

HCA International Limited

The Harley Street Clinic

Quality Report

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

Ratings

Overall rating for this hospital	Good	
Medical care	Good	
Surgery	Good	
Critical care	Good	
Services for children and young people	Requires improvement	
Outpatients and diagnostic imaging	Good	

Summary of findings

Letter from the Chief Inspector of Hospitals

The Harley Street Clinic is a 110 bedded private hospital, based in Harley Street, London. The Harley Street Clinic is part of HCA International group who have five other hospitals in London.

The hospital undertakes a range of surgical procedures, provides medical and critical care, children and young people services and also carries out outpatient consultations. These are five of the eight core services that are always inspected by the Care Quality Commission (CQC) as part of its new approach to hospital inspection.

The hospital has four operating theatres, 97 consultation rooms, six treatment rooms, 96 inpatient and 14 day case beds all with en-suite facilities.

The hospital provides care to patients from birth. The majority of adult patients are from London and the South East. Over 50% of children seen or receiving treatment at the hospital are from overseas.

At the time of the inspection the hospital was not providing any NHS funded care. The hospital was selected for inspection as an example of a medium size independent hospital in our wave 2 pilot.

Our key findings were as follows:

Safe:

- There was an electronic incident reporting system that staff were aware of and incidents were investigated and findings were fed back to staff to promote and encouraging learning.
- Medicines were stored securely to ensure that unauthorised personnel did not have access to them. However, the processes for amending prescriptions when medical staff were not present on some wards was not in line with national guidance.
- The principles of the 'Five steps to safer surgery' checklist was embedded into practice and the surgical safety checklist paperwork was completed.
- There were sufficient, appropriately trained staff to meet patient's individual needs.
- There was an effective early warning system in place to monitor patients conditions and to identify patients at risk of deterioration to facilitate a timely and appropriate response.
- Patient records were legible and the majority of patients were seen daily by the nominated consultant who was available 24 hours a day, seven days a week.
- Mandatory training compliance was reviewed by core service and the percentages were as follows: Medical Care 77%; Surgery 74%; Services for children and young people 84%; Critical care 89%; Outpatients 76% Diagnostic imaging 81%.

Effective:

- Staff were encouraged and supported with their continual professional development and all staff had received an annual appraisal.
- There was effective communication between all staff involved in patients' care and treatment and we observed examples of multidisciplinary team involvement.
- There were processes in place for reviewing clinical and non-clinical policies. However not all policies we reviewed were up to date.
- Care pathways were evidence based in line with national guidance from NICE and the Royal Colleges.
- Patients had access to most services 24 hours a day, seven days.

Summary of findings

Caring:

- Staff treated patients and their relatives with respect and compassion. Patients were positive about their care and treatment and said staff were professional and kind.
- Patients felt supported and involved in decisions about their care and treatment. The majority of responses to the provider's patient satisfaction survey were positive.

Responsive:

- Patient admissions were arranged in a timely manner with minimal delays for patients and their individual needs were met.
- Patients had access to information about the service and their treatment. There were interpreter services available in the hospital as required.
- Complaints were responded to within the appropriate timescales and there was identified learning and changes to practice.
- There was cooperation across the hospital and divisions to ensure patients received appropriate care and treatment.

Well-led:

- There was no documented vision and clinical strategy to support innovation and growth of the services that had been shared with all staff.
- Staff reported that the senior management team were visible and accessible; department managers were supportive and approachable. Staff felt there was an open culture which was encouraged by the management team.
- Middle managers and senior staff were aware of the priorities for their service areas and departments and shared the hospital and corporate vision.
- There were governance structures and reporting mechanism in place where performance and the quality of the service was discussed. The hospital risk register documented risks and assigned a manager responsible although date of entry or a review date and some environmental risks lacked detail.

We saw good practice including:

- The electronic national early warning score (NEWS) to identify deteriorating patients by monitoring patient observations automatically calculated the level of risk. When a certain level was reached, the registered medical officer (RMO) on call was automatically informed and reviewed the patient.
- The falls programme including the introduction of a falls assessment tool to identify patients at risk and posters to remind staff of the nine key points to consider. Staff considered the environment, access to call bells and patient foot wear. There were signs in patient rooms to remind them to call for assistance stating 'call don't fall' and staff believed these initiatives were having an impact on the number of falls.
- Staff were caring and compassionate and focused on meeting individual patient needs.
- The multidisciplinary team (MDT) meeting discussed complex care and the management plans for cancer patients requiring surgery and a range of other treatments. An electronic record of the meeting was completed in real time providing a clear and accessible plan of care.
- Physiotherapists worked within the multi disciplinary team. They had full access patients' records and were able to inform treatment decisions made by patients and doctors. Each patient had individual outcome goals agreed and these were recorded in their notes. They were provided with a written discharge summary.
- There was a Macmillan's cancer information and support service available at the hospital from Monday to Friday. Patients diagnosed with cancer could find out what to expect and receive additional information, practical advice and support from qualified nurses.
- International multidisciplinary meetings were held for patients who came for treatment from abroad. These meetings involved their UK consultant and lead clinicians from the country of origin to ensure continuity of treatment.

Summary of findings

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

Importantly, the hospital must make the following improvements:

- The hospital must ensure all policies reflect the latest national and professional guidance.
- Ensure all intravenous fluids are stored in locked cupboards to prevent unauthorised access.
- The hospital must ensure that the process for amending medication prescriptions out of hours when the consultant is not present is in line with national professional guidance.
- The hospital must ensure that there is evidence that the vaccinations are consistently stored at the recommended temperature and fridges used to store vaccines are appropriately monitored and maintained.

In addition the hospital should:

- Ensure that the process in place for contacting consultant in unplanned situations should be explicit.
- Implement effective systems to monitor, review all patient deaths with independent input and share the learning from these reviews with staff.
- The critical care unit should implement a periodic multi-disciplinary team meeting to review unit performance, governance and review patient outcome data to identify potential improvements in the service.
- The hospital should review the need for dedicated support for ICNARC data collection and submission to ensure the data submission is timely.
- The hospital should ensure that there is a written plan including timescales for the replacement of the lift and all staff are aware of the actions being taken to mitigate the risks prior to the completion of this work.
- The hospital should ensure that all staff have completed the appropriate level of safeguarding training.
- The pre-operative checklist including theatre handover sheet used by nurses prior to taking children to theatre should be completed and used in all cases.
- The hospital should ensure the needs of patients with learning disabilities are assessed and met.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Medical care

Rating

Good



Why have we given this rating?

There were appropriate nursing staffing levels on the medical wards that met patients care and treatment needs. Unexpected deaths were reviewed at mortality review meetings but the patient's lead consultants were not present at the mortality review meeting. Staff were competent for the role they undertook and were regularly appraised and provided with career progression opportunities. Patients in medical services were treated with compassion, dignity and respect. Staff were passionate, motivated and focused on providing patients with a good experience during their stay in the hospital. There was effective multidisciplinary team working and line managers were supportive and visible to staff.

The medicines storage and management arrangements were in line with national guidance. Equipment was easily available and was suitably maintained and checked by an appropriate person. The hospital was able to provide appropriate isolation facilities to reduce the prevalence of health care associated infections. Staff assessed and responded to patient's risk and were able to deal with emergencies effectively.

Surgery

Good



There were processes in place to reduce the risks associated with surgical procedures. Nurses monitored patients after their operation and medical staff were available if there were any concerns. Automatic alerts were sent to the resident medical officers (RMOs) if a patient's observations were of concern via the electronic National Early Warning scoring tool. Pre-operative assessment was undertaken by qualified staff in line with NICE guidelines. There had been one reported incident of venous thromboembolism reported in the year January-December 2014. The number of falls had decreased following the introduction of a falls programme.

There were sufficient numbers of staff to care for patients. The majority of patients provided positive feedback about their care and treatment, although the response rate was low. The hospital had an audit

Summary of findings

programme in place but there was limited data on the outcomes for patients treated at the hospital. For some complex surgery the patient outcomes were reported nationally by individual consultants. Multi-disciplinary meetings to discuss patient treatment plans were evident. The pharmacy department provided support for ward staff and had audited medicine management across surgery to improve effectiveness on discharge following surgery. Senior management were accessible to staff and were reported to be supportive. There were governance processes in place; however some policies required updating at the time of our inspection.

Critical care

Good



Incidents were reported and investigated and where learning was identified this was shared. Policies and procedures followed national guidance and were in date and available to staff. Clinical protocols and pathways were available and followed best practice guidance. Patient outcome data was collected and submitted to ICNARC for critical care patients. However, ICNARC data for the period June to December 2014 had been collected but had not been submitted to ICNARC at the time of our inspection. The unit participated in local and national audits as applicable to demonstrate patient outcomes. Patients were admitted without delay to the unit however the number of discharges delayed over four hours were higher than the national average. Staff received appropriate training and assessment to ensure safe, effective clinical practice. We noted that 59% of the core nursing staff on the unit held a post registration critical care course which complies with the national standards for nurse staffing in critical care. Staff were caring and treated everyone with unfailing politeness, respect and dignity. Patients reported very high levels of satisfaction with all aspects of their care and treatment. There was identified clinical leadership and clear reporting lines for staff and managers in unit. There was no formal documented vision or strategy for the service however staff were aware of the role the unit played in meeting the hospital and corporate vision. Staff reported that the senior hospital management team were supportive, visible and accessible.

Summary of findings

Services for children and young people

Requires improvement



Care was provided to children and young people in well maintained accommodation and the equipment we saw was clean. We observed systems in place to ensure appropriate response to deteriorating children. There was 24 hour paediatric medical cover on site and access to consultants at all times but no anaesthetic rota. Staff used an electronic incident reporting system and demonstrated that learning from incidents took place. There were high numbers of medication errors that had not reduced despite action being taken.

Most care and treatment pathways were based on national guidance and local audits were undertaken to assess compliance with these. Data was submitted to some national audits such as paediatric intensive care audit network (PICAnet) and central cardiac audit data (CCAD). Some key policies were overdue for review and updating and did not reflect current best practice, for example the safeguarding policy and the Do Not Attempt Resuscitation policy.

Children and their families were involved in the planning of their care and treatment and staff were receptive to their wishes and choices. Staff took care to make sure children and their parents understood their treatment.

Outpatients and diagnostic imaging

Good



Staff had demonstrated an awareness of the process for identifying and recording patient safety incidents. Where serious patient incidents had occurred we found there were processes to investigate the incident and with actions were identified and implemented as a result.

Complaints were investigated and where necessary clinical and administrative practice was changed to prevent recurrence. Diagnostic and imaging staff followed national guidance and equipment was appropriately cleaned, tested and maintained. Radiation regulations were followed and staff received the necessary training and competency assessment to ensure patient safety.

We saw that staff were caring and maintained patient's dignity and privacy at all times. Patients understood their treatment options and their plan of

Summary of findings

care. Patients were able to choose the time for their appointment to suit their needs and there were no delays in booking appointments and some investigation results were available within an hour. There was evidence of effective multi-disciplinary team working across the services with shared responsibility for care and treatment. Patients were positive about the staff and the quality of the care and treatment they received. There was a vision for the development of OPD services and identified local leadership. The department strived for continuous improvement in the services it offered.

Good 

The Harley Street Clinic

Detailed findings

Services we looked at;

medical care; surgery; critical care; services for children and young people; outpatients and diagnostic imaging

Detailed findings

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Background to The Harley Street Clinic

The Harley Street Clinic is a 110 bedded private hospital, based in Harley Street, London. The Harley Street Clinic is part of HCA International group who have five other hospitals in London.

The hospital undertakes a range of surgical procedures, provides medical and critical care, children and young people services and also carries out outpatient consultations. These are five of the eight core services that are always inspected by the Care Quality Commission (CQC) as part of its new approach to hospital inspection.

The hospital has four operating theatres, 97 consultation rooms, six treatment rooms, 96 inpatient and 14 day case beds all with en-suite facilities.

The hospital provides care to patients from birth. The majority of adult patients are from London and the South East. Over 50% of children seen or receiving treatment at the hospital are from overseas.

At the time of the inspection the hospital was not providing any NHS funded care.

Our inspection team

Our inspection team was led by:

Chair: Professor Sir Norman Williams

Head of Hospital Inspection: Siobhan Jordan, Care Quality Commission (CQC)

Inspection manager: Fiona Wray, Care Quality Commission (CQC)

The team included CQC senior managers, inspectors, doctors, nurses and senior managers.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?

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

The inspection team inspected the following four core services at the Harley Street Clinic:

Detailed findings

- Medical care
- Surgery
- Critical care
- Services for children and young people
- Outpatients and diagnostic imaging.

We carried out an announced inspection visit on 17, 18, 19 February 2015, 06 May 2015 and an unannounced inspection on 25 February 2015. We spoke with a range of staff in the hospital, including nurses, consultants, administrative and clerical staff.

During our inspection we spoke with 40 patients and 119 staff from all areas of the hospital, including the wards and the outpatient department. We observed how people were being cared for and talked with patients and reviewed personal care or treatment records of patients.

