spoke highly about leaders and the support they received.

Good

Surgery

- Effective risk assessment and risk management systems were in place across the service.

However, we also found that:

- Whilst procedures were in place to ensure that patients were able to give informed consent to their care and treatment, we found that not all staff were clear about who would be able to give consent for the patient's surgery.
- Whilst patient's case notes generally provided clear and comprehensive information about their care and treatment, we found that not all case notes included fluid balance charts where they were required to do so.
- Whilst most staff were aware of how to support people living with dementia and some had had specific training in order to understand the condition, not all staff were clear of how to be able to help patients living with a dementia.

Are surgery services safe?

Good

Overall, we rated surgery services to be good for safe because:

- There were comprehensive systems in place to record, investigate and take action for any reported complaints, accidents and incidents.
- Staff at all levels were involved in the reporting of accidents and incidents and lessons learned were shared throughout the department.
- Patient's records were comprehensive and provided individualised information about patients care and treatment.
- Staff were using a National Early Warning System to identify patients whose condition was starting to deteriorate.
- There were effective systems in place regarding the handling of medicines, including controlled drugs.
- Standards of cleanliness and hygiene were generally well maintained. Generally, reliable systems were in place to prevent and protect people from a healthcare associated infection.
- The design, maintenance and use of facilities and premises met patients' needs. The maintenance and use of equipment kept people safe.
- The service was appropriately staffed and nurse staffing was flexed on a daily basis to take into account fluctuating activity levels and the complexity of patient's care.
- A resident medical officer was on duty 24 hours per day to provide medical support and emergency cover. Admitting consultants were available on call to support the resident medical officer.
- We found that all staff had undergone their annual mandatory training, and all staff had undergone an annual performance appraisal.
- Arrangements were in place to respond to emergencies and major incidents.

However, we also found that:

- We found that not all patients' records contained fluid balance charts where they were
- Not all equipment we checked was visibly clean. We raised this with senior managers, who took actions to address this during the inspection.

Incidents

- An appropriate range of safety information was being monitored by the service.
- Staff understood their responsibilities to raise concerns, record and report safety incidents, concerns and near misses, and to report them internally and externally.
- Incidents were recorded using an electronic reporting system. Staff received training at their induction to learn how to correctly use the system. They understood their responsibilities about reporting incidents and were aware of the types of situations where incident reports should be completed including near misses.
- There were 537 reported clinical incidents between January and December 2015, with four reported serious incidents in the same reporting period. Each incident had been reported and investigated in accordance with the service's procedures for incident management. The root cause of incidents had been identified and improvements plans put in place. Improvement plans had been monitored to ensure progress and effectiveness and had been completed.
- Records demonstrated staff had acted upon incidents that had occurred. Staff told us that reported incidents were sent to senior managers and discussed at staff meetings when necessary. Staff received feedback on incidents and action taken via staff meetings, team briefings and information updates. Minutes of recent meetings contained information about lessons learned from incidents.
- There had been no never events reported for this service in the past year. A never event is described as a wholly preventable incident, where 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.
- Providers are required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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.
- Staff documented use of the duty of candour in incident reports and understood their responsibilities during our conversations. This included speaking with people affected when something went wrong, giving an apology and informing them of action taken as a result.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were generally well maintained. Reliable systems were in place to prevent and protect people from a healthcare associated infection.
- Clinical hand basins were provided in utility areas but not in patient rooms. This meant that at the point of care, staff were washing their hands in patient's private bathrooms. National guidance recommends having dedicated clinical sinks within each ensuite rooms. Department of Health Guidelines 2013 HBN00-09 state that 'Ensuite single bed rooms should have a general wash-hand basin for personal hygiene in the ensuite facility in addition to the clinical wash-basin in the patient's room'. This guidance does not apply retrospectively but this risk was not contained on the service's risk register.
- Hand hygiene posters were on display next to all sinks to remind staff of the correct procedure for hand washing.
- Hand sanitising gel dispensers were available in corridors, ward areas, bedrooms and clinical areas. Staff were observed using hand sanitisers and personal protective equipment as appropriate such as goggles/ visors, aprons and gloves. Staff were observed decontaminating their hands in between patient interventions. Appropriate hand wash facilities were in place along with alcohol gel dispensers.
- The ward areas, theatres and clinical areas all appeared to be visibly clean, tidy, and free from clutter.

Good

Surgery

- The departments visited were all visibly clean and in good repair and had comprehensive cleaning schedules in place.
- Each department had a system of audit to monitor the standard of cleanliness. Audit results showed standards of cleanliness were reported as over 90% compliant with auditable requirements.
- The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed sharps containers, clinical waste bags and municipal waste were properly maintained and was in accordance with current guidelines.
- Storage of equipment was well organised and there was a clear system in place for identifying which piece of equipment had been cleaned.
- There were clear guidelines for staff about how to respond to a sharps injury (needles and sharp instruments). This complied with the Safe Sharps Act 2013.
- All patients who were admitted for surgery were screened for MRSA. There had been no reported incidences of Methicillin Resistant Staphylococcus Aureus, (which is an antibiotic resistant bacteria), or Clostridium Difficile, (which is a bacteria that infects the gut and causes acute diarrhoea) at the hospital during the period between January and December 2015.
- The operating theatre department was found to be visibly clean and tidy and the daily cleaning records were consistently completed. The service had appropriate facilities and systems to meet the National institute for Health and Care Excellence (
- For the period January to March 2016, there was a very low incidence of surgical site infections with no infection for hip replacements, knee replacements had 2 from 87 procedures (2%) which comparable with the national benchmark of 1.5% and other surgical procedureshad 4 out of 465 (0.4%)
- There had been seventeen reported incidents of surgical site infection during the reporting period between January and December 2015. Nine of these infections occurred in orthopaedic patients undergoing hip or knee replacement. Actions plans were in place to monitor this risk.
- The operating theatre department was found to be clean and tidy and the daily cleaning records were consistently completed.
- Staff compliance with infection control e-learning training was 82%, with training in hand hygiene at 97% against a target of 95%.
- Not all equipment we checked was visibly clean: we found dust on C-arm and a dirty weighing chair (which had I am clean sticker on). We raised this with senior managers, who took actions to address this. On the unannounced inspection, we found that all equipment checked was visibly clean.
- We found that there were limited body fluid spillage kits were available in the service. We raised this as a concern with senior managers, who took immediate action to address this by ordering appropriate equipment.
- The service provided care and treatment for some patients in bedrooms with carpets. Staff said that they would wipe up spillages with water and disinfectant and then requested the domestic staff to use the carpet cleaner. The infection prevention and control policy clearly set out which cleaning and disinfectant products should be used at what time.
- All the theatre staff were observed to be wearing appropriate theatre attire and when members of the theatre team left the department they were seen to be wearing disposable coats. However, theatre staff leaving the department did not change their shoes.The Association for Perioperative Practice guidance states that staff leaving the department should wear outside shoes.

Environment and equipment

- The design, maintenance and use of facilities and premises met patients' needs. The maintenance and use of equipment kept people safe.
- There were appropriate arrangements in place to meet the Control of Substances Hazardous to Health Regulations 2002 (COSHH). COSHH is the legislation that requires employers to control substances which are hazardous to health. We saw that cleaning materials used by the staff were stored in a locked room.

- There were systems in place to check and record equipment was in working order. These included annual checks of portable appliance testing of electrical equipment.
- We observed equipment within the department to be in a good state of repair. Records showed that each piece of equipment was registered on the maintenance register and had been serviced and maintained by a company experienced and qualified to do so.
- Staff had received training on how to use the equipment within their workplace.
- Policies and procedures were in place to support staff in the disposal of waste. Staff we spoke with understood how to identify the different types of waste and what method they should use to dispose of it. All areas were tidy with waste removed regularly.
- The theatre department's waste was managed by having a clear method of flow for the disposal of clinical waste and used instrumentation.
- The storage of instrumentation and equipment within the theatre department was well ordered.
- Resuscitation equipment for both adults and children was available both on the ward and within the operating theatres. Resuscitation trolleys were checked each day and the checks were recorded in books that were kept with each individual trolley. Records seen evidenced daily checks had been carried out.
- All members of staff had received training in resuscitation and the use of the equipment provided within each trolley. Records of the training were kept within the main training record.
- Other resuscitation equipment such as oxygen and suction machines were found to be clean, complete and in working order.
- A separate area was in use, which provided for the close monitoring for patients who had been identified as requiring closer surveillance post operatively. These patients were identified during pre-operative assessment or following review by an anaesthetist.
- A hoist with a selection of disposable single use slings were available and situated within the ward area. The hoist was serviced in accordance with manufacturer's instructions.
- Bariatric equipment was available in ward and theatre areas.
- Patient bedrooms in ward areas were well maintained and had appropriate nurse call system. All bedrooms were ensuite. Some bedrooms were carpeted and some had non-slip flooring.
- There was access to a pathology laboratory on site which undertook a full range of diagnostic testing, and provided access to blood and blood products. The laboratory team also managed the onsite blood bank.

Medicines

- There were effective systems in place regarding the handling of medicines, including controlled drugs.
- A comprehensive medicines management policy was in place, which provided staff with clear guidance about how to manage the prescription, storage, and administration of medications.
- The medicines management policy stated that medication management would form part of each staff members' induction. However, review of the induction documentation for theatre staff did not include a section for the management of medications.
- Medications, including controlled drugs and medicines requiring refrigeration were being stored appropriately.
- Controlled drugs were stored, administered and managed appropriately.
- Appropriate systems were in place for the provision and administration of medical gases within theatres. Oxygen cylinders were available for ward areas and were appropriately maintained and stored. Piped oxygen was available for the two bed spaces in the close care-monitoring unit.
- There had been no controlled drug incidents reported in the last 12 months.
- The pharmacy department was open six days a week. There were pharmacists on-call out of hours.There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis.
- A process was in place that identified when and how discretionary medicines could be given. At the time of our inspection, we found that that no discretionary medicines had been given.

Good

Surgery

Records

- Generally, patients' individual care records were written and managed in a way that kept people safe.
- Patient's medical records were stored securely on the wards. There was a separate medical records store for records that were not in current use. These records were stored in a records room uses solely for the purpose of recorded storage. The room was secured with a digital lock to restrict access.
- We looked at eleven patient medical records. A complete set of all aspects of patient care and treatment were kept on site including a record of the initial consultation and treatment provided by the admitting consultant.
- The records contained information of the patient's journey through the hospital including pre-assessment, investigations pathology results and treatment and care provided.
- Whilst patient's case notes generally provided clear and comprehensive information about their care and treatment, we found that not all case notes included fluid balance charts where they were required to do so. Two out of the 11 patients' records we looked at did not have appropriate documentation regarding hydration status.We raised this with the ward sister who took action to address this.
- Whilst the patients care records included clear and concise entries relating to care, we found that in some cases gaps were left between entries. If gaps are left within records, it leaves opportunity to insert information later.

Safeguarding

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Staff understood their responsibilities and were aware of safeguarding policies and procedures. Staff were able to explain the key aspects of safeguarding and how to deal with any incidences of suspected abuse.
- A comprehensive policy was in place to provide staff with guidance in relation to identifying and reporting any suspected safeguarding incidents. This policy reflected local safeguarding arrangements.
- The hospital implemented an action plan in April 2016 to address a decrease in the compliance rate of staff with safeguarding training. This occurred due to a system problem with electronic learning equipment. The problem had been resolved and the action plan was due to be completed in July 2016, when all staff groups would meet or exceed the hospital target of 95% safeguarding. In June 2016, compliance with level one training was 93%, compliance with level two training was 99% and compliance with level three and level four training was 100%. This was a combined safeguarding children's' and adults total.

Mandatory training

- The service had a mandatory training programme that included basic life support, information governance, infection control, health and safety, fire safety, data protection, information security, customer service and manual handling.
- Not all staff had undergone mandatory training, including training including adult and paediatric resuscitation, fire safety, infection control and moving and handling. Hospital overall compliance rates were 69% against a target of 95%. We saw that the service had a regular plan for updating all staff's training.
- Staff we spoke with told us that the training they received provided them with the information they required to continue safe practice.
- There was an induction programme for all new staff, and staff who had attended this programme felt it met their needs. Staff told us this training met their needs and they did not have any difficulties accessing training.

Assessing and responding to patient risk

- Comprehensive risk assessments were carried out for patients' and risk management plans were developed in line with national guidance. Risks were managed positively.
- Every patient who was referred for surgery was asked to complete a medical questionnaire. The information submitted was reviewed by a registered nurse who was experienced in patient pre-assessment. Depending on the information contained within the questionnaire and the complexity of the procedure for which the patient was due to be admitted the patient was then pre assessed by an experienced registered nurse either by

telephone or face to face. If, following a face-to-face assessment, the registered nurse had any concerns about the patients suitability to undergo surgery, the registered nurse arranged for the patient to see an anaesthetist or cardiologist who would then assess the patient and confirm whether it was appropriate for them to proceed to surgery.

- The care pathways used included risk assessments such as risk of falls, assessment of mobility and assessment of the risk of skin damage.
- Staff were using the National Early Warning Score, a national system, to ensure that any deterioration in a patient's condition was quickly identified and appropriate action taken in a timely manner. This system had been used in all the records we reviewed. We saw that where a patient's condition had deteriorated, appropriate escalation for medical review had occurred.
- The 'Five steps to safer surgery checklist' (World Health Organisation's checklist for surgery) was used. The two checks we observed in theatres were carried out safely and
- The service used ASAsurgery. Patients identified with several co-morbidities and classified as ASA 3 and above were routinely referred to an anaesthetist in accordance with the hospitals pre-admission policy. Anaesthetists had recorded their assessment on the anaesthetic sheet including the patient's height and weight and the ASA classification score.
- An appropriately trained resident medical officer (RMO) was on duty 24 hours every day on site and available to attend all concerns and emergencies. Nurses had had advanced life support training for patients in post-operative recovery.
- There were appropriate arrangements for ensuring blood required for elective surgery was available when required, and for obtaining blood in an emergency. There was access to the minimum requirement of two units of emergency supplies of O Rhesus negative blood. The blood fridge temperature and stock were checked and recorded daily.
- If a patient became unwell after treatment, there were arrangements for the patient to be seen promptly by the RMO and if necessary reassessed by the admitting consultant or anaesthetist where required. Consultant support was available and consultants able to attend site within 30 minutes of being called.
- There was a formal arrangement for patients to be transferred to the local NHS hospital if the patient required critical care to level two or level three.If a patient deteriorated, the consultant would arrange for transfer to the local NHS trust. There was a policy to support this process and a SLA between the hospital and the local NHS trust.
- The practicing privileges agreement required consultants to be contactable at all times when they had patients in the hospital. The guidelines said that consultants needed to be able to attend the hospital within half an hour, according to the level of risk to the patient.
- There is a two bedded 'Close Monitoring' unit which could accommodate patients who require closer nursing and medical monitoring. Patients were admitted into this area had been identified as needing closer monitoring during their surgical pre assessment or following anaesthetic assessment. There were no patients in this area at the time of our visit.
- The service had effective systems in place for monitoring risk from Venous Thromboembolism. Safety was monitored using a system of assessment of risk, with all patients being assessed for their risk of developing venous thromboembolism (VTE). Records showed that over 99% of all patients were screened for their risk of developing VTE. Four patients had developed VTE or pulmonary embolism in 2015 and these incidents had been investigated.