Facts and data about The Harley Street Clinic

Context

- The hospital is registered for 96 inpatient and 14 day case beds.
- 806 doctors have practising privileges. Their individual activity is monitored and in the period January 2014 to January 2015 this ranged from 1-1957 patient episodes. Of the 806 doctors with practising privileges 130 had seen over 100 patients per annum.
- The hospital employs 21 whole time equivalent (WTE) permanent doctors.
- There are currently 157 WTE nurses in post with 54 vacancies.
- There are seven health care assistants employed.
- The latest independently monitored patient feedback, based on 1729 responses for 2014 found that the majority of patients rated the overall quality of care as excellent or very good and rated the individual attention as excellent or very good.

Activity

- During January to December 2014 there were 39,376 adult outpatient attendances. The majority of these were cardiology, general medicine and oncology patients.
- During the same period there were 7,199 children's outpatient attendances. The majority of these were general paediatric, cardiology and oncology appointments.

- Around 3,014 overnight adult patients and 734 children were overnight patients between January and December 2014.
- Between January and December 2014 there were 2327 adult day cases and 1222 children day cases.
- In the last 12 months 23.5% of inpatient discharges in 2014 had a primary diagnosis of cancer.

Contacts with NHS

The hospital has a contract with King's College Hospital NHS Foundation Trust for specific neurosurgery, including extradural spine intermediate and cervical laminectomy to support the trust when they do not have capacity to provide care to these patients.

HCA International Limited has a contract with University College London Hospitals NHS Foundation Trust, to provide the trust with additional capacity but this does not state if this is solely for work at the Harley Street Clinic.

Inspection History

The Harley Street Clinic has been inspected three times between 2012 and 2014, with 11 of the core standards being assessed during these inspections. All standards assessed were found to be compliant.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Urgent and emergency services and Outpatients & diagnostic imaging.
2. If you have not followed the ratings principles, please highlight this here using a footnote with a brief explanation of the rationale. This information should also be included in the main text of the core service report

Medical care

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

Information about the service

Within the hospital there are fifteen single rooms available to treat medical patients on the cardiology ward with five additional beds that can be used as required in the coronary care unit and high dependency unit. There are also twelve single rooms for oncology patients. In 2014 there were 777 cardiology and cardiothoracic patients and 543 oncology patients admitted. The hospital treated a range of cancers including many forms of urological, head and neck, lung, breast and upper abdominal cancers. Patients on the cardiology and cardiothoracic ward included those who had previously undergone coronary intervention such as coronary artery vein graft surgery, or mitral valve treatment. Others were under investigation for arrhythmias, had congenital heart disease or valvular diseases. The hospital did not routinely admit patients who had a heart attack (acute myocardial infarction).

During our visit we visited both medical wards and spoke with patients, their carers and relatives, 29 members of staff including doctors, nurses, allied health professionals, senior staff and support staff such as cleaners and catering staff. We reviewed patient and medication records and observed care being delivered on the wards.

Summary of findings

There were appropriate nursing staffing levels on the medical wards that met patients care and treatment needs. Unexpected deaths were reviewed at mortality review meetings but the patient's lead consultants were not present at the mortality review meeting. Staff were competent for the role they undertook and were regularly appraised and provided with career progression opportunities.

Patients in medical services were treated with compassion, dignity and respect. Staff were passionate, motivated and focused on providing patients with a good experience during their stay in the hospital. There was effective multidisciplinary team working and line managers were supportive and visible to staff.

The medicines storage and management arrangements were in line with national guidance. Equipment was easily available and was suitably maintained and checked by an appropriate person. The hospital was able to provide appropriate isolation facilities to reduce the prevalence of health care associated infections. Staff assessed and responded to patient's risk and were able to deal with emergencies effectively.

Medical care

Are medical care services safe?

Good



All staff directly employed by the provider had access to the electronic incident reporting system and knew how to use it. Not all nurses and healthcare assistants were aware of learning from incidents. Unexpected deaths were reviewed at mortality review meetings but the patient's lead consultants were not present at the mortality review meeting.

Staffing levels met patient needs. Not all staff had completed the required mandatory training. Patient records were appropriately completed and fit for purpose. A baseline medication reconciliation audit carried out in September 2014 showed an improvement on the previous audit carried out in June 2014 when only 53% of patients had their medication reconciliation within 24 hours, which had been below the expected target set by the hospital.

All wards, toilet facilities and waiting areas were clean and isolation facilities were available if required. There was appropriate equipment available to respond to emergencies and unforeseen events.

Incidents

- There were eight serious incidents (SIs) requiring investigation in the reporting period between November 2013 to October 2014. None of these incidents related to medical care.
- Senior nursing staff were able to demonstrate how practice had changed in response to serious incidents that had been reported in the surgical division. For example in response to an incident when a patient developed a groin hematoma (collection of blood that forms outside of the blood vessels in the area of the groin), nursing documentation was reviewed and vascular observation charts were introduced. In addition two training days were organised to raise staff awareness of these changes. Other nurses and healthcare assistants were unable to tell us about other examples of shared learning from incidents including learning across the hospital.
- All staff employed directly by the provider had access to the electronic system used to record incidents and knew

how to use it. Staff gave us examples of how incidents were investigated and told us they had received feedback from their head of service during team meetings.

- Agency staff did not have access to the electronic system used to record incidents and we were told a senior nurse would record an incident on their behalf should there be a need. There was no paper incident reporting system which could be used by the agency staff.
- Safety alerts were monitored, a senior nurse we spoke with was aware of the most recent critical safety alerts which were relevant to their specialities
- The provider reported no unexpected deaths in cardiology and one in oncology between October 2013 and September 2014. We were told that these deaths were reviewed at the mortality review meeting the mortality review records that related to these deaths both recorded that the lead consultants were not present at the mortality review meeting.
- The provider had planned training relating to the Duty of Candour in February 2015. The protocols relating to how the hospital would implement the Duty of Candour had been shared with heads of departments.

Assessing and responding to patient risk

- Risk assessments were completed at the time of admission which prompted staff to order specialist equipment, such as pressure relieve mattresses. Nurses told us external contractor delivered equipment promptly. There was a tissue viability nurse working at the hospital which provided staff with advice related to pressure care and there were tissue viability link nurses identified on both medical wards.
- Nurses used pressure area risk assessment charts in line with national guidance. A care bundle was also used to prevent pressure ulcers and minimise variation in care practices. We noted pressure ulcers were reported in the electronic incident reporting system used at the hospital. Nurses were provided with tissue viability and wound management information and were guided by the wound classification charts to accurately assess wounds.
- Nurses assessed all patients at risk of falls on admission and we noted those at increased risk of fall had also been assessed by a physiotherapist who made recommendations on how to minimise risk.

Medical care

- The “call don’t fall” campaign was introduced in 2014 to encourage patients to use the buzzers and call for assistance whenever required. The quality matron told us the number of falls had decreased since the introduction of this initiative. Data provided confirmed this decrease in falls.
- A quarterly falls report was prepared for each ward and shared with the senior management team. There were 13 falls recorded on the oncology ward in 2014, of which six had resulted in minor harm.
- The hospital had reported one incident of VTE (venous thromboembolism) in the last 12 months. We observed VTE assessments were undertaken in line with national guidance and compliance with this guidance was monitored. The provider reported 87% compliance with this requirement for 2014. This was an improvement when compared with 2013 when compliance was reported to be 77%. This compliance rate continued to improve in January and February 2015.
- There were no catheter associated urinary tract infections (UTI) recorded as acquired at the hospital in 2014.
- The provider undertook an annual blood transfusion audit in 2014 to assess compliance with safe blood transfusion practice. The audit highlighted 88% compliance with the guidelines. However, this was lower than in 2013 when the rate was 92%. We noted local teaching had been planned to address the issue but had not taken place at the time of our inspection.
- In September 2014 the provider redesigned the blood transfusion system in line with recommendations made by the National Blood Transfusion Committee. The aim was to increase patients’ safety, incorporating barcode patient identification and bedside computers to prompt staff through every step and verify that the correct blood is transfused.
- There were systems to manage medical alerts related to drugs and medical devices to minimise potential risk to patients. Staff gave us examples of how it worked in practice and what changes had been introduced in response to alerts raised by the Medicines and Healthcare Products Regulatory Agency (MHRA).
- Patients had easy access to call bells and we observed their calls were responded to promptly. Additional staff were requested to support patients who required an increased level of support or one to one assistance as necessary.
- Most staff had received training in basic life support (93%). There was standard emergency equipment available to support patients in emergency, which included defibrillators. Staff discussed patients at increased risk of cardiac arrest and how to act in an event of emergency during their daily team meetings.
- A clinical software system was in use to record inpatient observations such as pulse, blood pressure and temperature at the bedside. The system used the data to calculate an early warning score (EWS) for each patient. The system used these scores to alert relevant staff to patients who may be deteriorating, as well as recording when the next set of observations should be taken, according to the patient’s individual level of risk. Nurses told us they received training in how to use the system and felt confident using it.
- The provider told us patients considered ‘high risk’ were supported by the RMO present on site who acted in accordance with instructions provided by patient’s consultant. Patients were also seen by their lead consultant, within one hour from when the alert was raised, or a named consultant who provided cover on their behalf.
- There was no formal arrangement for referral of patients to NHS services if their acute condition deteriorated and the hospital did not have the facilities to provide care, staff knew that if there was such a scenario then 999 would be called. No staff report to ever having to do this. The hospital worked within the corporate provider network and staff told us they would transfer to another corporate provider hospital should they be unable to care for a patient and one of their hospitals could.
- There was a process in place for supporting patients with ‘do not attempt cardiopulmonary resuscitation (DNACPR) decisions. This process involved the patient, their family and lead clinicians involved in the patient’s care. The DNACPR policy stated that “competent patient’s wishes cannot be overridden either by relatives, doctors or nurses” and that patient’s rights were central to the decision-making process. It also stated that they should be actively involved in the decision making process and their informed views clearly noted. This protocol was last reviewed in 2011 and had exceeded its review date as it was due to be reviewed in January 2015. We were unable to assess effectiveness of the process as no patients had a DNACPR decision in place at the time of the inspection.

Medical care

Cleanliness, infection control and hygiene

- Wards were visibly clean. There were cleaners allocated to specific wards during the day and night. They had completed basic infection control training the week before the inspection. This training was reported to be significantly overdue. In October 2014 a lead nurse in infection control had been appointed. There had been no lead in infection control at the hospital for the previous two years.
- We observed equipment used at the hospital was clean and that staff labelled it to indicate when it had been cleaned and that it was ready to use.
- Patients were cared for in single rooms with ensuite toilet and shower facilities, which assisted in minimising the risk of infection. Each room was equipped with a hand washing basin and hand sanitizers. Hand washing techniques were displayed next to hand washing basins.
- We noted appropriate hand hygiene practice and personal protective equipment such as gloves and aprons were also available and staff were observed using them appropriately.
- We observed when extra infection precautions were required before entering a patient's room. This was clearly indicated on the door. Staff reminded visitors to adhere to infection control prevention methods. For example we observed a member of staff approached an interpreter asking them to wash hands and put an apron on before entering patient's room.
- There were no clostridium difficile (C.diff) cases or methicillin-resistant staphylococcus (MRSA) infections reported by the hospital in 2014.
- Nurses told us one infection control audit was carried out in 2014 but they were unaware of its findings and unable to provide us with a details of the audit outcome. However before our inspection the hospital shared with us a number of audits including audits of hand hygiene, central venous catheter continuous care audit, personnel protective equipment audit and environmental audits. The audits had been undertaken sporadically and we were not provided with or told of actions being taken to address audit findings.

Environment and equipment

- We observed there was limited storage space on medical wards with equipment being stored in corridors. The physiotherapist we spoke with told us

space to store equipment was a problem as there was no designated easily accessible space. We noted that evacuation routes were clear of clutter and equipment did not obstruct main corridors.

- Resuscitation equipment was available in all areas and records showed that it had been checked daily. Staff were aware where to find it and could access it promptly.
- Each room was equipped with piped oxygen and suction which were ready for use. There were defibrillators available on each floor to allow staff to respond to cardiac arrest promptly, record showed that these were tested daily.
- The medical wards were not fully accessible to people with mobility difficulties. Although the medical wards could be accessed by two lifts, these occasionally were not functioning. The lift had broken down three times in the last 12 months. The lift issues had been risk assessed and were identified on the risk register as a major risk. To mitigate the risk all patients were transferred with emergency equipment. The provider had developed plans to install an additional lift to minimise risk, but there was no date for the installation of this lift. When the service lift was out of order it was impossible to transfer a patient on a trolley bed from and to the ward.
- We observed equipment used at the hospital was appropriately tested to ensure it was in working order. Equipment tested included fire fighting equipment, electrical portable appliances and clinical equipment such as medical infusion pumps. Measuring equipment was also calibrated to ensure measurements were accurate.
- Sharps boxes were appropriately assembled, labelled and not over full. There were suitable arrangements for waste management.

Medicines

- Medical wards had designated pharmacists and a medicine technician who visited the wards daily. Pharmacists were involved in medicines reconciliation when patients were admitted to the hospital, clinical scrutiny of the medicines charts to prevent medication errors and the discharge of patients. Technicians were involved with medicine supply top-ups to maintain supplies on the wards and dispensing and checking of medicines for people who were going home so that they could leave promptly.