Nursing staffing

- Staffing levels and skill mix were planned so that people received safe care and treatment at all times. At the time of our inspection, we found staffing levels on the wards and in theatres was appropriate to meet the needs of the patients in the hospital.
- We saw evidence that all registered nurses and professional staff that worked in the wards and theatres had valid nursing and midwifery registration or were registered with the Health and Care Professions Council. This confirmed that nurses and other practitioners, such

as operating department practitioners and physiotherapists, were trained and eligible to practise within the UK. There was a process in place to ensure these were updated which was reviewed monthly and staff reminded of the need to renew their registration.

- The service was appropriately staffed and staffing was flexed on a daily basis to take into account fluctuating activity levels and the complexity of patient's care.
- We reviewed the staffing rotas for each department and found that staffing numbers and the mix of skill was appropriate for the complexity of the patient caseload.
- There was no formal tool in place to assess patient acuity and hence inform staffing decisions, however staff rotas were reviewed on a shift-by-shift basis and staffing numbers and skill mix was adjusted to reflect activity and complexity of cases.
- Nurses and patients told us there were always enough staff to maintain the smooth running of the service and there were always enough staff on duty to keep patients safe.
- Theatre staffing was planned in line with the Association of Perioperative Practice guidelines.
- The ward handover was observed provided thorough information about each patient condition and care. Whilst individual staff made individual notes for each shift, there was no formal documentation of the handover process.
- Departments were staffed using regular members of the team. There was no recorded use of agency staff within the ward areas in the past year. Agency usage in theatres was at a minimum.
- Staff who were from a nursing agency or were a member of the hospital nursing bank undertook a brief induction to the department, which were recorded.

Surgical staffing

- Patient care was consultant led. The hospital practising privileges agreement required that the consultant visit inpatients admitted under their care at least daily, or more frequently according to clinical need or at the request of the nurse in charge or the resident medical officer (RMO).
- Our review of patients' case notes showed that daily medical entries had been made by consultants.
- There was an up to date out of hour's on-call list for consultants. Most consultants worked in specialty groups and provided cover for one another. If the consultant was not part of a specialty group, they had formally arranged for a colleague to provide cover in their absence. Staff said this on call rota generally worked effectively and that consultants were accessible when required.
- RMOs were employed through an agency the hospital's parent company had a formal contract with. They worked a two week on two week off rota then handed over to the other RMO. The RMO told us that they were never asked to complete a procedure that they did not have the skills to undertake.
- The RMO attended the evening nursing handover to ensure that patient care and treatment overnight was discussed.
- The hospital had a database of consultants who had been granted practising privileges that was also monitored centrally as well as locally. This included the status of each consultant about their indemnity, appraisal, General Medical Council registration and . At the time of the inspection, the consultants were seen to be compliant with all checks.

Major incident awareness and training

- Arrangements were in place to respond to emergencies and major incidents. There was a major incident policy in place.
- There was good understanding amongst staff about their roles and responsibilities during a major incident.
- 90% of staff were up to date with their annual fire safety training.
- Checks of fire extinguishers and emergency lighting had taken place at regular intervals. Records of recent fire drills and fire training within the last 12 months were maintained. We saw the fire evacuation route was clearly signposted.
- The service had a back-up generator in the event of power failures and this was of sufficient capacity to provide three days' worth of emergency power.

Good

Surgery

Are surgery services effective?

Good

Overall, we rated the service to be good for effective because:

- Patients care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- The service had effective evidence based care and treatment policies based on national guidance.
- We saw evidence of robust multidisciplinary working with staff, teams and services working together to deliver effective care and treatment.
- Staff had the necessary qualifications and skills they needed to carry out their roles effectively.
- Staff were supported to maintain and further develop their professional skills and experience.
- Staff generally had the necessary information they needed before providing care and treatment.
- The service ensured that patients were given effective pain relief.
- Patients' nutrition and hydration needs were assessed and generally plans of care with appropriate documentation were in place when required.
- Information was being collected to monitor patient care outcomes, and this information was used to improve practice. Outcomes were generally comparable to the national average.
- A safe system was in place to ensure each patient was able to give informed consent to their care and treatment.
- Where a patient lacked the capacity to consent a protocol was in place to undertake a Mental Capacity Assessment and to make a decision in the patient's best interests.

However, we found that:

- Some junior nursing staff told us that they were unsure about who could provide consent if a patient lacked the capacity to consent to their treatment.

Evidence-based care and treatment

- Patients' care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- Patient's needs were assessed taking account of their physical, clinical and mental health.
- Consultations, assessments and care planning and treatment were carried out in line with recognised general professional guidelines. A review of a sample of medical records and discussions with the clinicians on duty confirmed this.
- Policies were in place to ensure patients were not discriminated against. Staff were aware of these policies and gave us examples of how they followed this guidance when delivering care and treatment for patients.
- Policies were available on the hospital's intranet and staff were able to demonstrate how they gained access to them.
- Staff told us that adherence to local policies and procedures were monitored with a schedule of local audits, however, we only say audits for infection control, hand hygiene and various environmental audits. Venous thromboembolism (VTE) assessments were recorded and were clear and evidence-based, ensuring best practice in assessment and prevention and regular audits undertaken.

Pain relief

- The service ensured that patients were given effective pain relief.
- Patients said that their pain was effectively managed by the staff.
- The hospital met the national guidance from the Faculty of Pain Medicine (2015): Core Standards for Pain Management Services. This was because patients with acute pain had an individualised analgesic plan and staff conducted regular pain assessments using appropriate tools. The surgical pathways that were in use prompted staff to assess and record if pain was being managed effectively.
- The post-operative pain management policy provided a pain assessment score and provided guidance for staff

to follow. This assessment was part of the National Early Warning Score that was in place for each patient. This system highlighted any deterioration within the patient's condition where medical intervention was required.

- Our review of 11 patients' records found that this system was being used appropriately and that pain scores were recorded regularly. Where it was noted that the patient's pain score was increased the intervention, such as the administration of analgesia, had been recorded.

Nutrition and hydration

- Patients' nutrition and hydration needs were assessed and generally, plans of care with appropriate documentation were in place when required.
- Staff completed an assessment of patient's nutritional status and their needs as part of their initial nursing assessment and updated this, if their condition changed, during the patient's stay.
- Intravenous fluids were not always prescribed, administered, and recorded appropriately. Eight out of nine fluid balance charts had been completely accurately, however, we found in one case that intravenous fluids had not been recorded accurately and running totals not completed. We raised this with the ward sister, who took action to address this.
- People undergoing weight loss surgery had been reviewed by a dietician during the pathway to assess their suitability for surgery.
- Post-operative nausea and vomiting was managed by a regime of intravenous fluid and anti-emetic medication. The balance of patient's body fluid level was recorded until they were fit enough to eat and drink normally to ensure that the remained hydrated.
- Pre-operative fasting guidelines were aligned to the recommendations of the Royal College of Anaesthetists (RCOA) with patients on morning or afternoon lists fasted appropriately.
- The catering service had systems in place to meet each patient's individual dietary requirements. When the catering department was closed, patients had access to food, for example sandwiches and fruit. The catering department ensured the ward had suitable supplies to meet patients' needs.
- Patients we spoke with were positive about the food they had received.

Patient outcomes

- The service had an effective system to regularly assess and monitor the quality of service patients received and their outcomes. To facilitate this there was evidence the service carried out clinical audit and risk assessments.
- Information was being collected to monitor patient care outcomes, and this information was used to improve practice. Outcomes were generally comparable to the national average.
- The hospital participated in some national audits, such as the elective surgery Patient Reported Outcome Measures (PROMS) programme and the National Joint Registry (NJR).
- Data was collected in line with PROMs from patients who had undergone groin hernia repair, primary hip replacement and primary knee replacement. The collated data for each procedure showed that the outcome for patients treated at the hospital was in line with the average outcome for patients undergoing the same procedure in England.
- The service regularly reviewed the effectiveness of care and treatment. Each patient was followed up two days after their discharge and their progress reviewed. Patient also had the opportunity to complete a satisfaction questionnaire, the results of which were collated and benchmarked against other hospitals in the same group. Areas for improvement had been identified and action plans had been put in place to improve services.
- There had been 18 cases of unplanned transfer of an inpatient to another hospital between January and December 2015. This represented a very small percentage of the hospital's activity.
- There were 30 cases of unplanned readmission between January and December 2015. This represented a very small percentage of the hospital's activity.
- The five steps to safer surgery checklist record, designed to prevent avoidable harm was completed for patients undergoing invasive procedures. Completion of the checklist was audited and findings shared with the appropriate teams.

Good

Surgery

Competent staff

- Staff were qualified and had the skills they needed to carry out their role effectively.
- Staff were supported to deliver effective care through appraisal and reflective practice.
- Robust recruitment practices were in place which ensured that staff recruited were skilled and competent to undertake their role.
- For professionally registered staff, their registration status was checked as part of the recruitment process and then annually thereafter.
- A probationary period was in place to ensure that staff employed were competent before their employment was made permanent.
- All staff underwent annual appraisal. Staff said their appraisals also identified developmental needs. Appraisal compliance for the service was 95%, which met the service's target. Staff told us that they had clinical supervision, but this was rarely documented. The service did not have a formal policy in place regarding staff supervisions. Staff said they had appropriate ad hoc support whenever required.
- The service had named lead practitioners in a number of key areas such as resuscitation, close care monitoring, infection control and dementia.
- In-depth resuscitation training was available for staff. Staff members from the hospital ran resuscitation courses, which were attended by external delegates.
- Senior theatre staff had undertaken training on a recognised course to act as first assistant to the surgeon. Their continued competence was reviewed as part of their annual appraisal.
- The role of the medical advisory committee (MAC) included ensuring that consultants were skilled, competent and experienced to perform the treatments undertaken. Practising privileges were granted for consultants to carry out specific procedures. The MAC checked registration with the General Medical Council (GMC), the consultants registration on the relevant specialist register, DBS check and indemnity insurance.
- Practising privileges for consultants were reviewed regularly. The review included all aspects of a consultants performance.

Multidisciplinary working (in relation to this core service only)

- We saw evidence of robust multidisciplinary working with staff, teams and services working together to deliver effective care and treatment. Staff told us they felt supported, and that their contribution to overall patient care was valued.
- There were suitable arrangements in place for working with other health professionals to ensure quality of care for their patients. There was effective collaboration and communication amongst all members of the multidisciplinary team to support the planning and delivery of patient centred care.
- Heads of department attended regular morning meetings with the senior staff (called the 10 at 10) where the day's activity was discussed and any concerns highlighted. Staff said communication was effective throughout the staff team. Staff then worked together to ensure safe delivery of services.
- Details of all treatment patients had received were communicated back to their referring medical practitioner when they were discharged from the service at the end of their treatment. Discharge checklists were used to ensure patients were safely discharged and had all the information they needed.

Seven-day services

- Consultants were on call seven days a week for patients in their careStaff we spoke with confirmed that consultants reviewed patients at the weekend.We saw this recorded in patients' notes also.
- The resident medical officer (RMO) was available 24 hours per day, over 7 days of the week. There was 24 hour a day RMO cover in the hospital to provide clinical support to consultants, staff, and patients.
- The pharmacy was open six days per week, with pharmacists on call when the department was closed.
- A pathology laboratory was on site and was opened seven days a week. The laboratory was run by a third party company.

Good

Surgery

- Physiotherapists were available seven days per week, either on site or on call by arrangement.
- A blood bank was on site with access to blood and transfusion services seven days per week.
- There was a senior manager on call 24 hour a day for staff to access for support an advice.
- There were on-call arrangements in place to provide staffing if a patient needed to return to theatre.
- The medical imaging department at the hospital provided an out of hours on call service to support any patient care requirements.

Access to information

- Patient information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way.
- Medical staff confirmed they received appropriate information when the patients were referred. We saw that medical practitioners' referral documentation was in all patient notes reviewed. This meant when a patient was admitted for surgery, clinicians had all the information they needed including test results.
- Nursing staff could access the information they needed to assess, plan and deliver care to patients in a timely was and there were secure systems to manage care records.
- All staff had access to all the hospitals local and corporate policies via the company intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to care and treatment was obtained in line with legislation and guidance.
- A safe system was in place to ensure each patient was able to give informed consent to their care and treatment.
- Where a patient lacked the capacity to consent a protocol was in place to undertake a Mental Capacity Assessment and to make a decision in the patient's best interests in accordance with the Mental Capacity Act (2005).
- There was a consent policy in place and we looked at 11 sets of patient notes and saw consent forms were fully completed, signed and dated by the consultant and patient. There was also a document to fully record consent to anaesthetic.
- The forms identified the planned treatment, intent of treatment and the associated risks and benefits.
- A separate consent form was in place to be used when a patient lacked the capacity to consent. This form contained a section where a mental capacity assessment could be
- Staff told us that they had received training in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguard (DoLS), at the time of inspection there was 100% compliance.
- However, some junior nursing staff said that they were unsure about who could provide consent if a patient lacked the capacity to consent to their treatment. Senior staff said that they would seek advice form the service's dementia lead if there were concerns about a patient's capacity.

Are surgery services caring?

Good

Overall, we rated the service to be good for caring because:-

- During the inspection, we saw and were told by patients, that all staff working in the service were kind, caring and compassionate at every stage of their treatment.
- People were treated respectfully and their privacy was maintained in person and through the actions of staff to maintain confidentiality and dignity.
- Staff involved patients and those close to them in aspects of their care and treatment. Information about treatment plans was provided to meet the needs of patients.
- Patients we spoke with during our inspection were very positive about the way they were treated.

Good

Surgery

- All staff were sensitive to the needs of all patients and were skilled in supporting patients with complex needs.
- Patients told us that staff spoke with them about their care and treatment, and that staff were sensitive to their needs at all times.

Compassionate care

- We observed staff interacting with patients and their relatives in a caring and respectful way.
- Patients told us that staff spoke with them about their care and treatment, and that staff were knowledgeable and sympathetic to their needs.
- Results from the Friends and Family survey were positive and with results higher than 80%. The overall recommender score for the hospital was high during the period between July to December 2015.
- Privacy and dignity was observed being maintained. We observed theatre staff ensuring that patients were not unnecessarily exposed during procedures.
- We saw that the ward staff asked patient's permission before they entered patient's rooms at all times. We observed staff knocking on doors before entering rooms. Patient's dignity and privacy was respected at all times
- Patients told us that staff were kind and knowledgeable. All patients, and their relatives, told us that nothing was too much trouble for the staff.
- We observed a good rapport between patients, medical and nursing staff.

Understanding and involvement of patients and those close to them

- Staff communicated with patients so that they understood their care, treatment, and condition and recognised when patients needed additional support.
- New patients were asked to complete a comprehensive medical history and questionnaire. This questionnaire enabled the clinicians to gather important information about their previous medical and relevant social history. They also aimed to capture details of the patient's expectations in relation to their needs and concerns.
- Patients told us that staff spoke with them about their care and treatment options, and that staff were knowledgeable and sympathetic to their needs.
- Patients' said they were kept informed of their treatment at all times.
- Patients were given a copy of their treatment options and for self-paying patients the associated costs of the treatment planned. We found planned care was consistent with best practice as set down by national guidelines
- Patient's specific needs were identified during the pre-assessment, such as if a patient required an interpreter or required support with their mobility.
- The hospital had open visiting this meant that patients could be supported by friends and family.

Emotional support

- Staff demonstrated a good understanding of the emotional impact surgical treatment can have on patients' well-being. We saw staff were passionate about working within the service and providing good quality care for patients.
- Staff demonstrated a good understanding of individual needs of patients and a breadth of experience in ensuring the emotional impact of surgical treatment was minimised.
- Pre-admission assessments included consideration of patient's emotional well-being
- Patients told us that staff had time to listen to their concerns and to provide detailed information about their care and treatment.
- Staff were able to signpost patients to local advisory groups to offer both practical advice and emotional support to them and their carers.

Are surgery services responsive?

Good

Overall, we rated the surgical service to be good for responsive because:

- The service provided flexibility to provide appointments and admissions to meet patients' needs.
- Access to the service was timely and appropriate discharge arrangements were in place.

Good

Surgery

- All patients were pre-assessed prior to their admission and plans put in place to mitigate any risks identified.
- Individualised care planning was being undertaken based on procedure specific care pathways for all patients.
- Effective systems to record concerns and complaints raised within the service, to review these and take action to improve patients' experience were in place.
- The service received and acted upon feedback relating to complaints, accidents and incidents. Any lessons learned were communicated throughout the department.

However, we also found that:

- Whilst, there were systems to ensure that services were able to meet the individual needs, for example, for people living with dementia, not all staff were clear about how to support these patients.

Service planning and delivery to meet the needs of local people

- The booking system was flexible allowing patients, where possible, to select times and dates for treatment to suit their family and work commitments.
- Senior managers held a brief daily meeting to discuss the service and anticipated workload and daily planning activities for the service.
- Consultants had planned and dedicated theatre lists, which enabled patients to be booked onto these lists in advance.
- Staffing was flexed to deal with fluctuating activity levels.
- Patients told us they could decide on the date and time of their admission.
- Car parking was made available to patients prior to appointments. The service was also planning an expansion to the car park facilities.
- The service had its own pharmacy on site and had service level agreements with an independent provider for pathology tests and provision of blood products.

Access and flow

- The service did not have any waiting lists. Patients were seen within one to two weeks from referral.
- Access to the service was timely and appropriate discharge arrangements were in place.
- The hospital's admission policy and local contracts ensured patients received a pre-operative assessment. All patients were assessed and this meant patients were identified as being safe for surgery and unnecessary cancellations were avoided where possible. This meant that patients, who had co-existing conditions, were identified promptly so that any pre-operative tests, for example blood tests, could be arranged. This minimised unnecessary cancellations.
- Patients with multiple comorbidities were assessed by a consultant anaesthetist and if they were assessed as unsuitable, their admission was deferred.
- Comprehensive discharge information was provided to general practitioners in the form of a letter from the consultant detailing the patient's care and any post discharge care instructions and prescribed medications.
- Staff began planning the patient's discharge during the pre-admission process where they gained an understanding of the patient's home circumstances and daily care needs.
- Detailed information was sent to the patient's general practitioner following their discharge from hospital. Patients were also given clear information about their care, treatment and any post discharge interventions, such as the date and time arranged for suture removal or any physiotherapy appointment.
- The service carried out audits on patient notes, including discharge arrangements, but the service did not carry out specific audits of the discharge process, for example, medications to take home, or transport arrangements.
- If there was a need for a patient to return to theatre for a further procedure, the hospital had an on-call theatre team, who were called into the hospital ensuring that there was safe staffing available.

Meeting people's individual needs

Good

Surgery

- The service planned to take account of the needs of different people, for example on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation.
- Policies and procedures were in place to support staff in understanding the needs and managing the care of people with complex conditions. Policies were also in place to support staff in understanding the requirements of Mental Capacity Act and how issues related to people's capacity to make decisions affected their care.
- Individualised care planning was undertaken based on procedure specific care pathways for all patients.
- Whilst most staff were aware of how to support people living with dementia and some had had specific training in order to understand the condition, not all staff were clear of how to be able to help patients living with a dementia. Staff would seek support from the hospital's dementia link nurse in these cases.
- Staff told us that if they thought a patient had dementia or lacked capacity to make decisions they would raise this with their manager.
- Arrangements, such as access to a language telephone line, were in place so that an interpretation service was available for patients who required it.
- The service had a range of leaflets available for different procedures that gave clear information about pre and post-operative care. However, these were not readily available in different formats. Staff said they would prepare individual information leaflets for each patient to reflect their needs.
- Wards had a patient lounge available for patients and visitors. Visitors could request refreshments from the catering department whenever required.
- Where relatives wished to stay overnight, appropriated arrangements would be made by the staff to accommodate this.
- The service was able to accommodate patients in wheelchairs or who needed specialist equipment, for example, bariatric patients.

Learning from complaints and concerns

- The service received and acted upon feedback relating to complaints, accidents and incidents. Any lessons learned were communicated throughout the department.
- Patients we spoke with knew how to make a complaint or raise concerns, and were encouraged to do.
- The service used the hospital's complaints procedure and staff were aware of their role in resolving complaints.
- Systems were in place to learn from complaint and incidents. The root cause of complaints and incidents was investigated and any emerging trends monitored. Service improvement plans were then put in place to prevent recurrence.
- Senior staff told us that they were involved in the investigation of complaints, concerns and incidents. They explained that the causes of any incidents or complaints were investigated and any lessons learnt were communicated to their teams via departmental meetings.
- Complaints were reviewed by the senior management team on a weekly basis to review progress on responses. Trends were monitored and emerging themes identified.
- The service had received 105 complaints during January to December 2015. These had all been logged and investigated in accordance with the hospital's policy. We were told that complaints lodged were acknowledged within two working days and a full response was issued within 20 working days in line with the hospital's policy. Areas for improvement had been highlighted (such as the choice of meus available) and action plans put in place. A system was in place to identify and act upon any emerging trends.
- Information for patients about how to make a complaint was detailed within complaints' leaflets which were available throughout patient areas.

Good

Surgery

Are surgery services well-led?

Good

Overall, we rated the surgical service to be good for well led because:

- Senior managers worked effectively to manage risk, develop best practice and to communicate their vision to all areas of the service.
- Heads of department were visible and approachable and staff told us that they felt able to approach the managers for advice or to discuss any areas of concern.
- Staff were aware of the systems in place to manage clinical governance and the quality of service delivery, they were also aware of the part they played in reporting complaint and incidents.
- Staff engagement was positive and staff at all levels spoke highly about leaders and the support they received.
- A patient focus group met regularly to discuss service developments and to monitor patient experience.
- Staff were generally aware of risks in their own department, including awareness of the procedures in place to mitigate risk.

Vision and strategy for this this core service

- Staff were clear about the hospital's vision and values and the provider's overarching vision called "The Ramsey way".
- Staff were able to articulate that the vision of the service was to continuously improve the quality of the services in order to provide the best care and optimise health outcomes for each and every patient accessing the services.
- Whilst the service did not have a defined specific surgery strategy, the developments for the service were included in the hospital's overall strategy,
- Senior managers were committed and enthusiastic about taking the service forward.
- Staff we spoke with understood their role and what was expected of them. They were enthusiastic about the service and the future development plans.
- Staff engagement was positive and staff at all levels spoke highly about leaders and the support they received.

Governance, risk management and quality measurement for this core service

- Generally, there were arrangements in place to ensure that the information used to monitor and manage quality and performance was accurate, valid, reliable, timely and relevant.
- Effective risk assessment and risk management systems were in place across the service.
- Governance, quality and risks were managed by senior committees including the medical advisory committee (MAC), which oversaw the granting of consultants admitting privileges, monitored clinical performance and practice development.
- There was an effective governance structure within the hospital which consisted of various sub committees. All of these committees had terms of reference which accurately reflected their role in the hospital, their structure and purpose.
- The hospital had a schedule of audits with associated timescales. Audit reports were reviewed at meetings and results shared with staff through heads of department.
- There was a clinical governance committee which considered a range of complaints, incidents, health and safety issues and patient satisfaction.
- There was a hospital wide risk register in place however the register lacked sufficient detail to provide adequate assurance about the appropriate identification and management of clinical and corporate risk, the mitigating actions, the level of improvement and latest progress update.
- Staff were generally aware of risks in their own department and on the register, including awareness of the procedures in place to mitigate risk.
- Clinical effectiveness and audit meetings were attended by departmental leads, heads of clinical services, and

the governance lead for the hospital. This committee monitored and discussed a range of hospital issues such as safety alerts, shared learning from incidents, policy updates and reported to the corporate governance committee.

- The team safety 'huddle' meetings in the operating theatres had been introduced to ensure a safe and effective service.

Leadership / culture of service related to this core service

- The service was led by the two nursing heads of department: one for the wards and one for theatres. The MAC chairman was the medical lead for the surgery service.
- Leadership was clear and focused the staff team on the drive for improvements. Regular departmental meetings took place during which service improvement plans were discussed and their progress reviewed.
- Staff were aware of the plans for hospital development especially the planned expansion to theatres and the ward areas.
- Heads of department were visible and involved in the day-to-day running of their services.
- Staff engagement was positive and staff at all levels spoke highly about leaders and the support they received. Staff told us they were supported to undertake training to ensure they remained competent in their role. They also said that their managers were approachable and would effectively handle any issues they raised.
- Staff told us that they felt supported and able to approach their head of department for advice or with any concerns.
- Staff were aware of their responsibility to be open and honest when things went wrong and their responsibilities under the duty of candour and whistleblowing.
- Staff morale was generally positive and staff spoke positively about their line managers.

Public and staff engagement

- A patient forum met regularly to discuss service delivery from the patient's aspect. Service improvement issues identified were actioned and followed up.
- A patient satisfaction survey was undertaken to ensure areas requiring improvement were identified.
- Staff said they were regularly asked for their views about how the service could be improved.

Innovation, improvement and sustainability

- The hospital had a strong ethos of financial planning and surgery services were a key part in this forward focused strategy.

Requires improvement

Services for children and young people

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

Information about the service

Rivers hospital has 57 overnight beds and nine day case beds. Children and young people are treated as day cases from three years to 16 years and are discharged by 9pm on the day of their procedure. Paediatric procedures are booked in on specific days in order to ensure there is paediatric nursing cover. There is one registered Nurse (child branch) sister who works 37.5 hours per week and a registered Nurse (child branch) nurse who works 30 hour per week. Any additional paediatric nursing requirements are covered by the same paediatric bank nurse.

Children are cared for in four rooms on Meadow ward. Children's services at the hospital covers a range of disciplines, including surgery, diagnostic imaging, endoscopy and dental extractions.

Children from zero to two are seen as outpatients only. The outpatients department has a range of specialisms with consultants specialising in general surgery, ear nose and throat (ENT), oral facial maxillary, urology, general paediatrics, dermatology and plastics. The physiotherapy department treats children and young people from birth to 18. The radiology department undertakes a range of imaging for children, including plain x-rays, MRI, CT and ultrasound scans.

Between January and December 2015, the outpatient department saw 380 children aged zero to two, 219 children aged three to 15 years and 1,157 children aged 16 and 17 years. There were 211 day cases for those children aged three to 15 and 39 day-case discharges for those children aged 16 and 17. There were also five overnight discharges for aged 16 and 17 year olds.

Summary of findings

Overall, we rated the children and young people's service to be requires improvement. We rated the service as good for safe and caring and requires improvement for effective, responsive and well led. This was because:

- Some risks to children and young people using the service, especially regarding security, had not been recognised, assessed or mitigated against before our announced inspection. However, the service took immediate action once we raised these concerns and this had improved by the time of our unannounced inspection.
- Whilst there was evidence that the service was scrutinised and discussed at a local level, there was a lack of recognition of the service as separate from adult services provided. There was little security and access was not especially enhanced to offer robust protection to children at the time of the inspection. Whilst this was addressed in the days following our inspection, it had not been previously recognised as an issue by the senior leadership team. Children were nursed in the rooms nearest to the nurses' work station. The rooms were not for the sole use of children. There were some adaptations made to meet the needs of children and young people, for example, cartoon character duvet covers.
- The hospital was a predominantly adult environment, with some adjustments made for children and young people, all of whom were treated as private day case patients.

Requires improvement

Services for children and young people

- There was no dedicated registered nurse (child branch) in the outpatient department. All hospital staff had access to the paediatric nurses rota and paediatric appointments were planned in line with this.
- Information about the outcomes of children and young people's care and treatment was not routinely collected and monitored. The service did not have a robust system for monitoring the outcomes for patients. We were not assured the service could therefore drive improvements due to lack of monitoring and performance information.
- The hospital had some audit programmes specific to children and young people's service, including documentation, environmental and pain audits. Feedback from patients and learning from incidents was also reviewed.
- Safeguarding systems were in place and staff knew how to respond to safeguarding concerns. All staff that came into contact with children and young people had the appropriate level of safeguarding training. There was a paediatric lead nurse for safeguarding.
- Both resident medical officers had European paediatric life support (EPLS) and advanced life support (ALS).
- All areas we visited were visibly clean and equipment checks were in place and up to date.
- Children who attended the hospital for day case surgery were cared for by registered sick children's nurses (RSCNs).
- All staff had access to the electronic incident recording system and we were told that outcomes of any resulting investigations were shared with staff.
- Staffing was sufficient to meet the needs of children and young people and keep them safe.
- There was a culture of openness promoted by the senior leadership team.

Are services for children and young people safe?

Good

Overall we rated children and young people's services as good for safe because:

- Safeguarding awareness was high amongst staff. The safeguarding lead covered both children and adults and they had responsibility for delivering training to staff and ensuring that they had the correct safeguarding level of training appropriate to their role.
- There was a well-developed system of recording incidents and giving feedback to staff about outcomes and actions taken.
- Patient records were completed appropriately.
- Staffing was sufficient to meet the needs of children and young people and keep them safe.
- All areas we visited were visibly clean.
- There were appropriate systems in place to recognise and respond to deteriorating patients.
- The hospital had a process in place for the emergency transfer of a deteriorating child to the local NHS acute trust.