Medical care

- Medication reconciliation audits had taken place that looked at each patient's current medicines. Matching the medicines the patient should be prescribed to those they were actually prescribed, indicated that, in June 2014, 53% of all patients had medicines reconciliation completed within 24 hours. This level was below the target of 70% set by the hospital. However in September 2014 a re-audit showed 76% of patients had their medication reconciliation within 24 hours - above the target of 70% set by the hospital. Only 84% had their reconciliation completed within 72 hours. Result of this audit were reported to clinical audit subcommittee in February 2015 with improvements points identified.
 - Quarterly controlled drug audits were undertaken by the ward and pharmacists. The findings of these audits showed variable compliance levels between 78% and 96% on the oncology ward. The cardiology ward had achieved between 83% and 100% compliance. Findings of the audits were shared with the clinical audit sub-committee group and reported in the clinical audit annual report where improvements had been recommended to ensure appropriate storage and administration of controlled drugs. Discrepancies and incidents were reported to the accountable officer. The frequency of the audits had recently been increased following the identification of recording concerns.
 - The hospital had systems in place to report medication errors, missed doses and near misses and all staff we spoke with knew how to report an error. We saw evidence of audits carried out and heard about how interventions and errors were monitored and escalated to senior managers and the safety board. The audit found 6% of all medication doses across the hospital were omitted, 16% of which were critical medications. Result of this audit were reported to clinical audit subcommittee in February 2015 with improvement points identified. The most common reason for medicine dose omission was patients refusal and change in their medical condition. It also identified the reasons for other errors, such as lack of availability. We noted that nurses took appropriate actions if a medicine dose was omitted or delayed and staff responsible for the error received additional training. Those incidents were also escalated to the management to prevent future occurrence.
 - Nursing staff received medicines awareness training every two years. They were also assessed annually to ensure their knowledge and skills were up to date.
- Nurses and resident medical officers (RMO) had an introduction to the medicines policies and procedures as part of their induction and received medicines training from the pharmacist.
- The hospital had an aseptic production unit for production of sterile medicines for oncology patients at the hospital and other hospitals managed by the provider. There was external quality control, audit and validation of production process to ensure best practice. Oncology patients, where appropriate, were able to receive their blood tests, clinical assessment and treatment as a one stop service
 - The hospital used an electronic prescribing system for chemotherapy as recommended by a National Peer Review Report on Chemotherapy Services. All protocols for chemotherapy were reviewed by a pharmacist before preparation. A chemotherapy diary was given to patients when they had received their treatment. They were also provided with information on how to contact the hospital via the 24 hours helpline if they had side effects and needed medical attention.
 - Patients were provided with lockable storage next to their beds where they could store their own medicines safely.
 - There were emergency medicines available on each floor to allow staff to respond to emergency such as to support patients who experience low blood sugar (hypoglycaemia) or anaphylactic shock. These were in date and easily accessible to staff.
 - Staff we spoke with staff knew how to access medicines out of normal working hours

Records

- We noted all patients' paper and electronic records were stored securely. When required hard copies of electronic records were printed off for the temporary staff, who did not have access to the patients administration records used at the hospital. Paper records were then uploaded back into the system after being updated.
- The patient's records and observational charts including nutrition and fluid intake records and individual risk assessments we reviewed were complete and reviewed regularly.

Medical care

- The nurse's record keeping audit undertaken in 2014, to assess the standard and check if professional requirements were met, indicated 83% compliance. We noted this audit was completed on a sample size of 30 patient records.

Safeguarding

- The hospital had an up to date adult safeguarding policy that reflected national guidance.
- Safeguarding adults training was mandatory for all staff and had to be completed every three years. The duty manager and senior nurses were required to complete level 3 safeguarding training which provided advanced information on reporting strategies, policies and procedures.
- Records provided by the hospital indicated that 75% of staff had completed safeguarding adults training at the hospital; 86% had completed safeguarding children training levels 1 and 2 and 100% had completed safeguarding children level 3 training.
- There were no safeguarding incidents reported in the twelve month period prior to the inspection.
- Senior nurses were able to describe safeguarding procedures and provided us with examples of how these would be used. However other nursing staff's knowledge of the procedures was limited and they depended on a senior staff member to take action if they had a concerns.
- The chief nursing officer was the lead for adult safeguarding at the hospital, supported by the adult clinical services manager.

Mandatory training

- Mandatory training was available to staff through face to face training and online (e-learning). It included annual training in health and safety, ethics and code of conduct, equal opportunities and diversity, information security, basic life support and infection control. Clinical staff were required to complete training on blood transfusion, medical gas safety, intermediate life support, nutritional screening, VTE and pressure ulcers prevention training.
- All nurses told us they were happy with training opportunities provided and were up to date with their mandatory training. Figures provided for the medicine division showed that not all staff had completed the required training.

- The lowest compliance rate was reported for medical gases with 26% of staff, blood transfusion assessment 54.5% of staff, and nutrition 52% of staff completing this training. The overall compliance for mandatory training for medical care was 77%, with 75% of medical staff completing safeguarding adults training and 75% completing manual handling training.
- Support staff such as catering staff or cleaners told us they had been provided with health and safety training, basic life support, safeguarding, manual handling and control of hazardous substances training. They told us they had not received other mandatory training such as fire safety or infection prevention and control for a number of years.

Nursing staffing

- There were sufficient nursing staff on the medical wards with one nurse allocated to a maximum of four patients. There was no acuity tool used to identify the numbers of nurses required. There was also a healthcare assistant and a senior nurse available during the day to provide additional support to staff and patients.
- Nurses worked twelve hours shifts which they said gave them "time to care for patients properly."
- There were four vacant nursing posts, out of nineteen on the cardiology ward (21%). A senior nurse told us the provider was proactive in recruiting and other staff felt positive that these would be filled promptly.
- The ward sister told us cover for staff absence and annual leave was arranged and we noted it was recorded on the staffing rota. The sickness rate for nursing staff was 2.8%, administrative and clinical staff 3.2%, and for allied health professionals 2.2% in 2014. These figures were reported for the hospital and not reported for individual areas. We were unable to assess the rates for the medical division.
- At the time of our inspection approximately 9% of nurses working on the wards in the hospital were employed by an external agency. We noted this was less agency usage than in September (17%), October (16%) and November 2014 (19%).

Medical staffing

- There was a resident medical officer (RMO) present on each of the medical wards. They were responsible for reviewing patients daily and in communication with the patients lead consultant.

Medical care

- Lead consultants were available at the time of patient's admission and on call at all other times. There were formal, written arrangements in place to provide adequate cover to patients when the lead consultant was not available. Doctors were required to name another consultant who would oversee the patient during their absence. The admitting consultant was also required, as part of their practising privileges, to visit patients admitted daily or more frequently at the request of the nurse-in-charge of the patient or the RMO.
- The medical advisory committee (MAC), which included representation of all specialists working in that hospital, advised the hospital chief executive whether to consider an application for practising privileges. The hospital reviewed the practising privileges of each practitioner every two years to ensure doctors were competent. Individual data on activity and performance was reviewed to enable an informed decision to be made by the hospital on whether or not to renew practising privileges. It included information on medical practice, relationships with patients and colleagues and any training completed to date.
- We noted there was a low absence and sickness rate among the RMOs.

Major incident awareness and training

- There was a major incident procedure in place and all staff spoke with were aware of it. Each ward was equipped with a "major incident box" containing flash cards instructing staff on their roles and actions they should take should a major incident occur.
- There were business impact analysis continuity plans for adult medical wards updated in January 2015. They addressed potential short and long term service disruption and how to minimise the impact.

Are medical care services effective?

Not sufficient evidence to rate

As the hospital did not collect sufficient patient outcome data we were unable to assess this area. Care pathways, informed by appropriate national guidance were used for the management of patients' medical conditions. Patients were given information about pain and offered pain relief when needed. Patients' nutritional needs were assessed and monitored appropriately.

Staff were competent and knowledgeable. There was effective multidisciplinary team working and communication between all staff involved in patients care and treatment. Consent was obtained from patients prior to procedures being carried out.

Evidence-based care and treatment

- We were told the National Institute for Health and Care Excellence (NICE) guidelines which inform patient care were routinely communicated to all staff concerned via email. The quality matron told us they were working on new system to monitor all changes in the guidance provided by NICE but this had not been introduced at the time of our inspection. We were also told all new NICE guidelines were shared at regular Medical Advisory Committee (MAC) meetings and minutes of the MAC confirmed this.
- Protocols for patients' treatment were informed by professional best practice guidance. However, we noted that occasionally there were delays in implementing changes to guidelines. For example, changes in practice relating to assessing the risk of falls for all patients over 65 years informed by the NICE guidelines on "Falls: assessment and prevention of falls in older people" published in June 2013 were implemented by the hospital in 2014.
- Staff told us they were familiar with a range of local policies and procedures to support individual consultant's clinical management plans. However, they were unable to locate these procedures in electronic or written form when we requested. The quality matron told us these had recently been updated and reorganised. However, a nurse told us they had not been fully aware of any changes made.

Pain relief

- Staff had access to a specialised pain team working in the neighbouring NHS hospital; the team was available Monday to Friday with on-call support out of hours. This agreement had been formalised by a service level agreement. Nurses told us they rarely referred patients to the team as they have received support from the resident doctors and the pharmacist at the hospital.
- Patients we spoke with had been given information about pain and said someone regularly checked on them to make sure they were comfortable and they were offered pain relief if and when required. A pain scale chart, was used to measure a patient's pain

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intensity, based on their self-report and also observational and physiological information was considered. The pain scale charts were available in Arabic and Greek to support patients to self-report accurately.

Nutrition and hydration

- Staff used the 'malnutrition universal screening tool' ('MUST') as recommended by the NICE standard for nutritional support of adults. This tool was developed by the malnutrition advisory group of an organisation that raises awareness of malnutrition and its use was supported by the British Dietetic Association (BDA), the Royal College of Nursing (RCN) and the Registered Nursing Home Association (RNHA).
- We observed nutritional assessments were completed and that nutrition and fluid charts were completed accurately.
- We observed patients were offered snacks in between mealtimes and that drinks were available at all times.
- We saw that menus catered for cultural preferences of patients. It included halal, vegetarian and gluten free food. Hot food was routinely provided from 1.00pm to 7.30pm and patients could indicate the time they would prefer to eat their meal and the size of the portion they would like.
- Staff told us individual requests were considered and they were able to order food which was not routinely available on their menu. Food and hot drinks were also available to patients at night time on request.

Patient outcomes

- The hospital collected data for the National Audit of Cardiac Rhythm Management which collects information about all implanted cardiac devices on all patients receiving interventional procedures for management of cardiac rhythm disorders in the UK. Data reported in 2013 suggested 100% success rate and only one complication related to the procedure for the 430 cases treated. Similarly in the first two quarters of 2014 survival on admission rate was reported to be 100%.
- There was a lung cancer service established at the hospital in 2014 and a database developed to collect the National Lung Cancer Audit dataset. At the time of our inspection we were not provided with any comparative data to assess effectiveness of this service.

- The provider did not formally collect chemotherapy outcome data related to the chemotherapy treatment regime. We were told they were planning to start data submission in the next twelve months.
- As a private hospital it was not required to participate in the Heart Failure Audit. The hospital could not voluntarily participate as they did not meet the eligibility requirement for a minimum of 20 cases per month.
- The hospital did not participate in the National Diabetes Audit. Although, the provider told us measures contained within the dataset were monitored with an aim of future participation, they did not provide us with any data which allowed us to assess the quality of the service.
- There were 12 medical admissions for inflammatory bowel disease in 2014. Due to the low numbers of admission for this condition no outcome audit of these cases was carried out.

Competent staff.

- Staff we spoke with were competent and knowledgeable and clear about their responsibilities. They were aware of patients' individual needs and were able to answer patients' questions in a confident manner.
- Nurses' clinical competencies were assessed annually. For example nurses working on the cardiology ward were required to undertake assessment for; basic and advanced cardiac monitoring, endocardial pacing leads and epicardial pacing wires, performing and interpreting electrocardiogram, or use of patient controlled analgesia (PCA) syringe pump. Additional training was provided if it was required.
- The senior physiotherapist told all members of the team had completed an annual professional review which informed their personal development plans. The team leader undertook six monthly reviews with staff and progress against agreed objectives was reviewed.
- Nurses, doctors and allied health professionals told us that, although no formal supervision was provided, they felt they could challenge each other and inform changes in practice by having daily professional discussions among their teams.
- We spoke with a number of staff who told us they had been provided with opportunities to progress their career. For example one nurse told us they used to work as a healthcare assistant and the provider supported them to train to become a registered nurse.

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- Appraisals and performance plans were completed annually for nursing staff during a performance review meeting. These plans had individual competency task and behavioural objectives set, they also listed all trainings completed and training which was due to be attended in the near future. Appraisal rates for all staff, was reported by the provider to be 100% in 2014 and we were told that pay increments were linked to appraisals.

Multidisciplinary working.

- We saw some examples of effective multidisciplinary team working which was embedded in clinical practice. There were weekly multidisciplinary care meetings organised on the oncology ward where patients with complex needs were discussed. Staff participating in these meetings told us they were able to openly challenge each other regardless of their role and grade. All staff felt they were listened to and their views were taken into consideration when deciding on potential treatment options offered to patients
- There were specialist oncology nurses available which included breast, prostate, head and neck and oncology, who provided advice to staff and patients on issues related to their speciality .
- Patients could access physiotherapy services daily. Physiotherapists worked closely with doctors and nurses and told us they “felt part of the team”, they had full access to patients’ records and were able to inform treatment decisions made by patients and doctors. Each patient had individual outcome goals agreed and these were recorded in their notes. Physiotherapists provided patients with a written discharge summary.
- We observed patients records included entries made by allied health professionals, doctors and nurses. A member of staff told us “multiprofessional rapport enabled them to deliver a quality service.” We noted speech and language therapy and dietician advice was also routinely obtained with a dietician being available on site. Patients were supported by occupational health therapist who visited the hospital three times a week also.

Seven-day services

- Physiotherapist and dietician support were available daily between 09.00am and 5.00pm and with on-call support provided out of hours.

- Staff had access to palliative care team working in the neighbouring NHS hospita.The team was available Monday to Friday with an on-call support offered out of hours and at weekends.
- Pharmacy services were available Monday to Friday between 9.00am and 6.00pm, with an on-call service out of hours. There was also a pharmacist and a pharmacy technician working 09.00am - 1.00pm on Saturdays, and 09:30am to 12:30pm on Sundays and Bank Holidays.

Access to information

- The nurse in charge was responsible for updating the electronic handover documents daily.These were used at the morning and evening handover meetings. We noted it included information about the patient, key clinical decisions and information related to their care.
- Nurses and doctors told us they felt they had sufficient access to information in order to support clinical decision making.

Consent and Mental Capacity Act

- Patient information leaflets with basic information on various procedures were available to assist patients in making informed decisions when consenting to treatment. We were told that these leaflets were routinely given before a patient was asked to sign a consent form.
- Mental Capacity Act training was mandatory for all staff. The information provided demonstrated 78% of staff had completed this training.

Are medical care services caring?

Good



Patients reported that nurses and doctors were friendly and they treated them with respect and compassion. Patients felt involved in decisions about their care and treatment. We observed that staff were caring and that all staff spoke to patients in a dignified way.

Compassionate care

- We observed patients being treated with compassion, dignity and respect. This included reception staff being polite, explaining to patients if there was a wait.
- Patient consultations took place in private rooms which promoted their privacy and dignity.

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- Patients we spoke with made positive comments about the treatment provided at the hospital. We observed staff being friendly and compassionate in their approach. One patient told us “the nurses are excellent because they have time.” Another patient said the service was “first class.” Patient’s relatives also told us “everything has been excellent.”
- We noted the hospital's satisfaction survey given to all patients on discharge reported that 97% of all patients had rated the overall care as very good or excellent in 2014. The results had demonstrated a slight improvement when compared with 2013 and 2012. We were not provided with information how it related to individual wards.
- Chaperones were provided whenever required. Staff received no specific chaperones training.

Understanding and involvement of patients and those close to them

- Patients felt involved in their treatment and told us staff explained each of the stages and optional treatments available to them. One patient told us “the consultant pops in most days and keeps me well informed.” Patients were aware of their treatment plan and when they were due to be discharged, they were also fully aware of who their lead consultant and allocated nurse were.

Emotional support

- There was Macmillan’s cancer information and support service available at the hospital from Monday to Friday. Patients diagnosed with cancer could find out what to expect and receive additional information, practical advice and support from qualified nurses. This included complementary therapies and emotional support.
- There were two clinical psychologists who worked at the hospital with one attached to the oncology ward. They provided patients with psychological support whenever required.
- Patients at their end of life were supported by a palliative care team located the neighbouring NHS Hospital. There was a local service level agreement for provision of this specialist service. Staff understood the principles of end of life care and respected patient’s decision related to preferred place of care at their end of life.

- There was a spiritual care coordinator who supported patients and their relatives with accessing suitable services and provided information on how to access bereavement support.

Are medical care services responsive?

Good



There was cooperation across the hospital and divisions to ensure patients received appropriate care and treatment. Patients family could visit at any time during the day, patients had a choice of food which was served at their preferred time. The provider actively sought patient’s views. International multidisciplinary meetings were held for patients who came from abroad. There were in-house face to face translation services available for the three main foreign languages used at the hospital.

Service planning and delivery to meet the needs of people

- The medical service had fifteen single rooms on the cardiology ward with an additional five mixed sex beds located on the coronary care unit/ high dependency unit which were used occasionally as an overflow facility prior to a patient’s admission to the ward. A senior nurse told us the bed numbers were appropriate for the occupancy rates of on average 13- 14 patients being treated on the ward Monday to Friday with only two or three patients staying overnight at weekends.
- The oncology ward had an average bed occupancy of 85%, with no significant reduction at weekends. The cardiology ward had slightly higher occupancy rate during week days with significant reduction over the weekend.
- International multidisciplinary meetings were held for some patients who came for treatment from abroad before admission. These meetings involved their UK consultant and lead clinicians from the country of origin to ensure continuity of treatment.

Access and flow

- There was an up to date admission policy which specified that all patients would be admitted by a consultant who had practicing privileges granted by the medical advisory committee. In the case of patients

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being referred with potentially life-threatening emergencies, doctors were advised to refer patients, by ambulance, to the nearest NHS accident and emergency department unless advised otherwise by a consultant.

- There was reduced activity on the wards over the weekend with only a few patients staying overnight. Staff told us there were no weekend delays in discharging patients.
- Doctors and nurses told us they had access to diagnostics and test results promptly to inform patient's treatment plans.
- Patients were not moved between wards during their stay unless there was a medical reasons such as their condition deteriorating and they required intensive care. There had been one transfer out of the hospital to an NHS hospital in January 2014 due to no cardiac beds being available.
- The unplanned readmission rate was lower than the national average with 4 medical patients being readmitted in 2014 - 2 cardiac patients and 2 oncology patients .

Meeting people's individual needs

- The quality matron told us a new policy relating to people living with dementia was in process of ratification.
- There was no routine dementia screening for elderly patients. A senior nurse told us an assessment could be completed if patient "showed signs of dementia". It was unclear how staff would recognise the early signs of dementia. Staff were unaware of any liaison service that specialised in the diagnosis and management of dementia and older people's mental health.
- The provider told us a dementia self-assessment tool in line with the Department of Health self-assessment framework had been developed and an action plan was in place to address the variances. However staff we spoke to were unaware of these.
- Staff had no access to communication tools to facilitate communication with people who might be unable to read or had limited ability to understand spoken word.
- Nurses and doctors told us approximately half of all patients treated at the hospital were from overseas. The majority of these patients spoke Arabic, Russian or Greek. We saw that the guiding information displayed in corridors was translated into other languages. However it was inconsistent, with signs on one floor was displayed in Arabic and English and on another floor in

English and Russian only. Patient's information leaflets, for example on how to live with a heart condition, were provided only in English. We observed food menus were available in Arabic, Greek and Russian. There was variety of leaflets and patients guides available on the provider's internet site.

- There were in-house face to face translation services available for the three main foreign languages used at the hospital. Physiotherapists and nurses told us they had used the interpreters and found the service worked effectively. A senior nurse told us staff used interpreters for all medical consultations and staff would seek patient's family support only for informal day to day communication.
- There was written information available for patients. Some of the leaflets had been produced by the hospital and other items had been provided by external agencies such as the British Heart Foundation.
- All patients were cared for in single rooms with some patients occasionally having their pre-admission assessment in the five bedded coronary care unit (CCU) if a single room was not available. There was a quiet room on the oncology ward which was used for private conversations with the family members whenever required.
- Visiting times were flexible. Each room was equipped with two armchairs and footstool. A patient's family could stay next to their bed overnight if it was the patient's wish. Rooms were also equipped with a fridge, television and had internet access.
- There was no equipment or facilities designed to support bariatric medical patients. A senior manager told us these patients would be assessed prior to their admission and referred to another hospital who had appropriate facilities, managed by the same provider.
- There were no mortuary facilities at the hospital. The provider had a local agreement with an undertaker to use their facilities.

Learning from complaints and concerns

- Information on how to raise concerns or make a formal complaint was displayed on both medical wards. The provider had a policy which set out how complaints should be dealt with and timescales for responding to them.
- Patients we spoke to had no complaints or concerns relating to the treatment provided to them at the

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hospital. The provider sought patient's views, there was a patient's comments box with questionnaire available to patients encouraging them to comment on the quality of service provided.

- A senior nurse told us most complaints were resolved at ward level. Staff told us some patients complained about minor delays in dispensing 'take home' medicines, these delays were up to 90 minutes. The practice had changed in response to these complaints with a full prescription being available the day before patient's discharge

Are medical care services well-led?

Good



There no vision or strategy to drive the development of medical services. Staff were motivated and satisfied with the quality of care they were able to deliver. Risks were escalated to the risk register by the managers, but the risks identified during our inspection were not included on this register.

They were kept informed of developments and felt listened to by their line managers. We were told that they were able to raise concerns when required. We observed that staff worked as a team and the line managers were supportive and visible to staff.

Vision and strategy for this service

- There was no specific vision and strategy for medical services. Staff told us they were working to achieve a "common purpose" and they were working to provide the highest quality of care to patients at the hospital.
- Staff were unaware of any long term strategies which would involve their department. They told us they had been kept informed of developments at provider level through emails and newsletters.

Governance, risk management and quality measurement

- The provider had introduced a quality matron role in August 2014 with the aim to focus on quality care and provide a link between clinical and governance

structures. We noted the provider had identified priorities for this role and that the quality matron was clear about these, they were also able to update us on the progress they had made on achieving these.

- The quality matron reported to the chief nursing officer and supported the implementation of changes when required.
- There were weekly adult service meetings chaired by the head of clinical services at which day to day management issues were discussed.
- Senior nurses met monthly to share information and support each other. There were also ward meetings held bimonthly. Staff told us they felt there were sufficient opportunities to discuss clinical practice, service developments or any problems they had.
- The quality matron told us the provider was working on introducing a new system for audits and producing audit data. At the time of inspection there was no system to provide 'real-time' information on outcomes for services and assurance on the quality of care.
- The provider had carried out internal quality monitoring audits to assess effectiveness of discharge processes, nursing record keeping and VTE risk assessment completion audit. However, we noted some annual audits had been suspended in 2014 due to policies and procedures being reviewed. This suspension had impacted on the completion of audits including the early warning score audit, completion of the waterlow risk assessment audit, falls audit and consent audit which were last completed in 2013.
- the risk register was managed by head of the governance and CEO who had an overall responsibility. Risks were escalated by manager to be added onto risk register and staff did not have access to the risk register and senior nurses were expected to tell them what was on it. Staff were unable to tell us what risks were currently on the risk register or how risks were being mitigated and how they could be removed from it.

Leadership of service

- All staff were familiar with the management structure within the wards. Each ward had a ward manager/sister in charge who reported to the matron.
- All ward managers/sisters and matrons were supernumerary and staff told us that they were accessible. The matrons participated in the duty

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manager's rota to give 08.00am -8.00pm senior cover across the hospital. The night senior manager cover was provided by clinical nursing staff and duty rotas were provided which confirmed continuous senior support.

- Staff were all familiar with and spoke highly of the CEO and other senior managers and medical advisory committee members and felt that they could approach them should there be a need.
- The senior management team regularly undertook walkabouts and were visible and approachable.
- There was a senior manager available on call at all times with a six weekly rotational rota. The on call manager was responsible for dealing with staffing or patient issues and any concerns that needed to be escalated.
- Members of staff responsible for the different wards were knowledgeable and had the qualifications necessary for their jobs. Most of them had many years' experience. They told us they had been supported by the provider to develop their careers.
- Senior nurses on the wards told us they felt involved in the management decisions that affected their wards, they felt consulted on issues regarding service delivery.

Culture within the service

- Doctors and nurses working at the hospital told us they were proud and happy working at the hospital and felt part of the team. One person told us "it is a very unique place; we know each other and support each other." Another member of staff said "we all care and share the responsibility."
- Staff we spoke with were patient centred and focused on providing a good experience for patients who visited their departments.

- Support staff such as those working in catering and housekeeping told us they occasionally worked under increased pressures and the work allocated was on occasion difficult to manage. No staff cover was arranged for when one of their team members was unable to work due to being sick or taking emergency leave and work was reallocated among the remaining staff.

Patient and staff engagement

- The provider actively sought patient's views; there was a patient's comments box with a questionnaire available to patients encouraging them to comment on quality of the service provided.
- Patients feedback was reported, reviewed and discussed quarterly at the head of department meetings and senior nurses meetings.
- A formal staff survey is conducted every two years. The last published staff survey was completed in 2012 we noted in that survey that 57% staff felt engaged, this was a joined score taking into consideration; job satisfaction, motivation, commitment and overall satisfaction with the employer. Staff told us they felt mostly engaged and valued by the provider. The results of the November 2014 staff survey were pending during the inspection.

Innovation, improvement and sustainability

- The quality matron told us there were plans to improve point-of-care testing. Point-of-care testing refers to medical testing at/or near the patient's bed to generate a result quickly so that appropriate treatment can be implemented.

Surgery

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

Information about the service

The Harley Street Clinic provides day surgery and inpatient care for adults requiring a variety of surgical procedures. This includes general surgery such as orthopaedic, colorectal, ear, nose and throat as well as complex cardiac, neurology and cancer treatments. The hospital provides surgical treatment for private patients from the UK as well as from overseas.