However, we also found:

- During our announced inspection, we found that the physical environment of the hospital did not always ensure the safety of children. For example, we did not see staff make any challenges to adults who accessed the area around where children were accommodated before their procedure. The service took immediate action to address this once we had raised this as a concern.
- There was no CCTV in the area where these rooms were and no use of secure access to keep children and young people safe. The hospital had actioned by the time of the unannounced inspection.
- There were several medium oxygen cylinders around the ward. Although these were in designated areas, they were openly accessible to children. The hospital replaced them with small cylinders when we raised this.

Requires improvement

Services for children and young people

Incidents

- There had been no serious incidents or never events recorded in relation to children and young people between March 2015 and June 2016. A never event is described as wholly preventable incident, where 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.
- We were shown a range of incidents which were entered onto the electronic incident reporting system related to children and young people. There were 17 such incidents recorded from June 2015 to June 2016. These included operations cancelled, in most cases because the patient was deemed unfit for the procedure. Other recorded incidents included a child who was discharged without their prescription drugs and where parents rang in after their child was discharged with concerns about bleeding or high temperatures.
- An electronic incident reporting system was established throughout the children and young people's service. All staff had access to this system and were aware of how to log incidents and near misses. We were told that the matron and hospital manager had oversight of all recorded risks. They recorded the outcome and feedback onto the electronic incident reporting system and investigated reported incidents and near misses. Staff confirmed to us that when they reported incidents, they received feedback from the system.
- Feedback and lessons learned from incidents took place during children's service clinical governance meetings. We saw minutes of five of these meetings between October 2015 and May 2016 where adverse incidents relating to children and young people were discussed. We subsequently saw how investigation reports of recorded risks specific to children and young people were distributed in report form and displayed in the ward sister's office.
- Providers are required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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.
- Staff were fully aware of the duty of candour regulation (to be honest and open) ensuring patients always received a timely apology when there had been a defined notifiable safety incident.

Cleanliness, infection control and hygiene

- There were no recorded incidents of MRSA, Clostridium difficile (C. difficile), and Methicillin Sensitive Staphylococcus Aureus (MSSA) between April 2015 and June 2016.
- All staff complied with the 'bare below the elbow' guidance. There were numerous hand gel dispensers around the department, including outside all patients' rooms and all were well stocked. We saw staff use them before entering and as they exited patients' rooms.
- Staff whom we spoke with told us how they were aware of the importance of infection control and could tell us about the hospitals infection prevention and control policy.
- We were told that play equipment used by children in the physiotherapy department was cleaned and checked after each use. We saw 'I am clean' stickers on equipment to confirm this.
- Results of a hand hygiene audit from April 2016 showed a compliance level of 96%. The only areas to score less than 100% were 'hands and wrists are free from watches and jewellery' and 'taps are turned off using wrist/elbow levers or using a clean paper towel'.
- An environmental infection control audit scored 100% in all standards apart from where a dressing trolley was not free from rust or dust and used equipment was not stored or cleaned in a clean area.

Environment and equipment

- During our inspection, we found that the physical environment of the hospital did not always ensure the safety of children. There was a keypad on the doors at either end of the corridor where children's rooms were. However, these doors were unlocked at all times during the course of our inspection, which meant that there was free flow of adults around the area. We were told

that these doors were locked each night after 9pm .There was no CCTV in the area where these rooms were. We brought this to the attention of the senior management team at the time of our inspection who took immediate action to ensure the security of the ward area. During our unannounced inspection we found that the key pads to the doors were in use ensuring the safety and security of children and young people on the ward. CCTV was also now in place.

- Staff told us children were never left unattended in their rooms, and expected parents to remain with their children. In the event of a parent needing to leave the room for a period of time, then staff told us they requested that parents ring the call bell in order that a nurse or healthcare assistant could sit with the child. However, two parents we spoke with told us that although they had not needed to leave their child, they had not been informed of this arrangement.
- There were no rooms used solely for caring for children and young people, and the adult- oriented rooms were not specifically adapted to be child friendly.
- There were 12 oxygen tanks placed in designated storage areas where children were nursed and treated. There was a potential risk that these could therefore be accessed by an unattended child. Staff reported that children were not left unattended by their parents, and if so, nurses would then stay with the child. The hospital replaced them with small cylinders when we raised this.
- The hospital service equipment checklist showed that all equipment had been serviced within the past 12 months. Staff told us how they recorded any required repairs in a maintenance log and said that the response time to repairs was short.
- There was a dedicated paediatric resuscitation trolley on Meadow ward which had age and size appropriate equipment for children. There was also a paediatric resuscitation trolley next to the children's recovery bay in theatres. We saw that staff regularly recorded their daily checks of the resuscitation trolleys. In addition, each department had a blue lidded box which included first response equipment for an emergency with a child in that department. We saw that these boxes were checked on a weekly basis, with the contents individually listed and signed off as seen by a member of staff.
- Clinical waste was placed into bags, labelled and secured before disposal. Waste was stored appropriately.
- Staff we spoke with were aware of the policy and procedure for handling and disposal of sharps. Sharps bins were observed as being used correctly.

Medicines

- Medicines were kept securely in the children and young people's service. They were stored alongside medicines for adults, in a locked wall cupboard which was in a locked room.
- Children's weight and any allergies were recorded on the prescription chart.
- Controlled drugs, which are drugs controlled under the misuse of drugs legislation such as morphine, were appropriately stored. They were kept in a separate locked cupboard within the medication room. Whilst there was no separate register for controlled drugs for children and young people, we saw that there was a robust management system in place. We saw that the controlled drugs book was checked and signed by two nurses on each occasion, in accordance with recognised national guidelines.

Records

- Medical records were completed appropriately in the children's and young people's service. We reviewed five sets of medical records, all of which had all the appropriate assessments and reviews documented. We saw pain charts were completed and for younger children, a series of faces were used to help the child describe their pain level.
- The hospital used a paper based records system for recording patients' care and treatment. Records were clear, accurate and all entries made by nurses were legible. However, on two of the records we reviewed, the consultant's signature was illegible and undated.
- Patients' records were stored securely in a lockable trolley whilst in use on the wards, to maintain confidentiality. When the patient was discharged, we were told that records were stored in a patients' records room.

- There was a system in place to ensure that medical records generated by consultants holding practising privileges were integrated into the hospital record for children and young people. We saw consultants' notes had been added to the records we looked at.

Safeguarding

- The corporate provider's safeguarding policy for children and young people stated that all staff must have level 1 safeguarding training which is completed by e-learning. The minimum level required for staff that have some degree of contact with children and young people and/or parents/carers must be level 2 which is also done by e-learning. Clinical staff working directly with children, young people and/or their parents/carers must have level 3 safeguarding training which can be combination of e-learning and face to face training.
- Staff whom we spoke with demonstrated a good understanding of how to safeguard the vulnerable child. They spoke confidently of signs of abuse which they would look out for and could tell us what the appropriate process was which they should follow, in line with the corporate provider's policy. All those with whom we spoke were aware of who the safeguarding lead was and told us they ensured their safeguarding training was up to date.
- The hospital safeguarding lead was responsible for children and adults safeguarding. In their absence, the designated person was the hospital matron. They told us it was their responsibility to ensure that all staff had the appropriate level of safeguarding training, which they delivered. They told us they had completed their training to meet the required skills and competencies as laid out in the Intercollegiate document 2014 (Safeguarding children and young people: roles and competences for health care staff). The safeguarding lead and another paediatric nurse were trained to deliver levels 1 and 2 safeguarding children to other staff members throughout the hospital.
- The lead paediatric nurse completed a safeguarding competency check list for registered nurses (adult branch) who were caring for children over three years of age in the outpatients department. This included three workbooks which were completed, dependent upon the seniority of the nurse. They told us it was their responsibility to ensure all staff had completed the relevant level but acknowledged that they had not managed to update this recently due to pressures of their workload.
- The hospital target set for all safeguarding training was 95%. Data submitted by the hospital demonstrated that 93% of staff had level 1 training. Training for staff who must have level 2 was 99% and those who required level 3 was 100%.
- Physiotherapists treated children and young people from birth to their 18th birthday. We confirmed that each physiotherapist had in-date level 3 safeguarding training.
- The safeguarding lead told us they ensured their knowledge of safeguarding was kept current through linking with NHS England and the local authority. The hospital subscribed to an NHS telephone application which was distributed to all heads of departments. This included guidance and updates of examples of current issues and practice.
- The corporate provider's chaperoning policy stated that a child would always be accompanied by a chaperone. Their parent or guardian should also be present. On each occasion when a child was taken to theatre, we saw that there was a paediatric nurse with them, as well as a parent or carer.
- We saw evidence of a draft hospital abduction policy that was finalised after the inspection.

Mandatory training

- Mandatory training for staff was composed of a mixture of e-learning and face to face training. It included fire training, manual handling, infection control, hand hygiene and basic life support. Compliance with mandatory training at the end of June 2016 showed that 78% of staff had completed their manual handling training, 80% completed their infection control training and 93% of staff had completed their hand hygiene training. Basic life support was completed by 84% of staff. Not all staff had therefore had all required mandatory training in line with the services' target of 95% but the service was on track with its annual plan.

- The paediatric nurses had recently updated their training in the British Resuscitation Council accredited courses for European paediatric life support (EPLS) and paediatric immediate life support (PILS).
- Paediatric basic life support was completed by 92% of those staff who had contact with children. There was a 73% completion rate for those staff who were required to complete a paediatric immediate life support. We saw plans were in place to deliver more training.
- The hospital had two resident medical officers, who worked alternating weeks. They both had EPLS and advanced life support (ALS).

Assessing and responding to patient risk

- We were told that young children were not kept in hospital overnight. Their procedures were planned for early morning in order to allow sufficient recovery time. We were told that if children became critically ill, the consultant who performed the procedure arranged their transfer to a bed in a local NHS hospital.
- In cases where a child's recovery was slower than expected, we were told that the attending paediatric nurse would remain on shift until discharge was possible.
- We saw evidence of a service level agreement in place with the local NHS trust for transfer of the critically ill patient.
- There was a flow chart in each department which outlined the process for when a child became critically ill. This included contact with the responsible consultant, local NHS hospital and contact numbers for the Children's Acute Transport Service (CATS).
- Between June 2015 and June 2016, there was one incident of where a consultant arranged emergency transfer to a local NHS hospital for overnight management. In the same period a further incident occurred when a child was taken to hospital from home on the day after their procedure.
- Parents were encouraged to contact the hospital if they had concerns about their child once they took them home. If the call was after 9pm, when paediatric nurses went off shift, then the consultant who performed the procedure would be contacted. They had an agreement to be available for 24 hours after the operation. There was also an informal arrangement with the paediatric nurses that they could also be called out of hours to offer advice and reassurance.
- A paediatric early warning scoring (PEWS) system was used to assess whether a child may be deteriorating. Early warning scores are generated by combining the scores from a selection of routine observations of patients e.g. pulse, respiratory rate, respiratory distress, conscious level.
- We saw that the service completed the World Health Organisation 5 steps to safer surgery checklist for children.
- We saw there was a document entitled the Paediatric Process which included guidance for staff in all parts of the hospital when children attended their service. This guidance stated that a Registered Nurse (child branch) must do the pre-operative assessment and also collect the child post-operatively from recovery. Staff confirmed this was the case in practice.
- We saw evidence of a local paediatric policy which outlined the hospital's admission criteria for children and young people.
- Environmental risk assessments were drawn up to enhance the safety of children and young people in the outpatients department. In particular, where a young person could be at risk of scalding themselves on a hot water dispenser, steps were taken on the day of our inspection to mitigate the risk.
- We were told that in the case of a deteriorating child, the patient would be transferred to a local NHS hospital.

Nursing staffing

- The hospital did not use a formal staffing acuity tool. Instead, staff levels and mix were planned in response to activity and acuity, whilst ensuring there was always a designated senior person in charge for children and young people. We were told how the skill mix and dependency was reviewed in advance on both a weekly and daily basis to assess the workload and ensure that appropriate safe staffing levels were maintained.
- Paediatric procedures were planned in advance, which allowed for the necessary number of staff to be on duty.

There were two full time Registered Nurses (child branch) and one bank nurse available to care for children and young people. These nurses were available to all hospital departments.

- People we spoke with, including those administrative staff responsible for booking paediatric procedures, told us that bookings were made once it was established that there was a registered nurse (child branch) nurse on duty. Each department had a copy of the paediatric nurse rota to assist with this process. Since all procedures were planned, we were told that this system worked effectively.
- In the event of neither nurse being available, then the bank nurse would be called. If this person was also unavailable, the hospital policy was that a paediatric nurse was brought over from the nearest Ramsay group hospital which was approximately 45 minutes away. The matron told us that in the event of all these contingency plans failing, then the procedure would be cancelled. She told us that she was unaware of this occurring since she had come into post six months prior to our inspection.
- The matron told us there was no dedicated full-time paediatric nurse available in the outpatients department. In the event of assistance being required, a registered nurse (child branch) would be asked to assist. The hospital's outpatient's rooms were in the immediate vicinity of the ward so the nurse would be available in the event of an emergency on the ward.
- Handovers took place at 7am and 8pm each day. In addition all heads of departments met daily to review the day ahead and to discuss potential issues and ensure the correct levels and skill mix of staff were on site.
- The children and young people's service did not use agency staff. Instead, they regularly used a suitably inducted and qualified registered nurse (child branch) bank nurse. In the event of the hospital's registered nurse (child branch) and bank nurse all being unavailable, and then a paediatric nurse from a neighbouring Ramsay group hospital would be called for duty.
- We found that this was reflected on rotas we looked at for the previous four weeks. The practice at the hospital was to ensure there was at least one paediatric nurse on duty at all times when a child was treated and both of these were European paediatric life support trained.
- Staff who were responsible for booking appointments showed us copies of advance rotas for child nurses. They told us these were readily available and enabled them to ensure there was a child nurse on duty before they booked a child in for a procedure.
- Children who attended the hospital for day case surgery were cared for by registered sick children's nurses (RSCNs).

Medical staffing

- All doctors and dentists worked under rules or practising privileges. There was a resident medical officer (RMO) on duty at all times. The admitting consultant took lead responsibility for children and young people while they were in the hospital and after discharge. For children and young people who had undergone an anaesthetic, an anaesthetist also remained responsible for their ongoing care. It was expected that consultants who admitted children confirmed at least one colleague who would cover in their absence. The hospital team had access to contact numbers for all consultants. The RMO liaised with consultants as to the provision of care for children post discharge. When the lead consultant was in the hospital, they were responsible for referring children to other specialists and seeking support from them as necessary. The hospital had agreements for support from other specialists to ensure the safe care of patients.
- The hospital operated an on call rota for all clinical areas and senior managers.
- We saw patient lists which demonstrated that paediatric procedures were scheduled for first thing in the morning. This allowed for the child or young person, to recover sufficiently to be discharged later the same day. Paediatric procedures were clustered on certain days in order to ensure consistency of staffing.