There was one surgical ward with fifteen private single occupancy rooms and a mixed medical-surgical cardiac ward with fifteen private single occupancy rooms. These wards provide 24 hour, seven days a week care with 30 private single occupancy rooms. The hospital has four main operating theatres available Monday–Friday 08.00am to 9.00pm, Saturday 08.00am to 4.30pm and Sunday if required. The day surgery surgical unit comprises of four beds. The service employs nurses, operation department practitioners (ODPs), physiotherapists, occupational therapists (OTs) and radiographers to care for surgical patients. Resident medical officers (RMOs) are employed to provide medical cover. The consultant surgeons and anaesthetists have practising privileges to carry out consultations, admit and treat patients having surgical procedures at the hospital. There were 2449 surgical inpatient episodes of care between January-December 2014 and 1728 surgical day-case procedures at the hospital in the same period.

We spoke with nine patients and relatives and 34 members of staff during the inspection. Staff we spoke with included medical, nursing, administrative and managerial staff within the surgical team.

Summary of findings

There were processes in place to reduce the risks associated with surgical procedures. Nurses monitored patients after their operation and medical staff were available if there were any concerns. Automatic alerts were sent to the resident medical officers (RMOs) if a patient's observations were of concern via the electronic National Early Warning scoring tool. Pre-operative assessment was undertaken by qualified staff in line with NICE guidelines. There had been one reported incident of venous thromboembolism reported in the year January-December 2014. The number of falls had decreased following the introduction of a falls programme.

There were sufficient numbers of staff to care for patients. The majority of patients provided positive feedback about their care and treatment, although the response rate was low. The hospital had an audit programme in place but there was limited data on the outcomes for patients treated at the hospital. For some complex surgery the patient outcomes were reported nationally by individual consultants. Multi-disciplinary meetings to discuss patient treatment plans were evident.

The pharmacy department provided support for ward staff and had audited medicine management across surgery to improve effectiveness on discharge following

Surgery

surgery. Senior management were accessible to staff and were reported to be supportive. There were governance processes in place; however some policies required updating at the time of our inspection.

Are surgery services safe?

Requires improvement 

There were systems and processes in place to promote patient safety. Staff knew how to report incidents and the hospital encouraged incident reporting, focusing on learning not blame. Serious incidents were investigated and action plans implemented with the intention to prevent a recurrence. Unexpected patient deaths were reviewed but the patient's medical team were not always involved in these reviews.

There were sufficient numbers of staff, who received appropriate training for their role. There were very few agency nursing staff used particularly in the theatre department. There were processes in place to identify and reduce the risks associated with surgical procedures, such as undertaking appropriate pre-assessment checks. Staff also ensured safe perioperative checks such as the five steps to safe surgery were embedded in everyday practice. Nurses monitored patients after their operation and medical staff were available if there were any concerns, although a formal anaesthetic on call rota was not in place.

Infection prevention and control processes were in place to protect patients from the risk of infection. There were minimal rates of surgical site infections reported. Risks associated with the environment and equipment were managed through checking processes and prompt repair or replacement when required. Records were legible and the majority of patients were seen daily by the consultant responsible for their care.

Incidents

- The hospital used an electronic incident reporting system and all staff we spoke with were familiar with how to report incidents on the system. Incident reporting training was included in the staff induction programme which all staff attended when they commenced employment at the hospital.
- The hospital reported 663 clinical incidents between November 2013 and October 2014. One of these incidents was an unexpected death that occurred in theatres and had been classified as a serious incident (SI).
- The matron and theatre clinical services manager told us that all serious incidents were investigated. Evidence

Surgery

submitted relating to SIs that had occurred in the hospital showed that a root cause analysis report and recommendations were made following each investigation. The investigation explored the factors that contributed to the incident, such as equipment, the escalation processes and service delivery.

- Following the investigation of the unexpected death in theatres action was taken to prevent a recurrence. This included reviewing and changing the equipment used for a specific operation and improving access to drugs required in an emergency situation as well as providing additional training for the duty managers. The additional training included obtaining access to pharmacy and a revised plan of the dispensary shelf layout and revision of the major haemorrhage policy which was completed in January 2015. The major haemorrhage policy included action cards for staff and instructions on how to access blood products in an emergency situation to prevent any delays.
- We were told all patients who had to return to theatre, were discussed in the Medical Advisory Committee (MAC). The minutes of the MAC we reviewed demonstrated that these discussions took place.
- All expected deaths were reviewed by the team involved in the patient's care. However we were not provided with evidence of the outcomes of these reviews. As there was no hospital wide mortality and morbidity meeting and each speciality took a different approach to reviewing patient deaths, there was no evidence of learning between specialities.
- We were told that all unexpected deaths that occurred either in theatres or on the surgical wards were reviewed using a mortality review tool by the medical director and an independent person but the patient's medical team were not always involved. The completed mortality review tools seen recorded who was present and identified learning points.
- The unit managers prepared a monthly report for the clinical governance group which included an outline of any incidents that had occurred. The three reports for July, November and December 2014 we reviewed identified the incident and the actions taken by staff. For example a member of staff received an injury whilst moving a patient under emergency circumstances. The action taken included referral of the individual to occupational health and a manual handling update training session was carried out for all staff in July 2014.

Cleanliness, infection control and hygiene

- Infection prevention and control (IP&C) policies and procedures were in place and accessible to staff on the intranet. We noted the IP&C policies were under review but this review had not been completed by the due date of 15 February 2015.
- There had been no infection control lead nurse in post for two years an appointment to this post had been made in October 2014. To support this individual the ward and theatre areas had recently identified infection control link nurses who would be responsible for ensuring infection control practices and audits were undertaken. Two IP&C study days had taken place and there were plans for future training for the link nurses throughout 2015.
- All the patient rooms were single occupancy on the wards we visited and therefore additional isolation areas were not required.
- Staff in all areas had access to personal protective equipment (PPE) such as gloves and aprons. We observed that theatre staff wore the appropriate PPE during surgical procedures to safeguard patients and themselves.
- Staff were appropriately dressed and adhered to the bare below the elbow policy. However, we noted that some staff in the theatre complex were wearing jewellery such as hooped earrings.
- The decontamination processes for surgical instruments included all instruments being coded and therefore traceable.
- The surgical wards and theatres were visibly clean. There were cleaning schedules in place for the wards and the theatre area which were audited on a daily and weekly basis. The audits we saw confirmed there were no areas of concern.
- The theatre complex was cleaned at night in line with NHS cleaning standards. All equipment seen had stickers to identify the date and time cleaning had taken place.
- Waste management practices were observed and complied with the hospital policy and good practice guidelines for segregation of waste. Sharps bins were labelled and dated and bed linen was bagged appropriately.
- There were hand wash basins in all patients' rooms and hand gel was available throughout the surgical wards and theatre department.

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- The environmental, hand hygiene and scrub procedures audits we saw showed between 98-100% compliance.
- The evidence seen demonstrated that 100% of inpatients in 2014 were screened for MRSA on admission.
- There were no reported cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) blood stream infections between October 2013 and September 2014.
- There were no reported surgical wound infections between October 2013 and September 2014.
- The hospital reported one case of Clostridium difficile and two cases of Methicillin-Sensitive Staphylococcus Aureus (MSSA) between January and December 2014.

Environment and equipment

- The theatre and ward areas were well equipped. Theatre staff told us they checked in advance to ensure equipment was available and met the surgical procedures scheduled.
- The four theatres varied in size and used for different procedures. Theatre one, one of the smallest theatres and used for major complex surgery such as breast and cardiac surgery, had been risk assessed to ensure it was compliant with the minimum space of 55 square metres recommended by Department of Health (HBN 26). Due to the complexity of the surgery involved there was a need for a range of specialist equipment which could have made the area difficult and restrictive to work in. However, the cardiac surgeon we spoke with confirmed the space did not compromise the complex surgery carried out and it met the recommendations required for safe practice.
- There were daily checks recorded as being carried out on all equipment prior to use and an annual service programme for all equipment.
- Minutes of the theatre users' committee recorded discussions about equipment needs and action to be taken to address the need for replacement equipment. Theatre staff told us they reported faults immediately and we saw an example of faulty and new equipment noted in the staff meeting minutes and the theatre users group.
- The patient lift was used to transfer patient to and from theatre post operatively had broken down three times in the last year. While this had been repaired within a

maximum of two hours, resulting in minimal delays in the transfer of patients, we were told that due to the age of the lift parts were very limited and would be soon no longer available.

- The lift issues had been risk assessed and was identified on the risk register as a major risk. To mitigate the risk all patients were transferred with emergency equipment. Staff told us there were plans to replace the lift later this year but no date was provided when this work would commence or the timescale for completion. Minutes of the January 2014 theatre user group meetings reported that the replacement of the lift was originally agreed for 2014 but this had not taken place and a revised date had not been set at the time of our inspection.
- There was a second lift that could take a patient trolley. In the event of the patient lift being out of order the two bedded intensive care area adjacent to the theatre department could be used to provide post operative care if required.
- The resuscitation trolleys in the theatre, the recovery area and the wards were recorded as being checked daily. Regular 6 monthly resuscitation audits were undertaken and results were available. Recommendations from these audits had been made that monthly audits should take place to improve compliance with checking. We were not provided with evidence to demonstrate these recommendations had been implemented.
- Staff told us there were sufficient computers available to access patient information and consumables were readily available to support them in their clinical roles

Medicines

- There was a hospital medicine management policy dated April 2013 which was accessible to all staff via the hospital intranet.
- The hospital medication management committee had senior staff representation from all clinical areas and was responsible for reviewing policies, medication audits and medication incidents.
- The pharmacy team reported quarterly on the number of medication errors in each clinical area and this report was discussed at the medicine management committee. The quarterly pharmacy reports had action plans attached but there was no evidence that these were shared at ward level.
- Information relating to themes such as reporting levels, drug omissions and prescribing errors were reviewed by

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the medication management committee. The inpatient areas had reported 13 medication errors between July and October 2014 compared to nine reported in the period January to March 2014.

- We were told the pharmacy audit results were cascaded to the ward sisters. However, senior sister and ward staff meeting minutes reviewed for December 2014 and January 2015 did not include information pertaining to the pharmacy audits and incident reporting.
- Pharmacists were allocated to each ward area to review medicines charts as well as providing patient-specific advice and support timely provision of discharge medication.
- The pharmacist reviewed the ward drug charts for all new patients to ensure medication was prescribed correctly. This included reviewing the antibiotics prescribed to ensure compliance with antimicrobial recommendations. Where issues were identified pharmacy staff contacted the medical prescriber.
- Audits of the management of medicine were carried out by the pharmacist on a quarterly basis and action plans developed to address issues identified. We noted that there had been a reduction in the number of issues identified from 6 in the surgical department in the period October to December 2014 to five in the period January to March 2015. We were told that the action plans were discussed at ward meetings and ward meeting minutes we saw confirmed that these discussions had taken place.
- A monthly tracker audit of all prescriptions written and take home medication was completed for each clinical area. This showed 80% of prescriptions in December 2014 had been written in a timely manner and did not delay the patient's discharge.
- The pharmacist audited controlled drugs on a quarterly basis to ensure staff had followed the correct administration procedures. We reviewed the controlled drug audit results and noted the errors included missing a second signature. There were action plans to address the issues identified and responsibility for investigating missing signatures and completion of the CD book had been allocated to a member of staff. The CD book was checked during the inspection and found to be completed correctly.
- We observed and discussed with staff the process for amending medication prescribed by the consultant out of hours verbally. The process involved the consultant verbally giving the instruction to an initial nurse and

then repeating the order to a second nurse; the verbal instruction was then given to the RMO by the nurse who wrote the instruction on the patient's prescription chart prior to it being administered.

- This process for amending medication was not followed up by a written instruction from the consultant such as an email to confirm the instruction. Nursing and Midwifery Council (NMC) document Standards for Medicine Management (2010) standard 11 states that verbal directives for changes in doses or new prescriptions if given verbally should be supported by either fax, text or email prior to administration.
- All medicines seen were stored securely in locked cupboards in theatres, day surgery and the surgical ward areas.
- The 14 sets of notes we looked at all included medication charts that were signed when medication was administered and were written legibly.

Records

- All 14 sets of patient paper and electronic records we looked at were legible, dated and all contained a plan of care which was reviewed on a daily basis by the consultant. All paper records containing medical documentation of the inpatient episode were scanned into the computer system and confidential records were then destroyed.
- Risk assessment and demographic information details were complete and entered on the electronic care planning system. Staff were prompted to enter information by the system, and patients were given a specific care plan relevant to their condition and the procedure the patient was undergoing.
- Daily observations of patients were recorded to monitor assessed risk and there were prompts on the electronic patient record (EPR) to remind nurses if these were not carried out as expected. Hourly comfort rounds were noted when completed, although some records were not consistently completed.
- The anaesthetist documented seeing patients prior to surgery and the patient notes contained a copy of the patient's consent form. The consent forms we saw were legible and included the risks and benefits of the procedure to be undertaken.
- We observed that patient records were stored appropriately and that electronic records were not left

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on screens for others to see. Access to the computers and patient confidential information was password protected, with staff having access via their own individual passwords.

- Copies of perioperative treatment was recorded in the patient's notes and this included the five step surgical safety check list and details of any implants or prosthesis used.
- The theatre registers included details of the patient, procedure and consultant operating. Theatres did not carry out any documentation audit on the patient pathway to ensure that all records were correctly completed.
- Agency staff told us that they completed all the nursing documentation on paper records as they did not have access to the EPR. The care records were checked by a permanent member of staff and uploaded to the electronic patient record.

Safeguarding

- Staff had access to the adult safeguarding policy dated December 2013, due to be reviewed in December 2016.
- Staff we spoke with were aware of how to access the safeguarding policies and raise concerns. There was information on the notice boards in all the surgical areas for staff to refer to.
- The nominated lead for safeguarding was the chief nursing officer and in their absence the clinical service manager for the hospital site. There had not been any safeguarding concerns raised within surgery to date.
- Safeguarding adults training was part of the mandatory training all staff were expected to complete. For non-clinical staff they were required to complete level one training and clinical staff were required to complete level 2 training. Training records held by the department demonstrated 100% of theatre staff had completed adult and children's safeguarding level 3 training as they also provided care to children. Training records for the ward showed that 87% of clinical staff had completed adult safeguarding training.

Mandatory training

- There was a corporate mandatory training policy in place which was due to be reviewed January 2015. However, at the time of our inspection this policy had not been reviewed.

- Mandatory training included health and safety, fire, moving and handling, infection prevention, customer care and control. All staff were expected to complete resuscitation training either at basic, intermediate and advanced life support dependent on their role.
- Managers were responsible for ensuring all staff were up to date with their mandatory training and completion was linked to salary increments. Mandatory training records provided and maintained by the individual departments showed that the overall compliance for the theatre and the wards was 90%.

Assessing and responding to patient risk

- Staff told us that patients were assessed for the risk of hospital acquired venous thromboembolism (VTE) at preadmission and on admission prior to surgery. We noted the electronic patient record included mandatory risk assessments such as VTE, falls and skin integrity to be completed.
- There had been one reported case of hospital acquired VTE or pulmonary embolism (PE) following surgery between October 2013 and September 2014.
- The adult surgery audit showed that 87% of patients had been assessed for the risk of VTE between January and December 2014. The matron stated there was an action plan to improve compliance with risk assessment for VTE to achieve 100% for 2015. The action plan which was provided included increasing staff awareness, daily monitoring by senior staff of the completion of VTE risk assessment within 24 hours of admission.
- We noted that there was evidence that VTE assessments had been documented as completed within 24 hours of admission in the 14 sets of notes we looked at. However in one case the prescribed prophylaxis had been not been administered and we saw another example a VTE assessment being completed postoperatively.
- The hospital had identified prevention measures for those patients at risk of falls. There were posters to remind staff of the nine key points to consider such as the environment, call bells to hand and foot wear. Patients were provided with yellow non-slip socks to wear and signs in their room to remind them to call for assistance stating 'call don't fall'.
- The number of falls reported had decreased from approximately 41 reported in 2013 to 23 in 2014 (44%), since the introduction of a falls assessment tool to identify patients at risk.

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- Consultants reviewed their patients' condition on a daily basis and ensured pre and post-operative treatment plans were up to date.
- Staff told us that if they had concerns relating to a patient's condition the surgical RMO who was permanently on site would be called to assess the patient as well as the patient's consultant.
- The wards used the national early warning score (NEWS) to identify deteriorating patients. Observations were recorded on an electronic system, which automatically calculated the level of risk which when a certain level was reached the registered medical officer (RMO) on call was automatically informed and reviewed the patient.
- The resuscitation and 'do not attempt resuscitation' policies were due to be reviewed in January 2015, this action had not been completed at the time of our inspection. Staff told us they would adhere to the existing policy until a new policy was available but this guidance did not comply with the latest requirements in the BMA joint guidance for DNR CPR.
- There were processes in place to reduce the risks to patients undergoing surgery. These included the use of the World Health Organisation (WHO) surgical safety checklist which was embedded in the patient journey and consistently adhered to. An audit of the WHO check list for quarter four showed that it had been completed in all 30 cases audited.
- We saw the hospital newsletter for December 2014 and January 2015 circulated to all staff highlighted topics including VTE, falls, urinary care bundle and skin risk assessments to remind staff of the preventative methods used to minimise this risk.
- Pressure relieving equipment was available and staff reported that this was delivered to the ward without delay when necessary. However, we were not provided with evidence to support the view that there were no delays.
- The clinical risk assessment carried out in January 2015 noted that due to the anaesthetic rooms not being adjacent to theatres two and three there was a potential risk of the patient becoming oxygen depleted during the transfer into theatre. Actions were highlighted these included two anaesthetic staff being present and the corridor being kept clear at all times to allow for a smooth transfer into theatres. We observed that these actions had been implemented to mitigate the risk.

Nursing staffing

- The current establishment for nursing in theatres was 40 whole time equivalents (WTE) and there was a vacancy rate of 9%. We were told three new staff had been employed in January 2015 but had not commenced employment at the time of our inspection.
- The matron and ward managers told us that staffing levels were reviewed if following an acuity assessment there were patients with identified risks, for example of falls. The matron told us that they used approximately 20% bank and agency staff to ensure staffing to patient ratios were maintained.
- On the surgical wards including the day surgery area, there was a ratio of one nurse to four patients; ward managers were supernumerary and able to provide additional support to staff as required.
- We observed on our unannounced inspection visit that there were two nurses for two patients on the surgical ward providing a 1:1 ratio and support for patients. We observed additional support was provided by a phlebotomist who took bloods and swabs for MRSA as required.
- We were told and duty rotas confirmed that the staffing levels in theatre during surgical procedure was compliant with recommendations from the Association for Perioperative Practice (AFPP) during all surgical procedures.
- Staff we spoke with said staff vacant shifts in theatres were covered by staff working additional hours, bank staff or agency staff. We noted most shifts were covered in the period January and December 2014. Records showed 70% of shifts were covered by permanent staff, 29% by bank staff and 0.5% by agency staff.
- The clinical services manager for theatres told us that the majority of staff, 94% had been employed in the organisation for many years and staff we spoke with confirmed this.
- Nursing handovers within surgery were carried out at the beginning of each shift and gave a briefing of all the patients on the wards.
- Theatre staff were allocated to an out of hour's emergency rota to ensure there was cover if a patient had to return to theatre in an emergency. They were expected to be available within an hour. During our unannounced inspection we spoke to two staff who had been on call who confirmed they had been called in and had been available in theatres within an hour of being called.

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Medical staffing

- The service was consultant led and they were expected to review their patients on a daily basis and the patient records we reviewed confirmed that this had occurred in the majority of cases.
- We were told that patients' individual consultants would attend the hospital if a patient review was requested by the RMO or senior nurses. If the patient's consultant was unavailable as they were working at another hospital or were on leave another consultant working in the clinical area would review the patient. However, there was no formal rota and the informal cover arrangements were not documented.
- There was 24 hour, seven-day resident medical officer (RMO) cover for the wards. The duty rotas provided confirmed that staff worked 12 hour shifts, from 8am to 8pm and there was seven RMO employed to provide 24 hours a day, seven days a week.
- The RMO attended ward handovers and daily bed meetings and were aware of all of the patients in the hospital, including surgical patients being cared for on non-surgical wards. Patients who may require additional medical support were supported initially by the RMO who liaised with the consultant responsible for the patients care.
- There was no formal on-call anaesthetic rota to cover emergencies or returns to theatre that may arise following surgical procedures. Staff told us the consultant who performed the operation was responsible for obtaining anaesthetic support if a patient needed to return to theatre, however, the time it took to identify this support was not monitored.
- Staff told us that the anaesthetist did not leave the hospital until the patient had returned to the ward and recovered from the anaesthetic. The surgical consultant also saw the patient prior to leaving the hospital to ensure they were stable.

Major incident awareness and training

- The hospital had major incident and business continuity plans in place. Staff we spoke with were familiar with how to access the guidance and instruction cards for their respective areas.

Are surgery services effective? Not sufficient evidence to rate

As the hospital did not collect sufficient patient outcome data we were unable to rate how effective the hospital was. The provider had processes in place for reviewing clinical and non-clinical policies. However not all clinical policies we saw were up to date. Care was evidence based in line with national guidance from NICE and the Royal Colleges. There was an annual clinical audit programme in place and action was taken as a result of audits. The hospital had a limited audit programme in respect of contributing to national clinical outcomes for patients.

Staff were supported, could access training and all staff had received an annual appraisal. There was evidence of multidisciplinary team working across all staff groups. Records showed that patients were provided with information and consent was obtained prior to treatment being undertaken.

Evidence-based care and treatment

- The selection of surgical and theatre clinical policies and procedures we looked at all referenced the relevant NICE and Royal College guidelines. For example the breast care pathway and procedural policy dated February 2015 referred to recommendations for best practice published in 2013.
- We were told there were arrangements in place for the review and updating of clinical and non-clinical policies, however the policy referring to the pre-assessment process was dated for review in 2009 and therefore out of date. We also noted a number of policies were due to be updated in January 2015 and had not been done at the time of our inspection and therefore some such as the DNAR CPR policy did not contain up to date guidance.
- Care was delivered in line with the relevant NICE and Royal College guidelines as well as taking account of individual consultants' preferences. There were patient pathways and protocols based on national guidance that were used to deliver care to surgical patients. These included patient pathways for a variety of complex procedures such as neurological, cardiac, breast, lung and gastro-intestinal conditions.
- The clinical audit programme for 2015 which included blood transfusion, VTE risk assessments, continuing care of central venous catheters (CCVC), nursing

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documentation and discharge audit which were carried out in 2014 in the surgical wards. The blood transfusion and CCVC audit results we saw highlighted areas for improvement. There was an action plan to improve practice which included staff receiving further training and the introduction of patient information leaflets. We saw that the leaflets were available on both wards and most staff had completed the blood assessment training.

- The clinical audit programme showed that all the nursing audits were scheduled to be repeated between April and June 2015 which included blood transfusion and CCVC.

Pain relief

- Patients' records showed the level of pain was assessed regularly as part of the observation records. Patients' rooms had a copy of the pain tool present for staff and patients' to refer to.
- Patients' notes showed that pain relief was prescribed prior to their surgery by the anaesthetist and reviewed by the consultant. The RMOs played an integral part with nursing staff in ensuring the pain relief prescribed was effective when they reviewed patients on a daily basis.
- Pharmacists were available to provide advice to ward staff and medical staff. Staff told us that they also had access the pain team from a local NHS trust, for advice. Patient records we reviewed confirmed that patients were referred and seen promptly by the pain team.
- The 14 sets of medical notes we reviewed showed that patients had been given regular pain relief post operatively. Patients confirmed that they were asked by staff what their pain level was and were not kept waiting for analgesia.
- Theatre staff told us that all patients were reviewed by the anaesthetist prior to leaving the recovery area to ensure they were comfortable.
- Staff from the day surgery unit confirmed that when patients returned to the unit post surgery their pain had been controlled. The day surgical unit did not stock controlled drugs and medication would be provided if required by the ward staff.

Nutrition and hydration

- The wards used a Malnutrition Universal Screening Tool, to assess patients for the risks of dehydration or malnutrition on admission. Compliance rates for

completed the tool were audited in 2014 and showed that the two inpatient wards scored 95% and 89%. The action plan identified that the nurse in charge should remind staff to complete the assessment at handover.

- Records showed food and fluid intake on the wards was recorded used to monitor patients post-operatively. Regular 'comfort' rounds were undertaken which included patients being offered oral fluids. All fluids given intravenously (through a vein) were recorded as well as urine output recorded and calculated over a 24 hour period and reviewed by staff to ensure patients remained hydrated.
- Nursing staff had access to advice from a dietician based at one of the provider's other hospitals if necessary. We found examples of patients such as those with diabetes being referred to the dietician and seen within 24 hours of referral. Dietary planning was recorded in the patient's notes and additional food supplements prescribed.
- Patients commented on the excellent and wide choice of food, which met the needs of groups of patients from a variety of religious and cultural backgrounds. The chef was available and ensured individual needs/requests were met where ever possible.

Patient outcomes

- Data provided showed 2449 inpatient surgical cases were carried out between January and December 2014, 23.5% of these had a primary diagnosis of cancer and required follow up treatment via the oncology service.
- The hospital reported that 97 of the 1728 day cases procedures were converted to inpatient stays between January-December 2014. The reasons were analysed and showed that approximately a third (38 patients) were incorrectly booked as day cases. It was unclear if action had been taken to address this issue.
- Information provided in the Medical Advisory Committee minutes dated 19 August 2014 reported 24 unplanned re-admissions across all specialities between January and July 2014 (1.09%) of a total of 2,196 patients treated; 18 of the unplanned re-admission were following surgical procedures. The reasons for the re-admissions were not documented in the minutes provided. There were three patients for the same period that had unplanned returns to theatre.
- There was limited patient outcome data provided and involvement in national audits of patient outcomes. The hospital participated in the tracheostomy and sepsis

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National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) study for 2013 and 2014. No other information was provided that related to surgical patients outcomes.

- A cardiac surgeon told us the outcomes of his private work were collated with his NHS work and published nationally, however, no evidence was provided of this and no other surgeon informed us they took this approach.