Major incident awareness and training

Requires improvement

Services for children and young people

- There was a service contingency plan in place in the event of interruption to essential services. Staff whom we spoke with told us they were aware of the escalation process if there was an incident requiring a major response.
- Emergency bleeps were carried by the paediatric nurses, which we saw them responding to during our inspection.

Are services for children and young people effective?

Requires improvement

Overall, we rated the service for effective as requiring improvement because:

- Information about the outcomes of children and young people's care and treatment was not routinely collected and monitored. The service did not have a robust system for monitoring the outcomes for patients. We were not assured the service could therefore drive improvements due to lack of monitoring and performance information.
- The hospital had some audit programmes specific to children and young people's service, including documentation, environmental and pain audits. Feedback from patients and learning from incidents was also reviewed.

However, we also found:

- Staff spoke positively about the quality and regularity of supervision and training they received. The hospital had an annual appraisal system available to all staff and we saw that staff appraisals were in date.
- Consent forms were completed with parents by nurses and consultants. There was a brief summary of the discussion on the form, which was signed by the parents and all involved professionals.
- Parents told us that the hospitality at the hospital was of a good standard. Children were offered a children's menu from which to choose their food. Parents had access to an on-site restaurant. Whilst there were no refreshment making facilities available to parents on the ward, drinks were readily supplied by health care assistants or nurses.
- Pain assessments were embedded into the paediatric pathway.
- Staff had received training on the Mental Capacity Act (MCA) 2005 and deprivation of liberty and safeguarding.

Evidence-based care and treatment

- The hospital did not have an audit schedule specific to the children and young people's service this meant that care was not monitored to demonstrate the compliance with best practice and guidance.
- Policies were accessible to staff on the hospital intranet and based on professional guidance such as the National Institute of Health and Care Excellence (NICE) guidance and Royal College guidelines.
- The hospital had a chaperone policy, which followed NHS, General Medical Council (GMC) and Nursing and Midwifery Council (NMC) guidance. Staff followed this, for example, whenever a child was transferred to or from the operating theatre to recovery, when they were always accompanied by a registered nurse (child branch).
- Patient records were audited every six months from a sample of ten records. Most areas scored 100%, including recording patient medical alerts or allergies on the drug chart and recording a chronological account of the patient's care. There were areas which scored lower, including two records which did not have the initials, full name or designation of the clinician (80%) and one where no postoperative care instructions were given.

Pain relief

- Pain assessments were embedded into the paediatric pathway. Consultants and the RMO prescribed the relevant pain relief, which nurses then administered.
- Pain was monitored from surgery through to discharge.
- Nurses used the Wong-Baker smiley faces pain rating tool and a 1 to10 visual analogue scale tool. The Wong-Baker tool was originally developed to help children more effectively communicate their pain relief

needs with health care staff. Patients and parents whom we spoke with told us they received prescribed pain relief in accordance with what was written on their pain chart.

- The hospital's 'Assessment and management of pain in children and young people' policy stated that a child's pain should be assessed using the hospital's pain assessment tool and pain ladder appropriate to the child or young person's cognitive and developmental ability. We saw this tool was applied on each of the patient records we reviewed.
- We saw that there was a policy for assessing and managing pain in children and young people which included use of a paediatric analgesic ladder.

Nutrition and hydration

- We were told that special diets, such as gluten free or lactose free, would be supplied where children required them. Whilst we did not see any evidence of dietetic input during our inspection, the hospital nutrition and hydration policy stated that there must be access to a dietician who was responsible for providing support and guidance on food services and nutritional care. Nursing staff told us they would request support if required.
- Parents told us that the hospitality at the hospital was of a good standard. Children were offered a children's menu from which to choose their food.
- One parent told us how their child had been asked to fast from early morning in accordance with hospital procedure, and was very hungry since the procedure was booked for mid-morning. We heard a discussion between this parent and a registered nurse (child branch). Following a check of the patient's medical record, the nurse told the parent the child could have a small drink of water, as per the anaesthetist's advice.
- There was a menu choice for children which included a range of food and drink, supplied by the in-house catering team. Parents of children we spoke with told us the food was of a high standard.
- Parents were supplied with hot drinks as required. They also had access to an on-site restaurant, which was open all.

Patient outcomes

- Information about the outcomes of children and young people's care and treatment was not routinely collected and monitored. The service did not have a robust system for monitoring the outcomes for patients. We were not assured the service could therefore drive improvements due to lack of monitoring and performance information.
- The hospital had some audit programmes specific to children and young people's service, including documentation, environmental and pain audits. Feedback from patients and learning from incidents was also reviewed.

Competent staff

- All employees received a comprehensive and organised introduction to their new place of work. This included orientation to the workplace, an introduction to their job, their unit, their team, key policies and the parent company.
- All staff were required to maintain competencies relevant to their job role. We saw workbooks entitled: 'Competencies for all Lead Children's Nurses in Ramsay Health Care UK Hospitals/Units' which the matron told us were completed in keeping with the corporate policy.
- The corporate provider had developed a series of workbooks for all clinical staff who were involved in the delivery of care and treatment to children and young people. There were three workbooks, with all staff required to complete workbook one, whilst the paediatric nurse and sister were expected to complete workbooks two and three.
- We spoke with seven members of staff, including paediatric nurses, who told us they received supervision on a regular basis. They told us they found the process to be supportive and developmental. They said it gave them a chance to reflect on their practice and identify areas where additional support or training may be required.
- The hospital had two resident medical officers, who worked on a two week on and two week off rota. They both had European paediatric life support (EPLS) and advanced life support (ALS).
- Anaesthetic and recovery staff received training on paediatric intermediate life support (PILS) which meant they had the skills to identify a deteriorating child.

Requires improvement

Services for children and young people

- When children over three years of age were seen in outpatients, a paediatric nurse was present within the hospital and could be called on if required.
- We confirmed, by checking the surgeons practising privileges and scope of practice, those who undertook surgery on children and young people, at Rivers hospital all conducted the same operations in their NHS practice. In addition the same group of anaesthetists were used for both Rivers hospital and the NHS. This meant that surgeons and anaesthetists were not doing surgery at Rivers hospital that they were not routinely doing within the rest of their practice.

Multidisciplinary working (in relation to this core service)

- The hospital provided a multidisciplinary service to children. This included general surgery, ear, nose and throat (ENT), oral facial maxillary, urology, general paediatrics, dermatology and plastics. Children and young people also attended the imaging department.
- Staff whom we spoke with told us there was good communication between teams and disciplines, which they felt contributed to enhancing the patient experience. We saw some patients' records where there was input from different consultants. For example, we saw a record of a consultation between an anaesthetist and an ear, nose and throat specialist.
- The children's and young people's service was small; however the hospital did not have play specialists to support children and young people during their visit to hospital. We were told that since children were on site for a limited amount of time and did not experience prolonged waits, there was no requirement for the services of a play specialist.
- Children and young people were seen post operatively in the physiotherapist department as required. A physiotherapist told us this was on an outpatient basis in order to aid recovery.

Seven-day services

- The hospital did not offer a seven-day service to children and young people. Most paediatric procedures were done as day cases Monday to Friday. Very occasionally, a procedure may have been booked for a Saturday morning, with the patient expected to be well enough to go home later the same day.
- Children had access to radiology, pathology and physiotherapy services six days a week if required.
- The pharmacy department was open six days a week. There were pharmacists on call out of hours. There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that patients normally had access to medicines when they needed them.

Access to information

- The hospital was a small environment and staff were easily able to seek advice or support from other professionals around the building.
- There were arrangements in place to ensure that staff were able to access all necessary information to deliver effective care.
- Computers were available in the wards and theatre areas, all staff had secure, personal log in details and had access to e-mail and all hospital systems.

Consent

- There was a consent form specific to the needs of children and young persons in each of the four records we looked at, for patients aged between five and seven. This included a record of the discussion between the consultant and the parent. They were signed and dated by the consultant and the parent.
- The hospital's consent policy stated that a child's capacity to consent should be evaluated using the Gillick competencies. This assesses whether a child under the age of 16 had the maturity to make their own decisions and to understand the implications of those decisions.
- The hospital's 'Pre-procedure pregnancy checking in children under 16 years of age' policy stated that professional judgement should be exercised and consideration given to guidelines as outlined in Gillick competency and Fraser guidelines.
- On the day of our inspection the patients we spoke with were aged between five and seven, and whose parents had consented on behalf of their child. Therefore we did not see older children's competency to make decisions being assessed. However, the nurses we spoke with who were caring for children were fully aware of their responsibilities around Gillick competency.

Requires improvement

Services for children and young people

- The lead paediatric nurse told us children and young people were included and engaged in conversations around consent and shared information with them.
- Parents we spoke with told us they felt well informed about the process which their child was about to undergo and understood what they were consenting to when they signed the consent form.
- Training in the Mental Capacity Act (2005), where applicable, and Deprivation of Liberty Safeguards (DoLS) was provided by the hospital. Staff we spoke with confirmed that they had received this training.

Are services for children and young people caring?

Good

Overall, we rated the children's and young people's service as good in relation to caring because:

- In order to reduce some of the anticipated fear of coming to the hospital, children and parents were invited in to look around the hospital prior to a procedure. This happened at a weekend, when the hospital was quieter. A nurse showed the family around the operating theatre, where the child could try on an oxygen mask if they wished. They also visited the anaesthetic and recovery rooms where they were likely to be before and after the procedure.
- Parents spoke positively about the care families received and said nursing and medical staff were approachable and explained the care provided. We were told that staff provided care which was compassionate and empathetic.
- The hospital invited parents and children to complete a satisfaction survey. Whilst the response rate was relatively low, the data recorded high levels of satisfaction.

Compassionate care

- Patient feedback from Friends and Family Test (FFT) data was available for July to December 2015. Whilst there was no differentiation of information for children and young people, the results were high (greater than or equal to 85%).This meant that a majority of patients would recommend this service. The response rates varied from low (less than 30%) to moderate (between 30% and 60%) in the same period.
- Children and parents were invited to complete patient satisfaction surveys. Data from this survey from May 2015 to April 2016 showed that the overview of satisfaction ranged, when marked out of ten, between nine and ten over the 12 month period.
- Parents of patients told us that all members of staff had been kind and understood the anxiety they felt in advance of their child's procedure.
- We saw examples of how nurses helped to comfort children when they were upset or experiencing pain. In some cases, they sat with them to chat and in others, provided activities such as art materials.
- We observed staff respecting the privacy, dignity and respect of patients by knocking before entering a patient's rooms and ensuring the door was shut.
- We noticed that staff respected patient confidentiality by placing records face down when they were on the nurse's desk.

Understanding and involvement of patients and those close to them

- Younger children and their parents were invited in to hospital prior to their procedure in order to familiarise themselves with the process. This included a trip to the operating theatre and included trying an oxygen mask on if they wished. One parent we spoke with praised this and said it had dramatically lowered their child's anxiety levels. Another parent told us their views and opinions were taken into consideration during the planning process for their child's operation and post-operative care.
- We heard staff communicate appropriately with children and young people and their relatives and gave thorough explanations of the process.

Emotional support

- We observed those nurses caring for children communicating with them in a calm relaxed and compassionate manner, using language appropriate to the child's age and level of understanding.

Requires improvement

Services for children and young people

- We saw how a nurse responded quickly to a child who became very upset. The nurse was swift to establish the reason for the distress and offer reassurances to the child and their mother.
- All staff we spoke with were very passionate about their roles and dedicated to making sure children and young people received the best patient-centred care possible.
- Parents had access to the anaesthetic and recovery area. We noted they were called to recovery when their child was returned there from theatre.

Are services for children and young people responsive?

Requires improvement

Overall, we rated responsive as requires improvement because:

- There was a lack of recognition of the children and young people's service as a separate, distinct service in the hospital.
- There was no dedicated paediatric nurse in the outpatients department. If support was required, the paediatric nurse from in-patients would be called to lend assistance.
- Children did not have a dedicated waiting area separated from adult patients
- There was no child friendly information about their hospital visit available for children. The literature that was available was aimed at adult carers and parents.

However, we found that:

- Where children under 16 were having an operation, procedure or treatment, a registered nurse (child branch) was present and was the named nurse caring for the child.
- All children and young people were pre assessed prior to surgery. Children and young people and their parents and carers received a follow up telephone call within 48 hours of discharge.
- There was an open and transparent approach to handling complaints. Information about how to make a formal complaint was readily available and the hospital responded to complaints within their 20 day target.
- Staff were informed of complaints and the outcome of any ensuing investigation.

Service planning and delivery to meet the needs of local people

- There was a lack of recognition of the children and young people's service as a separate, distinct service in the hospital.
- Children and young people shared the same environment as adult patients in all areas of the hospital. There was no dedicated registered nurse (child branch) in the outpatients department and in the event of a patient to the outpatients department requiring additional nursing support, the registered nurse (child branch) would be called to assist leaving the ward uncovered.
- There were no separate areas for children in which to wait prior to being called for assessment, treatment or procedures. However, we were told that this was not considered to be an issue since when children and young people arrived at the hospital; they were usually with their parents or legal guardian and were shown to the consulting room with minimal delay.
- We noted that the waiting area, which had young visitors who had come to see relatives, did not have any child friendly toys or books readily available. We were told that crayons and papers could be provided if required.
- All paediatric procedures were planned in conjunction with the paediatric nurse rota. This was embedded practice and confirmed to us by a range of staff. When they were admitted for a procedure, the rooms nearest the nurse's station were reserved for use by children.

Access and flow

- We saw the department had a paediatric day care pathway. This was a comprehensive record of a child or young person's journey from pre-admission to admission, recovery and discharge. There was no waiting lists for the service.

Requires improvement

Services for children and young people

- Procedures for children and young people were scheduled first on a consultant's list. Children's procedures were mainly clustered on the same days each week. We were told that if a parent required a Saturday appointment, then this would be accommodated, subject to careful pre-planning.

Meeting people's individual needs

- All children, young people, and their relatives/carer received a follow up call within 48 hours of discharge. Parents we spoke with were aware of this and told us it gave them reassurance.
- We observed a physiotherapy session with a toddler who had a learning disability. This member of staff demonstrated a high degree of skill in engaging the child and worked in partnership with the parent throughout the session. They later told us their area of speciality when not working at Rivers hospital was working with children with a learning disability.
- The parent spoke highly of the support they got from the hospital in general and the physiotherapy department in particular.
- The hospital was a wheelchair accessible environment. Bedrooms and consulting rooms were on the ground floor, which was laid out in a horseshoe shape.
- In the event of a patient attending for whom English was not their first language, staff told us they had access to interpreting services through use of the 'Language Line' telephone service. Whilst they told us there was no difficulty in accessing this, the need to do so was rare, and most likely to be for an adult.
- Staff could describe the ethnic and religious diversity of the people who used their services and explained how they could make modifications to ensure they were respecting cultural sensitivities.
- Information was provided in leaflets for parents. This included leaflets on the specific procedure which their child had undergone, post-operative care and pain management. We found some of the language used in one leaflet to be misleading, for example, local anaesthetic cream was referred to a 'magic cream' and general anaesthetic 'special sleep'.
- There were individual consulting rooms where children were seen and their medical needs discussed in confidence.
- When caring for paediatric patients, children's duvet covers were used, children's channels on the TV highlighted, parents advised to bring in their child's favourite cuddly toys as these posed less infection risk than if using their own toys. All children were given their own Ramsay soft toys and colouring sheets and their own pack of crayons. There was a children's menu which catered for all tastes and included ice lollies for children.

Learning from complaints and concerns

- Complaints were handled effectively and confidentially.
- The hospital had a complaints policy and parents we spoke with knew how to access it. They could show us the leaflet in which how to make a complaint was clearly documented. Staff we spoke with were familiar with the complaints procedure and felt the process was open and honest.
- The hospital general manager had overall responsibility for complaints, all of which were logged on the electronic incident reporting system. The senior team met weekly to review progress on complaints. We were told that complaints lodged were acknowledged within two working days and a full response was issued within 20 working days in line with the hospital's policy.
- We were told how complaints, compliments and lessons learned were discussed at each senior management team meeting and heads of departments meetings. These were then shared with the relevant department. We saw a copy of an outcome to a complaint on display in the ward sister's office. They told us this transparency was important to encourage staff to continue to strive to do better for the good of the patients and the service as a whole.

Are services for children and young people well-led?

Requires improvement

Overall, we rated well-led as 'requires improvement because:

Requires improvement

Services for children and young people

- Risks to children and young people using the service had not been recognised, assessed or mitigated against before our inspection. However, the service took immediate action once we raised these concerns.
- Whilst there was some evidence that the service was scrutinised and discussed at a local level, there was a lack of recognition of the service as separate from adult services provided.
- There was limited assurance that improvements were being driven in the service due to a lack of effective performance and outcomes measurements.

However, we also found that:

- The hospital had a high level of staff stability and a low level of sickness rates.
- Staff strongly identified with the values of the organisation.
- Staff told us they felt the leadership team was strong and stable.
- The hospital manager and the matron were known to all staff we spoke with, who told us that they were both very visible, knew people's names and frequently helped out.

Vision and strategy for this this core service

- Staff we spoke to frequently referred to 'the Ramsay Way' when we asked them about their vision for the service. This included integrity and credibility, achieving positive outcomes for all and recognition of the value of people and teams.
- There was not a separate strategy for the service that defined how the service was to develop and improve outcomes for children and young people.

Governance, risk management and quality measurement for this core service

- Risks to children and young people using the service had not been recognised, assessed or mitigated against before our inspection. Security risks had not been recognised by the service prior to our inspection.
- The issues with regards to safety and access for children and young people, where the doors at either end of the corridor where children's rooms were remained open, were resolved by the time we did an unannounced inspection nine days after we completed our announced inspection.
- We saw minutes of monthly children and young people clinical governance meetings which included agenda items such as incident management, safeguarding and equipment and facilities but significant concerns such as security had not been discussed. These were chaired by the hospital manager or matron.
- Paediatric team meetings were held monthly. We reviewed the minutes of two of these meetings and saw evidence of some local scrutiny and discussion around the children and young people's service. However, we found that the service was not collecting any outcomes of the service so we were not assured that the service was using outcome and performance measures to drive improvements.
- The medical advisory committee (MAC) was attended by a group of consultants who held practising privileges and represented colleagues from each speciality, including children and young people at Rivers Hospital. Its terms specified membership, quorum and responsibilities, which included review and advising on regulatory compliance, practising privileges, quality assurance and proposed new clinical services and techniques.
- The MAC carried out checks before granting new consultants practising privileges, including checks on their scope of practice to ensure they were only undertaking procedures that they were competent to perform. This included checking that operating on children was also undertaken in the consultant's NHS practice.
- The matron, who was the senior lead of the children and young person's service, attended the MAC meeting.
- Staff were able to describe to us what the governance structure of the hospital was.
- Staff we spoke with could tell us of recent themes entered onto the electronic incident reporting system. This meant that staff were informed by their managers of the general governance of the service they worked in.

Leadership / culture of service

Requires improvement

Services for children and young people

- Staff felt valued by their managers. All staff we spoke to told us how visible and supportive the hospital manager and matron were. Staff told us how the manager made sure he visited all parts of the hospital almost every day, greeting staff by name. We were also told how the matron was always willing to 'roll her sleeves up' and support staff on the ward as necessary.
- Teamwork was a trend throughout our discussions with staff most of whom referenced teamwork as a good thing about working in the service.

Public and staff engagement

- Staff felt engaged and were enthusiastic about the service they worked in. Updates and feedback were circulated on what was happening in the service, both at a local level and across the Ramsay group.
- The hospital had a staff rewards system in which the employee of the quarter and the team of the quarter were rewarded with vouchers for restaurants or shops. We were told that this was further evidence to staff that they were valued and their efforts noted.

Innovation, improvement and sustainability

- Staff were unable to tell us of any plans for innovation or sustainability.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

Rivers Hospital provides outpatient services to patients who are funded by private health insurance and those who are paying for their own treatment, as well as those referred from the NHS. Between January and December 2015, there were 61,904 outpatient visits. The majority of patients (64.2%) seen in its outpatient and diagnostic imaging departments were insured or self-pay patients; the remaining 35.8% were NHS funded. Both adults and children attended the outpatient department.

The outpatient department is in two areas of the hospital; the main building and the Thomas Rivers building. It has 17 consulting rooms and three treatment rooms which are used for minor procedures. It offers the following services: allergy clinic, audiology, breast surgery, cancer services (including oncology), cardiology, care of the elderly, chest and respiratory, colorectal, cosmetic and plastic surgery, dermatology, diabetes and endocrinology, dietician and nutrition, ear nose and throat, fertility clinic, gastroenterology, general medicine, general surgery, gynaecology, obstetrics, haematology, lymphatic, nephrology and renal medicine, neurology, neurophysiology, ophthalmology and orthoptics, oral maxillo facial, orthopaedics, paediatrics, pain management, phlebotomy, podiatry, psychiatry, rheumatology, urology and continence, vascular and weight loss.

The diagnostic imaging department (also known as radiology) is also split between two areas, with x-ray, digital mammography, ultrasound scanning and dual energy x-ray absorptiometry (DEXA) scanning on the ground floor of the main building and computerised tomography (CT) and magnetic resonance imaging (MRI) services on the lower ground floor of the Thomas Rivers building.

The physiotherapy department has seven treatment rooms and a large gymnasium.

During our inspection we observed how staff interacted with patients and spoke with four patients and three relatives of patients attending the departments. We spoke with a range of staff including three department managers, two nurses, four administrative staff, a consultant and the hospital's resident medical officer. We also looked at six sets of patient records in radiology and 12 in the outpatient department.

Good

Outpatients and diagnostic imaging

Summary of findings

Overall, we rated the outpatients and diagnostic imaging service as good. We inspect but do not currently rate effective for this core service.

We found that:

- Incidents were well managed and staff understood their responsibilities regarding the reporting of incidents and concerns.
- There were good infection control processes and the departments were clean and tidy and equipment was well-maintained.
- There were enough suitably qualified and experienced staff to provide a good service to patients. Staff absence rates and vacancy levels were low.
- Staff were aware of and followed policies and procedures and national guidelines for effective treatment.
- Staff competency was regularly assessed and monitored. Staff had the skill, qualifications and experience to carry out their roles and some staff had received specialist training to improve services for patients.
- There were good examples of effective multidisciplinary team working.
- Patients told us they received care that was compassionate and respectful.
- Access to appointments was good and referral to treatment times were in line with the national average.
- Staff sought and acted on the views of patients to improve services. Information about how to complain was available to patients and complaints were responded to and used to improve services.
- Staff were clear about the vision and values for the service and were committed and highly engaged.
- Leadership was strong and there was a culture of supporting staff.

However, we also found that:

- The environment was not suitable in all areas for the work being undertaken because some parts of the department, such as reception and waiting areas, were too small.
- Some areas did not comply with the Health Building Notes for hand wash basins in a clinical area.
- A hot water urn in the department presented a risk of accidental scalding to staff and people who used services. The service took immediate action to address this.
- Some risks in the departments had not been identified and adequately assessed and managed.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

Overall, we rated the service as good for safe because:

- Staff knew the types of incidents to report and could demonstrate how these would be recorded, escalated and reviewed. There was evidence of learning from incidents being shared.
- The areas we inspected were visibly clean and safe. Staff were observed to be bare below the elbow and use suitable personal protective equipment. They followed appropriate hand washing guidelines.
- Sufficient equipment, including equipment for use in emergencies, was available that was well maintained, appropriately checked and cleaned regularly.
- The radiology department complied with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).
- Medicines, including contrast media, were appropriately stored and used in line with national guidance and hospital policies.
- Records were kept securely and were available in the department when required.
- Staff were aware of how to ensure patients were safeguarded from abuse.
- Staff maintained high levels of mandatory training.
- There were systems to ensure the right patient received the correct diagnostic procedure.
- Staffing levels were sufficient to meet the needs of patients.
- The hospital had a sufficient number of staff trained to safeguarding children level 3 to manage the service safely, supported by access to level 3 trained staff when required. Clinics were consultant led.

However, we also found that:

- The area of the radiology department used for reporting on scans and x-rays was not suitable for the purpose because it was shared with other staff, which meant that staff were at potential risk of being interrupted while reporting. However, there was low throughput in this area.
- Clinical hand wash basins in the outpatient departments did not all comply with Health Building Note (HBN) 00-09.
- There was a hot water urn in the main hospital outpatient department which presented a risk of accidental scalding to staff and people who used services. The service took immediate action to address this to make this safe.

Incidents

- Staff in the outpatient and diagnostic imaging departments understood what constituted an incident and told us that the incident reporting system was accessible and showed us how they would access it. They told us they always received an acknowledgment of incidents they reported.
- Incidents that occurred in the departments were recorded on an electronic system. All incidents reported triggered an email alert to the departments' managers and members of the hospital's management team.
- Incidents were investigated and discussed at the departments' staff monthly meetings. We saw minutes of meetings that confirmed this.
- One serious incident had occurred in the radiology department in the 12 months prior to our inspection. There had been no serious incidents in the outpatient or physiotherapy department. We saw that the incident was appropriately recorded and reported to CQC and that lessons had been learnt as a result of the incident. For example, improvements had been made to the system for reporting urgent scans and x-rays.
- We also saw evidence that changes were made as a result of learning from other incidents that occurred. For example, patients attending for check on their wounds following surgery had routine observations of their temperature, pulse and blood pressure taken following an incident when a patient was readmitted for a post-operative infection. In radiology, staff had

introduced a checklist which asked patients about recent procedures to ensure they were not booked for a CT colonography too soon after having had a biopsy taken.

- Providers are required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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.
- Staff understood the hospital's duty of candour obligations should an incident result in harm to a patient. They explained to us that this meant being open and honest with the patient and offering an apology.
- There had been no never events reported for this service in the past year. A never event is described as wholly preventable incident, where 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.
- There had been no reportable incidents resulting from a patient undergoing a medical exposure (The Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) Regulation 4(5) in the radiology department in the year leading up to our inspection.

Cleanliness, infection control and hygiene

- During our inspection, all areas of the outpatient, radiology and physiotherapy departments were visibly clean and tidy. All of the patients and relatives we spoke to told us that they found the departments to be clean and tidy each time they visited.
- We observed that all staff in the department were 'bare below the elbow'. There were sufficient supplies of personal protective equipment, such as gloves and aprons, available for staff.
- There was a cleaning schedule for the departments and we saw that clinical and domestic staff kept records to show when they had carried out cleaning duties.
- Staff placed "I am clean" stickers on equipment they had cleaned so that colleagues could be assured that equipment they were using was clean.
- Disposable curtains were used in the outpatient department and these were dated with the date on which they were put up. We looked at eight sets of curtains and found that all except for one had been changed in the last six months.
- Staff carried out audits of infection prevention and control in the outpatient departments. Results ranged from 94% to 98% compliance with the hospital's infection prevention and control standards in the 12 months prior to our visit. We saw that actions were identified and logged, with staff responsibility for actions being assigned. We saw that actions were carried out and compliance improved at subsequent audits.
- All of the consulting and imaging rooms we inspected had hand-washing facilities, antibacterial hand gel, paper towels, and cleaning wipes available. Posters describing the World Health Organisation's 'five moments for hand hygiene' were displayed. Staff told us that they washed their hands before and after each patient's appointment and patients confirmed that they observed this. The hospital carried out audits of hand hygiene every quarter. We saw the results of these which showed that compliance with hand washing guidelines ranged from 96% to 100% in the three audits carried out prior to our inspection.
- Some of the hand-wash basins in the consultation and treatment rooms did not comply with Department of Health Guidance (Health Building Note 00-09: Infection control in the built environment) because they had overflows and recesses that were capable of taking a plug. A sink in one of the clinic rooms had a plug on a chain that was tucked into the overflow. Overflows are difficult to clean and may become contaminated and a plug allows the basin to be used to soak and reprocess equipment that should not be reprocessed in such an uncontrolled way. When we raised this with the outpatient department manager, they immediately arranged for the plug to be removed from the sink overflow. They completed a risk assessment for the non-compliant hand-wash basins with actions to reduce the risk of overflow and infection.

Good

Outpatients and diagnostic imaging

- Consulting rooms in the outpatient department were carpeted. Staff told us that these rooms were only used for consultations and not treatment. Where rooms were used for treatment, they were either completely uncarpeted or had an uncarpeted area where treatments took place. The carpets appeared clean with no visible staining. Spill kits were available and staff told us that soiled carpet tiles could be removed and replaced. The outpatient department manager showed us a risk assessment for infection prevention and control in relation to the use of carpets in these rooms.
- There had been no incidences of MRSA, MSSA or C. difficile infections reported in the hospital in 2015.
- In one of the sluice rooms in the department the sluice was not regularly used. Staff told us that the sluice was regularly flushed to help reduce the risk of legionella contamination and we saw records that confirmed that this flushing was carried out.