Competent staff

- There were processes in place to ensure staff employed by the hospital had access to regular appraisals and opportunities for professional development. Managers were prompted by an email when appraisals of clinical and non-clinical staff were due. Information provided by the hospital showed that the majority of staff had received their annual appraisal.
- All new staff were provided with a mentor and preceptorship, they were also expected to complete local training during their probationary period to ensure they had the necessary skills for their role. We spoke with a newly qualified nurse who told us she had been provided with this support.
- The wards looked after a number of different specialties such as neurology, cardiac, and colorectal surgery. A training and competency package was in place to ensure staff developed the appropriate skills to look the patients in wards.
- We reviewed nine competency documents which included the use of patient controlled analgesia, cardiac monitoring and the management of chest drains. The documents showed evidence of the completed assessments and competency checks. Staff told us they had their competencies assessed by a mentor/senior member of staff and they could approach senior staff for help and support.
- Agency nurses completed an orientation booklet on their first shift and worked under the supervision of unit staff. An agency staff nurse told us they received an orientation on their first shift and felt supported by staff.
- Some staff in theatre reported development opportunities such as attending courses to complete additional qualifications such as degrees or anaesthetic training.
- We were told that consultants brought their own surgical assistants and that their qualifications,

insurance indemnity and criminal record checks were carried out prior to them assisting in surgical procedure. We observed that a log of this information was kept in theatre to confirm the checks had been carried out.

- Professional registration and validation of qualification were undertaken for all staff employed at the hospital. Medical staff holding practicing privileges were required to demonstrate their revalidation had been undertaken by their employing NHS trust. We were told by consultants we spoke with they had submitted evidence of revalidation, however evidence of how this was monitored was not provided.

Multidisciplinary working

- We saw examples of multi-disciplinary working between medical, nursing, therapy and pharmacy staff, such as cardiac nurse specialist and the multi-disciplinary breast team, which included a clinical nurse specialist and reconstruction specialist consultant.
- Multidisciplinary team (MDT) meetings were held to discuss complex care and management plans for cancer patients requiring surgery and a range of other treatments. We attended and were provided with the minutes of a MDT held during our inspection visit. The meeting was attended by all members of the MDT involved in the patients' care.
- Nursing and physiotherapy staff we spoke with said they were able to telephone the consultant surgeon for advice if required.
- Theatre recovery staff said they contacted the anaesthetist if they had any concerns about a patient in the immediate post-operative period, although we were told that the anaesthetist did not usually leave the recovery area until the patient went to the ward.
- A discharge letter was generated and sent to the patient's General Practitioner (GP) or given to the patient to take with them if they preferred to ensure the GP aware of the procedure and post-operative treatment recommended. The discharge letters also included contact details of the hospital should they require further advice or treatment post discharge.

Seven-day services

- There was a 24 hour, seven day a week rota of on-call RMO to cover surgical inpatient care.
- Consultant surgeons were expected to be available 24 hours a day, seven days a week if their patients required urgent review, or if they were not available they were

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expected to have arranged cover by another surgeon. However, we were not provided with evidence of formal monitoring of doctors availability arrangements were in place.

- There was 24 hour seven day a week on-call rota for a radiologist and an intervention radiologist.
- There was an on-call pharmacist service out of hours when the hospital pharmacy service was not available.

Access to information

- Staff were positive about the electronic patient record (EPR) and told us they were able to access information about patients promptly and there were sufficient computers available to staff. Portable computers on wheels were available for staff to take to patients enabling direct entry of information on admission.
- All medication was entered onto the EPR and all prescription charts were checked daily by the ward pharmacist to ensure all medication was written on drug charts correctly and we observed this practice taking place.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a hospital consent policy available to staff on the intranet which detailed the steps to be taken if a patient lacked capacity to make a decision for themselves and the policy made reference to the Mental Capacity Act 2005.
- Staff told us they did not have patients who lacked capacity and did not demonstrate that they understood their responsibilities in relation to the Mental Capacity Act.
- Consent was generally obtained on the day of surgery by the patient's consultant surgeon.
- There were checks that consent had been obtained on the ward, on arrival in theatre, and before the administration of anaesthesia in line with the WHO surgical safety check list and best practice guidance.
- The 14 sets of notes we reviewed confirmed that all consent to surgical procedure forms were signed, dated and legible.
- Where physiotherapists had provided care each entry confirmed that they had sought verbal consent prior to treating patients and all entries were legible, dated, timed and signed.

Are surgery services caring?

Good



Patients provided positive feedback about their care and treatment. They said that doctors explained their treatment to them and visited them usually on a daily basis. Nursing staff were reported to be professional, kind, polite and caring. Patients told us that they felt supported by competent staff whilst in hospital and by the nurse specialist following discharge from hospital.

Compassionate care

- The seven patients we spoke with provided positive feedback about the treatment and care they had received from the staff.
- Patients told us that the staff were 'amazing' and 'extremely professional at all times'. One patient said the call bell was responded to very quickly and they had been delighted with the care and treatment they had received.
- We observed staff being kind, respectful and polite when speaking to patients and delivering care.
- Patients were encouraged to complete a patient experience questionnaire on the day of their discharge; however, staff told us that many choose to take it home with them and did not return the completed form.
- The results from the patient experience questionnaire were collated by an external company on a monthly basis and fed back to the hospital. The results from April 2014-December 2014 showed that patients (85%) were extremely with happy their care, although there was only a 35% response rate.
- We observed that patients' privacy and dignity were respected within theatres as well as within the ward environment.

Understanding and involvement of patients and those close to them

- We observed staff explaining to patients and their relatives the care and treatment that was being provided, in order to reduce their anxiety. Patients told us they given sufficient information before their procedure to prepare them for their surgery.
- Patients told us that meeting with the pre-assessment nurse and being shown around the ward areas and being given the opportunity to ask questions was very helpful.

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Emotional support

- All the patients and relatives we spoke with told us they felt supported at every step of their journey. The support provided by staff from consultation, pre-assessment and surgical intervention was very good. Patients told us that this included the administrative staff.
- Patients told us they could access specialist nurses and physiotherapists prior to and after their procedure.
- Support included follow up after discharge by the specialist nurses included colorectal/stoma, cardiac and breast care.
- Patients had access to spiritual support and complimentary therapies such as reflexology. There were also a variety of support groups for cancer patients after their surgery such as the Macmillan team.
- There were bereavement and religious belief policies in place. The member of the chaplaincy team we spoke with told us they visited patients and their families on request and the team were present on a daily basis in the hospital.

Are surgery services responsive?

Good



Services were responsive to the care provided at the hospital and patients were able to access inpatient services in a timely manner and their needs were met. There were processes in place where staff reviewed the hospital activity daily to meet the hospitals patient admissions. Patients had access to information about the treatment and interpreter services. Complaints were responded to within the appropriate timescales and there was identified learning and changes to practice.

Service planning and delivery to meet the needs of people

- As the hospital provided mainly private care the patients chose to use the service. elective surgery. Admissions to the surgical inpatient wards were generally planned in advance to assist with service planning although emergency admissions were also accepted and notified by surgeons in liaison with the admissions office.
- The range of surgical services had developed in response to demand and the specialties of the consultant surgeons using the hospital with practicing privileges.

Access and flow

- Bed meetings were held daily with representation from each department to ensure there were sufficient beds for the expected admissions and any issues from the previous day were discussed. This approach facilitated the management of admissions and identification of any issues such as shortage of staff or beds which could delay admissions. We were not provided with any data to show surgery was cancelled due to the lack of beds.
- The hospital reported an average length of stay in 2014 of 4.9 days which showed a reduction of 0.39 from 2013 for cardiac, cancer and neurology. We were told that improvement was as a result of more effective care being provided.
- Patients were admitted by consultants with practising privileges following either direct referral from general practitioners or from the consultant's outpatient consultation.
- The majority of admissions for surgical procedures were elective and planned in advance. Admission was facilitated in a timely manner and could be arranged at short notice to meet patient's individual needs and ensure they received treatment as soon as possible. We spoke with two patients who stated their admission had been arranged very quickly to meet their needs. For example within one day of referral to the specialist and the other within three days. Patients told us they had been pre-assessed prior to admission.
- The hospital recorded the number of episodes by type and speciality these included neurology, colorectal and cardiothoracic surgery. For example the activity summary showed that 438 neurology and 255 cardiothoracic patients were admitted in 2014.
- There were minimal reported discharge delays due to waiting for medication and pharmacy monitored the time of medication requests and the time dispensed. The wards were supported by an allocated pharmacist who visited the ward daily and ensured any take home drugs were prescribed and dispensed in a timely manner.

Meeting people's individual needs

- Patients' individual needs were identified prior to surgery by the consultant responsible for the patients care and during the pre-assessment process.

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Consultants identified when patients' would benefit from a telephone assessment, information about the patient was sent by the secretaries to the pre-assessment nurse.

- The pre-assessment nurse told us there were three methods of contact these included telephone, attending the clinic and on-line completion of a questionnaire. This included gaining information about each patient, such as medication taken, medical history and factors that might affect the safety of general anaesthesia.
- Where possible patients were invited to attend the pre-assessment clinic, however as some patients came from overseas it was not always possible. In these cases an information pack explaining the process and procedure was sent by e-mail.
- There were systems to identify high risk surgical patients pre-operatively these included surgical pre-assessment processes. The pre-assessment nurse followed NICE when developing telephone pre-assessment and identify the diagnostic test documented for specific conditions.
- The pre-operative assessment form noted whether there was a need for an interpreter. Interpreters were available face to face and on the telephone. In-house translation for Arabic, Greek and Russian information was available on site and the surgeons informed staff if interpretation of other languages would be required.
- People requiring surgery who had complex needs and required additional support at pre-assessment following surgery were supported by specialist nurses and provided with information leaflets relating to their condition for example patients undergoing breast surgery for cancer. We were told the pre-assessment nurses had additional training to provide them with the necessary skills to deliver care to this group of patients such as body image and giving psychological support.
- Staff told us that they had not received specific training to care for people living with dementia or with learning difficulties and that they had not had any patients with either learning difficulties or living with dementia that have required treatment at the hospital to date.
- There was a service level agreement with a local NHS trust to carry out some NHS neurosurgery at the hospital to increase the trust's capacity. There were clear guidance on which patients would be transferred from the NHS and for which procedures.

- Patient information leaflets were available for those surgical procedures commonly undertaken at the hospital in different languages. Leaflets were downloaded and printed as required.
- Staff told us that they could obtain information in the majority of languages and the majority of patients were currently Arabic or Russian. We noted that signage within the ward areas was also in Arabic.
- Translation and interpreting services were available in the hospital for Arabic, Greek and Russian speakers, and by telephone for other languages to ensure those patients and their relatives whose first language was not English understood their treatment plans.
- We were told by the team a variety of reading material to support all cultures and beliefs could be provided for patients during their hospital episode. There was a bereavement leaflet explaining the services available.

Learning from complaints and concerns

- Patients were aware of how to raise concerns and complaints and were provided with an information leaflet as part of their information pack on admission. There was a complaint's policy in place due to be reviewed in August 2016 and staff were aware of the actions to take when a patient complained and how to escalate to senior staff.
- The complaints policy contained a flow chart of the process and response times for example to provide a written acknowledgement within two days and a formal response following investigation within 20 days.
- Staff told us that where ever possible they tried to resolve any issues with patients prior to a written complaint being made. There was an expectation that any concerns raised by patients on the wards would be immediately addressed by the manager and if possible resolved immediately to the patients' satisfaction.
- The hospital received 80 complaints January-December 2014 with 20 being for adult inpatients, although this was not broken down by speciality and three for theatres. For inpatient complaints 100% were acknowledged within two days and 90% of complaints received full response in within the agreed timescales of 20 days. Theatres had a 67% acknowledgement rate but 100% were completed within the 20 days.
- Themes for formal and informal complaints were analysed and were mostly related to clinical care and finance. Actions plans and learning from complaints were discussed at ward and senior management team

Surgery

meetings. Theatre staff told us that following a complaint changes had been made to the amount of equipment present during paediatric procedures in the anaesthetic rooms to make the area more child friendly.

Are surgery services well-led?

Good



There were governance structures and reporting mechanism in place where performance and the quality of the service was discussed. Staff vacancy, sickness and use of agency staff was monitored across the service. The hospital risk register documented risks and assigned a manager responsible although date of entry or a review date and some environmental risks lacked detail.

Staff had confidence in the senior management team and felt able to raise concerns and were aware of the whistleblowing policy. Staff felt there was an open culture which was encouraged by the management team. Consultants felt that senior management were approachable and reported good working relationships.

Vision and strategy for this service

- There was no formal vision or strategy for surgical services senior staff told us there was emphasis on renewing contracts for cardiac services outside of the UK as well as development of vascular surgery at the hospital.
- There was a focus on patient satisfaction at the hospital and to increase the customer focus of staff, additional training had been given to all staff. Staff we spoke with understood the focus on customers and the importance of maintaining high standards of care.

Governance, risk management and quality measurement

- There was a defined governance and risk management structure from corporate provider level to hospital and departmental level. There was a designated reporting structure for committees, for example the medicines management committee and the infection control committee, reported to the hospital clinical governance Group (CGG) which held monthly meetings.
- The medicine management committee met quarterly and reports and data, such as medication errors and timely discharges for each area were reviewed. The CGG

also reviewed unplanned readmissions, unplanned returns to theatre and incident reports. It was noted from the CGG meeting minutes provided not all department managers, including the theatre manager attended on a regular basis, which would impact on information flows into the CGG meetings.