Environment and equipment

- Resuscitation equipment and medicines for adults and children were available in the department or in adjacent departments. Oxygen cylinders were kept on stands in corridors in the outpatient department. We saw that the cylinders were full and that adults' and children's facemasks were available. All staff we spoke with knew the location of the nearest oxygen and resuscitation equipment. We saw that staff checked the equipment daily and records showed that they had done so.
- We inspected a selection of consumable items in three trolleys in consulting rooms in the outpatient department and found they were all properly stored in intact packaging and were in date.
- Guidance on the appropriate disposal of clinical waste and sharps was available in all consulting rooms and clinical areas in the department. Clinical waste was sorted and disposed of in appropriate, foot-operated waste bins. Sharps bins were available in all consulting and clinical rooms. We observed that these were signed and dated and were not over-full.
- Records showed that all electrical equipment in the departments had been portable electrical appliance tested and that radiology and other equipment was serviced regularly under contractual arrangements with the suppliers.
- Sterile equipment was supplied by Ramsay Sterile Services under a contractual arrangement which included a service level agreement and key performance indicators which were regularly monitored.
- There was a radiation protection policy which was regularly reviewed and the radiation protection officer carried out regular audits that demonstrated compliance with the Ionising Radiation (Medical Exposure) Regulations 2000 (). Radiation warning signs were clearly displayed outside all appropriate rooms in the diagnostic imaging department.
- The area of the radiology department used for reporting on scans and x-rays was not suitable for the purpose because it was shared with other staff which meant that staff were interrupted while reporting. This presented a potential risk that staff could misdiagnose scans and images due to being interrupted by other staff. However, there was a low number of images reported so the potential risk was small.
- There was a hot water urn in a small, open kitchen area at the rear of the main hospital outpatient department. This was used by staff and consultants to make hot drinks. A "hot water" warning sign was displayed on the urn. However, there was no lock or guard to prevent children or others from accidentally opening the hot water tap, giving rise to a risk of accidental scalding. We spoke with the outpatient department manager who was not aware of any risk assessment in relation to this hot water urn. The day after our inspection they completed a risk assessment in relation to the urn with actions to reduce the risk of scalding and a plan to replace the urn with an alternative device.

Medicines

- Medication was stored securely in locked cabinets in rooms that required keypad access. Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use.
- We looked at a selection of medicines in the outpatient department medicines cabinets and refrigerators and found they were all properly stored in intact packaging and were in date.
- All medicines cabinets and refrigerators had thermometers which recorded minimum and maximum

temperatures. We saw records of daily temperature checks and guidance to staff for dealing with abnormal temperature readings. In the four weeks' records we reviewed there had been no incidences of abnormal temperature readings.

- There was a pharmacy top-up service for department stock and other medicines were ordered on an individual basis. This meant that patients normally had access to medicines when they needed them. We saw that pharmacy staff took time to explain medicines to patients, including how to take them and possible side effects.
- Contrast media, a type of medicine used during diagnostic imaging procedures, was kept in a locked cabinet in the radiology department, which could only be accessed by suitably qualified staff. There were appropriate policies and a questionnaire for the avoidance of acute kidney injury, a potential complication of the use of contrast media.
- No patient group directives were used and prescriptions for all drugs were written at the time of the patient's consultation.
- Blank prescription pads were stored securely and there was a process in place to identify which doctors had used them.

Records

- The hospital kept records for anyone who was seen in the outpatient department. Records for all NHS patients, and private patients whose consultant's secretary was based at the hospital, were kept on site at all times. Where consultants whose secretary was not based in the hospital saw private patients, they provided the hospital with a copy of their consultation notes prior to taking their original notes with them. Records were stored securely in a digitally locked medical records store room on the lower ground floor of the hospital.
- Less than 5% of patients were seen in the outpatient department without a full medical record being available. Staff told us that if records were not available, they obtained copies of referral letters, clinic letters, and medical histories from patients' GPs or consultants' secretaries so that appointments could still go ahead.
- Staff told us that they could transfer CT and MRI scans, x-rays and ultrasound images and reports from hospital to hospital through a secure image exchange portal for radiologists' opinions and to provide results to services that had referred patients.
- Records demonstrating compliance with Ionising Radiation (Medical Exposure) Regulations (IRMER) were clear and well kept.
- There was a file containing comprehensive risk assessments in each of the outpatient departments. These were also recorded on an electronic system.
- Computer screens in all departments were either in private rooms or had a privacy filter which meant that nothing displayed could be read by patients or relatives.

Safeguarding

- The outpatient department manager and senior sisters were trained to level three safeguarding children training. All other clinical staff were trained to level two, and non-clinical staff were trained to level one. We saw records, which showed that 100% of clinical staff and 96% of non-clinical staff were up to date with relevant safeguarding children training.
- The hospital had a sufficient number of staff trained to safeguarding children level 3 to manage the service safely, supported by access to level 3 trained staff when required. Clinics were consultant led.
- All staff we spoke with knew who the hospital's safeguarding lead was and knew how to report any concerns.
- None of the staff we spoke with had ever had to make a safeguarding referral but all said that they felt confident they would be able to do so.
- We saw that a safeguarding flow chart and contact details for relevant authorities was available to all staff. There were also guidelines for staff in dealing with cases of suspected female genital mutilation.

Mandatory training

- New staff attended a corporate induction course and had a department level induction. Records showed that staff received mandatory training in the following subjects: basic life support, customer service,

information governance, fire and personal safety, equality, and diversity, health and safety, infection prevention and control, manual handling, and safeguarding.

- The outpatient department manager kept records to show how many staff had completed their mandatory training. In outpatients, 93.5% of staff had completed mandatory training, while 78% of staff in x-ray and 92% in MRI and CT had done so. The hospital's target for compliance with mandatory training was 95%

Assessing and responding to patient risk

- Risks to patients, visitors, and staff were assessed, scored and recorded on an electronic system as well as on paper. The outpatient department manager told us that where a high score was identified, risks were notified to the hospital matron and other members of the senior management team.
- There were signs in the radiology department to denote where radiation exposure occurred to ensure that patients and staff only entered when it was safe to do so.
- There was a radiation protection officer who ensured that the diagnostics departments complied with the Ionising Radiation (Medical Exposure) Regulations (IRMER) through a programme of audits. Staff referred to justification guidelines which helped ensure that patients were only exposed to radiation when necessary and that radiation dosages as low as possible.
- Staff in the radiology department used patient pathways and the World Health Organisation (WHO) safety checklist for patients undergoing interventional radiology and scans to ensure that the right patient got the right scan or procedure at the right time. We reviewed six sets of notes for patients who had attended the radiology department and found that WHO checklists had been appropriately completed and recorded.
- The form used to refer patients to the radiology department included a safety check to ensure there was no risk that the patient might be pregnant before undergoing radiation exposure. There were also signs around the radiology department to alert female patients of childbearing age to tell staff if they might be pregnant.
- The MRI and CT waiting area on the lower ground floor did not have a reception desk. Patients were required to ring the bell in order to get the attention of a member of staff when they arrived in the scanning department, or if they felt unwell while waiting before or after their scan. During our inspection we observed that staff were not always able to respond to the bell immediately and this put patients at risk as they could not be observed by staff at all times while in the scanning department.
- All areas of the departments had access to emergency resuscitation equipment for use in medical emergencies. Staff we spoke with knew what actions to take if a patient in the department deteriorated and required emergency care. There was a protocol and a service level agreement between the hospital and the local NHS trust for patients who needed to be transferred to the trust in an emergency.

Nursing and radiographic staffing

- There were no staff vacancies in outpatients, diagnostic imaging, or physiotherapy at the time of our inspection. During 2015, the outpatient department had not used any agency nursing staff. Shortfalls were covered by bank staff who were familiar with the hospital processes and colleagues in the outpatients' team.
- In the outpatient department, 46% of nursing staff were qualified and 54% were care assistants. There was no formal tool for assessing staffing requirements; the manager allocated staff to the various clinics according to the needs of the consultants and the experience and competency of the staff.
- An interventional radiology nurse had been appointed in the imaging department to provide care for patients undergoing interventional procedures, and to give support and advice to staff. Radiology staffing met patients' needs at the time of the inspection.
- Radiographers operated an on-call rota in case imaging services were required out-of-hours.

Medical staffing

- All consultants who saw patients in the outpatient department had practising privileges at the hospital. Staff told us that they were able to contact consultants easily if needed. One member of staff told us that they

had needed to call a consultant at the weekend when a patient returned to the outpatient department following a minor complication and that the consultant had been available and had provided appropriate advice.

- Radiologists provided cover on a rota from Monday to Saturday and had a formal on-call system to provide cover when the radiology department was closed.
- There was a resident medical officer (RMO) at the hospital 24 hours a day. They could be easily contacted by staff for advice or to review a patient for example, for a wound review.
- All doctors who had practising privileges were at consultant level and were registered with the General Medical Council (GMC). This meant patients could be assured that registered practitioners treated them.

Major incident awareness and training

- There was a major incident policy and business continuity plan which was available to staff on the shared drive of the computer system.
- Staff we spoke with were aware of the hospital's major incident plan and knew what they needed to do in the event of a major incident.

Are outpatients and diagnostic imaging services effective?

We inspect but do not currently rate effective for this core service. We found that:

- Staff followed policies, procedures and clinical care pathways in line with local and national guidance.
- Staff undertook clinical audits and quality assurance for equipment was carried out regularly.
- Staff received regular appraisals. They had appropriate skills and many had received specialised training to allow them to increase their competency in specialist areas.
- There was evidence of effective multi-disciplinary working, particularly in the physiotherapy department.
- The departments' opening hours offered good access at times convenient to patients including evenings and weekends.
- Staff understood and complied with guidelines and policies for patient consent.

Evidence-based care and treatment

- Clinical staff we spoke to were aware of the National Institute for Health and Clinical Excellence (NICE) guidelines relevant to their specialist areas and knew how to access these guidelines.
- The hospital followed World Health Organisation (WHO) and Royal College of Radiologists guidelines for interventional radiology.
- The radiation protection officer ensured that the diagnostics departments carried out a programme to maintain compliance with the Ionising Radiation (Medical Exposure) Regulations (IRMER). We saw a copy of the audit undertaken in 2015 which indicated that the department was fully compliant with the regulations.
- There were systems to ensure that the radiology department complied with diagnostic reference levels (DRLs). Staff showed us audits of these which demonstrated that radiation doses to patients were kept as low as reasonably practicable.
- The physiotherapy department was participating in a pilot of a multidisciplinary functional restoration programme "Start Back" following NICE guidelines to rehabilitate patients with lower back problems.
- The outpatient departments undertook a programme of audits of their practice. For example, to ensure that referrals were completed appropriately and to monitor compliance with medical records guidance. We saw copies of these audits and saw that staff ensured that improvements were made as a result of issues found through audit.

Pain relief

- If patients required pain relief while in the departments it was prescribed by the resident medical officer (RMO) and administered by a staff nurse. Staff told us that the need for pain relief in the departments was very rare.

Nutrition and hydration

- There were water coolers and hot drinks machines around the departments for patients and visitors to help themselves. We observed that staff offered drinks to patients and visitors and assisted them if required.

Good

Outpatients and diagnostic imaging

- Staff told us that if patients were in the department for a long time they would arrange for them to be offered food from the hospital's menu

Patient outcomes

- The hospital participated in audits to measure patients' outcomes, such as patient reported outcome measures (PROMS) and the National Joint Registry. Staff were aware of these, and PROMS scores were displayed around the outpatient department.
- The physiotherapy department carried out a survey of patients who received treatment. In the quarter ending in June 2016, 96% of patients who completed the survey said they felt that their treatment had resulted in an improvement in their condition.
- The hospital did not participate in the Improving Quality in Physiological Services (IQIPS) programme, a voluntary scheme for accreditation of services providing physiological diagnostics and treatment.
- The radiology department carried out annual audits to ensure compliance with radiation protection guidelines. We saw that in the last audit in 2015 the department had been fully compliant with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).
- The radiology department did not participate in the Imaging Services Accreditation Scheme (ISAS), a national assessment and accreditation programme for radiology services

Competent staff

- Staff we spoke with were competent and knowledgeable in explaining their specialist areas.
- Some nursing staff had received specialist training, for example in ophthalmology, so that they could support those specialist clinics. Others were generally trained and operated in all of the outpatient clinics.
- One of the nurses had been specifically trained in interventional radiology to support the work of this area. Staff working in dual energy x-ray absorptiometry (DEXA) scanning had received training in osteoporosis to help them support patients attending for this service.
- A physiotherapist was being trained in providing cognitive behavioural therapy for pain management.
- All nursing staff and 72% of care assistants in the outpatient department had participated in an appraisal in the last 12 months.
- The outpatient department manager held a file containing competency assessments for staff who used equipment in the department which demonstrated compliance with provision and use of work equipment regulations (PUWER).
- Newly appointed radiographers underwent assessments of their competency and we saw that records of this were kept by the radiology department manager.
- Staff told us that consultants applying for practising privileges had to demonstrate their competency prior to carrying out procedures in outpatients and radiology. Staff also said that any existing consultants wishing to undertake new procedures had to demonstrate competency. This was done by reference to their NHS practice. The department managers kept records of procedures and preferences for each consultant.

Multidisciplinary working (related to this core service)

- Some nurses in the outpatient department had received specialist training, for example in ophthalmology and gynaecology. These nurses worked alongside consultants to support their specialist clinics.
- There were good examples of multidisciplinary working in the physiotherapy department where physiotherapists worked alongside consultants and nursing staff. Physiotherapists attended the wards each morning to speak to night staff about inpatients, and visited patients immediately post-operatively to apply splints or braces.
- In the radiology department, we saw that medical staff participated in a reciprocal audit with another hospital in the Ramsay group.
- Radiologists reviewed discrepancies in reporting alongside those in their NHS practice.

Seven-day services

- The outpatient department was open from 7.45am to 10pm, Monday to Friday, and 8am to 8pm on Saturday.
- The radiology department was open from 8am to 9pm, Monday to Friday and 8am to 2pm on Saturdays. There

was a radiographer in the radiology department at all times while patients were being seen in the outpatient department, to provide cover for any x-rays or scans that may be required. Outside normal working hours radiology services were provided on an on-call basis.

- Physiotherapy staff provided an outpatient service from 7am to 8pm Monday to Saturday. Physiotherapy staff had a rota to provide weekend cover for inpatients.

Access to information

- Less than 5% of patients were seen in the outpatient department without a full medical record.
- Staff had access to hospital policies and procedures, either on the hospital's computer system or in paper format. Staff we spoke with were able to show us where these were.
- Consultants told us that they had access to reports from previous x-rays and scans when reporting on new tests.
- Staff told us that results of diagnostic tests were reported electronically and were available promptly.
- We requested information about how the outpatient department communicated with patients' GPs but we did not receive a response to this request.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There were hospital policies for consent, mental capacity and deprivation of liberty. Staff we spoke with were aware of these policies and understood their responsibilities in relation to them.
- We saw copies of consent forms for patients undergoing minor procedures in the outpatient department. These had been appropriately completed with explanations of possible complications documented.
- Verbal consent was gained as a minimum prior to any diagnostic procedures.

Are outpatients and diagnostic imaging services caring?

Good

Overall, we rated this service as good for caring because:

- Patients were treated with compassion, dignity and respect. They were well informed and felt involved in their care.
- Staff were encouraging and respectful whilst providing care.
- We observed positive interactions between staff and patients.
- All patients we spoke with spoke highly of the care they had received.

Compassionate care

- Patients were treated with compassion, dignity and respect. The main reception area was welcoming and reception staff in all areas were polite and took time to explain the process to patients and their relatives.
- We observed doctors, nurses and support staff speaking to patients in a dignified way; they all wore name badges and greeted patients warmly, introducing themselves by name.
- We saw that reception staff knew some patients very well and took time to talk to them and their families while they were in the hospital.
- All patients and relatives we spoke with told us that their experience in the outpatient and radiology departments was very positive.
- In the six months from July to December 2015, between 98% and 100% of patients who completed the friends and family test said they would recommend the hospital.
- There was a hospital-wide patient satisfaction survey, and staff in outpatients were aware of the results, in particular those relevant to their areas. There was a separate satisfaction survey in the physiotherapy department. This showed that 94% were satisfied with the advice and information given to them.
- There were signs in the outpatient department that indicated to patients that chaperones were available for examinations if required. Only registered staff were able to undertake chaperoning duties. There was a chaperone policy which included guidance on where the chaperone should stand and how to record that a chaperone had been present.

Good

Outpatients and diagnostic imaging

Understanding and involvement of patients and those close to them

- Patients we spoke with said they felt they were involved in their care. For example, they said they had been able to ask questions and were given choices about which treatment would be the best for them.
- Patients told us staff gave them useful and thorough information prior to their appointment and prior to any treatment.
- Patients' relatives were able to accompany them for consultations and treatment where appropriate.

Emotional support

- Staff were sympathetic and made time to support patients in the departments.
- Staff understood that patients and relatives receiving bad news may need extra time and support, and told us how they would offer them a private room where possible.
- NHS patients who had joint replacement surgery attended physiotherapy groups to help them develop support networks with other patients.

Are outpatients and diagnostic imaging services responsive?

Good

Overall, we rated this service as good for responsive because:

- Patients found it easy to book appointments that suited them.
- Waiting times for outpatient appointments were within the national guidelines and clinics usually ran on time.
- There were one stop clinics available to minimise the number of times patients had to attend the hospital.
- Access for disabled people was good throughout the departments.
- Interpreters could be booked when required for patients whose first language was not English.
- Managers had made adaptations to enable staff with specific needs to work effectively.
- Information about how to complain was readily available to patients and staff took complaints seriously.
- Staff made efforts to ask people for their views on the service and used these to make improvements where possible.

However, we found that:

- The environment in the outpatient and radiology departments was not suitable for the level of activity carried out there and meant that staff were unable to ensure patients' comfort and protect confidentiality. However, staff told us that if patients asked to discuss matters in private they would take them to a vacant consulting room if it was possible to do this but that patients' privacy could not always be maintained in the departments.
- The Thomas Rivers outpatient department and radiology department reception areas were cramped and there was not enough space for the numbers of patients and relatives attending for appointments.
- Staff found it difficult to ensure patient confidentiality in these areas was maintained. Staff in the MRI and CT department were unable to observe patients in the waiting area at all times.
- Parking was insufficient to meet the demands of the hospital at busy times.

Service planning and delivery to meet the needs of local people

- The main outpatient reception was in the main entrance of the hospital and easily accessible to patients.
- Other areas of the department, such as physiotherapy, radiology and scanning were clearly signposted and staff directed patients to the relevant area.
- Facilities and premises were not appropriate for the services that were planned and delivered. The waiting areas in the Thomas Rivers building and in radiology were small. Some patients had to wait in the corridor outside the radiology department at busy times. The reception areas in the Thomas Rivers building and on the ground floor of the radiology department were cramped. Conversations at the reception desks could be

overheard from the seats in the waiting area. Staff told us that if patients asked to discuss matters in private they would take them to a vacant consulting room if it was possible to do this but that patients' privacy could not always be maintained in the departments.

- There was no separate waiting area in the radiology department for patients who had changed into gowns for their procedures. Staff had been involved in the procurement of new design gowns that helped, as far as possible, to preserve patients' dignity while they waited.
- We were shown plans for refurbishment and told that these had been approved, although funding and a works timetable had not yet been agreed.
- The outpatients, radiology and physiotherapy departments all offered early and late appointments as well as appointments on Saturdays.
- There was free car parking but the number of car parking spaces was not sufficient for the number of patients and relatives attending the hospital and the car park was very busy. Patients we spoke with said that it was often difficult to park and that there were no good public transport links to the hospital.
- There were one stop clinics where all investigations, diagnosis and treatment planning was carried out in one day, for example there was a one stop breast clinic.

Access and flow

- Referral to treatment time is the term used to describe the period between when an appropriate referral for treatment is made and the date of the initial consultation or treatment. The Department of Health stated for NHS patients, 95% of non-admitted patients should start consultant-led treatment within 18 weeks of referral; this was withdrawn in June 2015.
- During 2015, more than 99% of NHS patients were seen within the target of 18 weeks from referral.
- The percentage of patients who did not attend their appointment was 3.7%, which was lower than the national average of 7%.
- Patients were able to make appointments within a reasonable time of being referred by their GP. Self-funding and insured patients were offered a choice of appointment times.
- In physiotherapy, patients were usually able to get an appointment within two days.
- Patients we spoke with told us that appointments usually ran on time and they did not have to wait long in the outpatient department. Staff told us that they informed patients if appointments were running more than fifteen minutes behind schedule. During our inspection, clinic appointments ran on time.
- The outpatient department manager monitored when consultants cancelled clinics. We saw that when clinics were cancelled, sufficient notice was usually given to minimise inconvenience to patients.
- Staff told us that diagnostic test results and radiology reports were available promptly so that patients visiting the outpatient department could be diagnosed and have their treatment planned during one visit.

Meeting people's individual needs

- There was a range of seating in the waiting areas with high and low seating available.
- There was a range of written information regarding conditions and treatments available for patients in the outpatient waiting areas.
- Patients were sent information about any procedure they were having prior to their visit. The hospital did not provide this information in different formats, for example in other languages for people whose first language was not English. Information regarding common children's procedures was available for parents, however, there were no information leaflets specifically designed for children.
- All areas of the departments were accessible to people who were wheelchair users and the reception desks had lowered areas suitable for patients in wheelchairs. There were wheelchairs by the front door for people who needed them.
- Staff had completed dementia e-learning training and there was a dementia link nurse in the hospital available to support patients and staff. We requested information about how the outpatient department supported patients living with dementia when they visited the department but we did not receive a response to this request.

Good

Outpatients and diagnostic imaging

- Treatment tables and equipment in the physiotherapy department had been weight tested and there was equipment suitable for bariatric patients.
- There were toilet facilities in the departments including disabled facilities and baby change areas.
- Staff told us that language interpretation services were available either face to face or by telephone. They also told us that sign language interpretation service could be accessed if required. There was no induction loop for people with hearing loss.
- Patients told us they were informed about the fees for their consultation before their appointment.
- Patients attending the departments reported to the hospital's main reception desk before being asked to wait in the main waiting area, or directed to separate reception desks in the Thomas Rivers outpatient department, radiology or physiotherapy. There was a sign at the main reception desk indicating where patients should wait in order to give more privacy to patients at the desk.

Learning from complaints and concerns

- There was a complaints policy which staff were aware of. We saw that copies of a complaints leaflet for patients were available in the departments. Patients we spoke with said they were not aware of the complaints policy but would ask staff or look on the hospital's website if the need arose.
- We saw minutes of outpatient department monthly meetings at which complaints were discussed by staff and actions taken to help prevent their recurrence.
- During the period from 1 July 2015 to 30 June 2016, there had been 45 complaints relating to the outpatient departments, including informal verbal complaints. We saw that staff analysed these complaints and identified trends and took actions to improve services as a result.
- The hospital told us that most complaints in the departments related to charges for self-funding patients and told us that they had made efforts to ensure patients understood charges before having treatment. We noticed that charge lists for all services were displayed in all rooms in the outpatient department. The radiology department manager told us that costs were explicitly discussed with patients at the time of their appointment booking.
- Staff told us that they would try to resolve verbal complaints informally and that if they were successful they would not always record the complaint. This meant that the hospital was unable to analyse and learn from trends in verbal complaints.
- One patient told us that they had complained that they had found reception staff in radiology to be a little abrupt when they had visited the x-ray department on a previous occasion. Staff told us that as a result of this, they had increased the number of staff on reception to allow them more time to deal with patients.

Are outpatients and diagnostic imaging services well-led?

Good

We rated this service as good for well-led because:

- The hospital's vision and values were embedded in the departments and staff embraced the values in the work they undertook.
- There were regular departmental meetings which were clearly minuted. Relevant information was cascaded to all staff.
- Staff were highly engaged and committed to the organisation.
- Staff valued the views of patients and levels of satisfaction were good.
- There were clearly defined and visible local leadership roles in each speciality within the outpatient, diagnostic imaging and physiotherapy areas.
- Senior staff throughout the hospital were visible, provided clear leadership and were supportive of staff.

However, we also found that:

- The hospital's governance arrangements did not always ensure that risks were well managed.

- Although most risks in the departments had been assessed, at the time of our inspection, some risks in the departments had not been identified.

Vision and strategy for this this core service

- Staff in the departments were familiar with the "Ramsay Way" values for the service. They
- Posters about the "Ramsay Way" were displayed in staff areas around the departments.
- All staff we spoke with were highly committed and enthusiastic about their work and that of the departments.

Governance, risk management and quality measurement for this core service

- The outpatient departments had a risk register which clearly identified risks and detailed mitigating actions that were being taken. For example, this included the risks of infection posed by the use of carpets in consulting rooms, which were mitigated by the use of non-carpeted areas for procedures and the cleaning procedures for carpets. However, it was not clear how risks identified in the outpatient departments were included in the hospital's overall risk register.
- When we carried out our inspection, the management team had not identified the risks posed by the non-compliant wash-hand basins and the hot water urn in the outpatient department.
- There was clarity about who was responsible for the clinical and non-clinical performance of the departments.
- Department managers attended monthly heads of departments meetings and kept up to date with matters that affected the hospital and their areas.
- Managers were kept up to date about consultants' competency to carry out procedures and ensured that staff were aware via documented consultants' preferences which were kept in a folder in outpatients, and a chart in radiology reception.
- Managers we spoke with were aware of performance in their areas of responsibility. The hospital participated in a number of quality measures, such as PROMS and the National Joint Registry and the results of these were displayed around the outpatient department.
- The hospital maintained a medical advisory committee (MAC) whose responsibilities included ensuring any new consultant was only granted practising privileges if deemed competent and safe to practice
- One of the radiologists was a member of the hospital's MAC and represented the views of the radiology department there.

Leadership / culture of service

- Members of the hospital leadership team and department managers were well respected by staff. They told us that they were visible and approachable. They also said that they were supportive of staff.
- Staff working in the departments told us that they felt able to discuss any issues with their line manager and felt able to contribute to the running of the departments.
- Staff told us that they felt supported by their local clinical managers and had confidence in the hospital's senior leadership team. They said they felt valued by managers and colleagues.
- In the outpatient department there was a staff "family tree" and all staff had a colleague who was their "buddy" within the department, as well as a line manager to support them.
- Reasonable adjustments were made for staff with disabilities. The department and hospital managers had made adjustments to the workplace and relevant processes to support the staff and enable them to work effectively.

Public and staff engagement

- The outpatient, radiology and physiotherapy departments all held regular staff meetings where staff were actively encouraged to contribute. Meetings were held on different days to ensure that part-time staff were not excluded from attending meetings.
- There was a hospital-wide patient satisfaction survey, and staff in outpatients were aware of the results, in particular those relevant to their areas. There was a separate satisfaction survey in the physiotherapy department. This showed that 94% were satisfied with the advice and information given to them.

Good

Outpatients and diagnostic imaging

- We saw that staff encouraged patients and relatives attending the outpatient department to complete the friends and family test survey after their visits.
- Staff told us that they were involved in the plans for the refurbishment of the departments. They told us that they had made suggestions regarding room utilisation that had been implemented by managers.

Innovation, improvement and sustainability

- The physiotherapy department was participating in a pilot of a multi-disciplinary functional restoration programme to improve the outcomes for patients with lower back problems.
- In the outpatient department there was a staff "family tree" and all staff had a colleague who was their "buddy" within the department, as well as a line manager to support them.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Ensure effective quality assurance and performance measures are used to drive improvements in the children and young people's service.
- Ensure all risks in the medical care and children and young people services are recognised, assessed or mitigated against and that risk registers accurately reflect the level of risks and actions taken to minimise them.
- Ensure the legibility of medical records in the chemotherapy service.

Action the provider SHOULD take to improve

- Monitor how consent to care and treatment is recorded before any procedure takes place. This may include implied consent or consent using non-verbal communication.
- Monitor assessments and observations of care and treatment are accurately and routinely documented and that all records are legible.
- Monitor that effective systems are in place so all equipment in medical care is fit for use to meet needs of patients.
- Consider the risks and sustainability surrounding the paediatric nursing service, where it currently relies on two registered nurses (child branch) to cover all eventualities in relation to children and young people in the hospital.
- Give consideration to having a dedicated paediatric nurse in the outpatients department.
- Enhance the environment of the hospital to make it more child-friendly.
- Review the requirement to make child friendly information available to children and young people.
- Consider improving the environment in the outpatient and radiology departments as it is not suitable for providing dignified care to people who use the service
- Share results from infection control audits, including hand hygiene audits, consistently with staff using a method they can readily access.
- Review the signage relating to the safe operation of fire doors is up to date.
- Improve the security of patient records at all times when not being used by staff.
- Review the on-call nurse cover available in the chemotherapy service to ensure staff working hours are balanced and services are available to patients in line with their published standards.
- Review the arrangements in place so that staff at all levels are clear about patients' consent for surgery.
- Review the systems for ensuring all patients requiring hydration monitored have the appropriate record to do this in place.
- Review the clinical hand washing facilities in the bedrooms in the wards.
- Monitor staff mandatory training is line with the annual plan and with regard to helping patients living with a dementia.
- Monitor the process for documented patients' handover.
- Monitor the arrangements for medicines' storage in the pharmacy.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service was not meeting this regulation because: • The risk register for medical care was not updated regularly and in a manner that reduced the risk of disruption to the service. The risk register did not identify risks to the delivery of safe care and treatment that we found during the inspection. These risks to the safety and quality of care and treatment of patients had not been recognised by the service. • Security risks for children and young people had not been recognised by the service prior to the inspection. • Effective quality assurance and performance measures were not consistently used to drive improvements in the children and young people's service. • The risk that consent was not fully documented in chemotherapy patient records and staff had proceeded with treatment was not identified as a risk on the risk register or through governance action plans. There was a potential risk that as there was no record of discussions; patients may not have fully understood the treatment and potential risks involved. • The risk posed by illegible medical records in the chemotherapy service had not been recognised by the hospital