- The matron and clinical services manager told us that all areas provided a report to present at the CGG. The reports provided confirmed that incidents, quality of the service and patient feedback and activity. As these were included with the other CGG papers circulated prior to the meeting staff were often unable to read these prior to the meeting as they were frequently circulate the day before the meeting
- The theatre user group, which included the theatre clinical services manager, consultant anaesthetist and theatre staff, met each quarterly to review incidents reported and any staffing or equipment issues, and discussed methods to improve processes.
- The service's risk register documented risks such as environmental, equipment, health and safety, infection control and staffing. The theatre department had escalated some risks such as 'unable to evacuate theatres in the event of a fire' and the lack of qualified surgical assistants to the hospital risk register. We noted that there was a designated named person responsible for each risk, and entries were updated and closed when the level of risk was reduced. However, the copy of risk register provided did not include date of entry or review date of the individual risks.
- The risk register identified the controls put in place, the current level of risk and the target level of risk to be achieved. Managers we spoke with were aware of the risks pertinent to their specific areas, the environmental risk assessments provided such as the theatre size were brief and it was not clear if all risks had been anticipated.
- Ward and department performance indicators and quality indicators were reported monthly to the recently introduced Quality improvement and Patient Safety (QIPS) group as well as to the Medical Advisory Committee (MAC) meeting which was held two monthly.
- The MAC was responsible for reviewing consultants practicing privileges renewals and acceptance of applications for new clinicians. Minutes of the MAC reviewed for February, June and August 2014 confirmed this was part of the meetings standing agenda and discussions. We did note that on the February and June

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2014 MAC meeting minutes that notes referred to a table relating to practicing privileges but this was not provided as an attachment; we therefore cannot confirm the content or relevance.

- The Clinical Governance Group monthly report for July 2014 highlighted the provider's new policy effective from 01 September 2014 regarding the information required prior to surgical assistants supporting consultants during perioperative procedures. This policy was introduced to ensure all surgical assistants working in the hospital held the necessary qualifications and had been DBS checked.

Leadership of service

- There was a clear management structure within the wards and theatres. Each ward had a ward manager/sister in charge who reported to the matron covering the surgical wards. Senior clinical theatre staff managed individual theatres to support junior nursing, operating department practitioners and the portering staff in the day to day running of the theatres. The theatre complex was managed by theatre manager/matron and all staff reported directly to the post holder.
- All ward managers/sisters and matrons were supernumerary and staff told us that there were accessible. The matrons participated in the duty manager's rota to give 8am -8pm senior cover across the hospital. The night senior manager cover was provided by clinical nursing staff and duty rotas were provided which confirmed continuous senior support.
- Staff spoke highly of the support the ward managers, matrons and unit managers provided across the surgical unit to the whole team and they told us they felt valued as team members. We observed the ward managers/sisters and matrons were visible across the surgical wards and theatre complex during our inspection. A new

chief nursing officer had been appointed to the hospital in January 2015 and staff told us at our unannounced visit he had attended some ward staff meetings and had been visible in all areas across surgery.

Culture within the service

- Staff across the hospital reported a very visible management team who were approachable and supportive. We spoke staff working in the hospital at both the announced and unannounced visits and we were told staff felt able to contact any of the management team if they had concerns. They were confident about challenging poor practice if necessary and were aware of the whistleblowing policy and procedure.
- Medical staff reported good working relationships with managers in the hospital and felt they were accessible
- There was low staff turnover and vacancy rate within theatres and minimal use of agency staff. The surgical wards had a higher turnover with 77% of staff having been employed for less than one year; the vacancy rate of 32% resulted in higher use of bank and agency staff. The use of bank and agency staff in inpatient areas for surgery was 20% between January and December 2014.
- Sickness rates for nursing, allied health professionals and administrative staff was below 5% in for the period August 2013 to November 2014. Sickness rates for theatre staff was also below 5% for the period June 2013 to October 2014.

Patient and staff engagement

- The hospital had a programme of charitable work that enabled patients who were unable to fund their care to access specialist surgical procedures.
- There were a number of events held to support people following cancer treatments with managing their appearance such as make-up classes.

Critical care

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

Information about the service

The adult intensive therapy unit (ITU) comprised of nine beds, one six bedded unit on the ground floor and a three bedded unit in the basement. The intensive therapy unit (ITU) provided care to level 3 patients with multiple organ failure or advanced respiratory support and level 2 patients with single organ failure, post-operative care or those requiring high levels of monitoring. There were four 'open' bays and five single rooms, two of which were negative airflow pressure, one bay was closed and used for storage in the basement unit.

The majority of patients were planned admissions following neurological surgery, cardiothoracic surgery and spinal surgery and other surgery requiring close patient monitoring. The most recent Intensive Care National Audit and Research Centre (ICNARC) data reporting period used to inform our findings covered the period from July 2013 to June 2014 and showed 717 patients had been admitted to the unit, 26 were unplanned and eight were nonsurgical patients.

More recent ICNARC data for the period June to December 2014 had been collected but had not been submitted to ICNARC at the time of our inspection.

Summary of findings

Incidents were reported and investigated and where learning was identified this was shared. Policies and procedures followed national guidance and were in date and available to staff. Clinical protocols and pathways were available and followed best practice guidance. Patient outcome data was collected and submitted to ICNARC for critical care patients. However, ICNARC data for the period June to December 2014 had been collected but had not been submitted to ICNARC at the time of our inspection. The unit participated in local and national audits as applicable to demonstrate patient outcomes. Patients were admitted without delay to the unit however the number of discharges delayed over four hours were higher than the national average.

Staff received appropriate training and assessment to ensure safe, effective clinical practice. We noted that 59% of the core nursing staff on the unit held a post registration critical care course which complies with the national standards for nurse staffing in critical care. Staff were caring and treated everyone with unfailing politeness, respect and dignity. Patients reported very high levels of satisfaction with all aspects of their care and treatment.

There was identified clinical leadership and clear reporting lines for staff and managers in the unit. There was no formal documented vision or strategy for the

Critical care

service however staff were aware of the role the unit played in meeting the hospital and corporate vision. Staff reported that the senior hospital management team were visible, supportive and accessible.

Are critical care services safe?

Good



Staff reported incidents and there was evidence of feedback and learning from incidents. The environment was visibly clean and staff followed infection prevention and control practices. Equipment was regularly monitored and maintained and staff were trained to use it. However, the issues with the patient lift not always being in working order placed patients at risk. Emergency equipment such as a difficult airway management trolley, emergency chest opening pack and resuscitation equipment was available and ready for use.

The majority of staff had undertaken mandatory training and plans were in place to ensure all staff had completed training before their end of year appraisal. There were sufficient staff to meet the needs of patients and there was regular usage of bank and agency staff all of whom had the skills required to work in ITU to cover vacancies. Consultant medical staff were available 24 hours a day seven days a week covering a one in three week rota. They were on site daily and available on call to the ITU resident medical officer (RMO) who was available 24 hours a day, seven days a week.

Incidents

- The ITU service had reported 54 incidents in the past 12 months, four of which were unexpected deaths. The majority of incidents were drug errors which had resulted in low or no harm to patients.
- Incidents resulting in harm were investigated and there were action plans in place to address learning points. These identified the lead person taking action and the date by which it would be completed. An example of change in practice in response to a serious incident was the care and management of patients with an endo-tracheal tube. We also saw staff audited the length of endotracheal tubes to ensure they were always of an appropriate length.
- All staff we spoke with knew how to report an incident and demonstrated the electronic reporting system to us. Staff told us they received an acknowledgement and feedback on incidents they had reported.
- Senior staff told us incidents were discussed at the weekly sisters' meeting and action plans and learning

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arising from an incident were disseminated to staff at handover and by email. The action plans were available to staff on the hospital intranet with the minutes of unit meetings.

- There were some arrangements in place to review and learn from patient deaths however resident medical officers (RMO's) did not attend as a group to the multi-disciplinary meeting and only the RMO on duty at the time of the death was invited. The consultant intensivist told us it had been identified that all RMOs should be invited and this was due to start in 2015, but had not commenced at the time of our inspection.

Cleanliness, infection control and hygiene

- The critical care units were visibly clean and dust free. Equipment was labelled after cleaning with the name of the person and the time and date. Domestic staff had access to appropriate cleaning equipment and cleaning schedules were available for every area. Standards of cleaning were monitored twice weekly by the domestic managers. The results of the January 2015 audits showed a score of 83% for environment and 88% for equipment. Actions plans had been developed to address the areas which required improvement.
- Infection prevention and control policies were available to staff and were in date and followed national guidance. Infection control advice and support was provided by the hospital Infection Prevention and Control Nurse (IPCN) who liaised with a consultant microbiologist. The IPCN attended the unit multidisciplinary team (MDT) ward round.
- There was a programme of infection control audits carried out which included audits of hand hygiene, central venous catheters and urinary catheters by the link infection control practitioner for the area. The results for January 2015 showed 100% compliance with MRSA screening with one positive patient MRSA screen on admission.
- The unit submitted evidence to the Intensive Care National Audit and Research Centre (ICNARC) regarding infection prevention and control, the most recent results available were for the period April – June 2014 and reported one acquired blood infection on the unit.
- Hand sanitising gel was available at every entrance to the unit and patient rooms. Hand washbasins were equipped with soap, disposable towels and sanitizer. The seven step guidance for effective hand washing was

displayed at each basin. Staff were compliant with bare below the elbow guidance and wore scrub suits when on duty. Visiting consultants were seen to observe the guidance.

- The hand hygiene audit results had fallen from 91% in December 2014 to 78% in January 2015. The unit manager told us they were developing an action plan which would be submitted to the infection control committee to address the result. We were told the lower score was due to staff failing to follow all seven steps when washing their hands and staff had been informed of the result and more frequent audits were planned but we were not provided with dates of when these audits would commence.
- The central venous catheter and urinary catheter audit results for November /December 2014 showed 100% compliance.
- There were two reported hospital acquired E.coli bacteraemia infections and no healthcare associated MSSA bacteraemia or clostridium difficile (C. Difficile) in the last 12 months.

Environment and equipment

- Access to the critical care units was restricted by the structure of the building, corridors were narrow and ITU 3 had a significant slope on entering the unit. There were issues with the patient lift which impacted on patients moving off the unit or to get to ITU 3 from theatre.
- Equipment was labelled and listed in the unit asset register. Maintenance and servicing was planned and carried out in accordance with manufacturer guidance. We saw the haemofiltration machines being serviced by the manufacturer during the inspection. The servicing records for the arterial blood gas machines were up to date however we were unable to determine whether the hospital participated in the National Quality Assurance System (NQAS).
- Nursing staff carried out daily room checks to ensure the equipment and facilities were available and in good working order.
- There was a resuscitation trolley with equipment and emergency drugs available on each unit that was checked daily. Checking records were concurrent and records indicated when either unit was not in use.
- There was an emergency theatre chest pack available for use in the event of an emergency chest opening. The

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RMOs knew it was available and told us they could perform the procedure if needed, we saw records to show staff had received update training. We saw records to show the pack was checked weekly.

- There was a difficult airway management trolley available which we saw was checked weekly.
- Staff completed competency based equipment training during the probationary period of their employment and worked under supervision until the first line assessment had been successfully completed. We looked at six staff records which showed competence was reassessed bi-annually. Agency nurses were required to sign a declaration of the equipment they were competent to use and were provided with training for any equipment they were not familiar with.

Medicines

- Most medicines were securely stored in locked cupboards in a locked room. Controlled drug stocks were checked twice daily and a spot check of the register confirmed levels were correct.
- However, we observed intravenous fluids were stored in an unlockable cupboard on ITU 3 and the drug fridge was also found to be unlocked. The ITU manager informed us the key for the fridge had been lost and could not be replaced. We saw appropriate action had been taken, a new fridge had been ordered and the matter had been entered onto the unit's risk register and showed the assessed level of risk and the actions to be taken to minimise unauthorised access by creating a physical barrier to the fridge and staff overseeing the reception area at all times and reducing the amount of drugs stored in the fridge.
- The unit had a designated pharmacist who checked supplies and prescriptions to prevent errors in giving the wrong medication or drugs being given that could contribute to interactions between medicines. Pharmacists were involved in medicines reconciliation when people were admitted to the hospital and clinical scrutiny of the medicines charts.
- There were quarterly controlled drug (CD) medication audits the two units were assessed and reported separately. In the January - December 2014 audits ITU 2 scored 96% in quarters one and two, 91% in quarter three and 87% in quarter four. A recurring issue in three of the four audits for ITU2 was the management of errors in that staff had not signed and dated the error.

There were action plans to address the non-compliant areas and work had commenced on developing medicine competencies in conjunction with the ITU pharmacist.

- ITU3 scored 100% in the first two quarters, 96% in quarter 3 and 87% in quarter four, the lower result in the last quarter related to staff not recording twice daily CD checks and documenting when the unit was closed. Action plans had been developed to address the shortfalls and the results and plans were shared with staff to raise awareness and improve practice.

Records

- Patient bedside physiological and ventilation monitoring equipment was linked to the electronic patient record and the record was continuously updated. RMOs were able to view patient telemetry at the nurse's station and staff escalated concerns as appropriate.
- Nursing staff updated patient risk assessments every shift for a range of clinical risks including those associated with skin integrity and pressure, malnutrition and venous thromboembolism.
- Care plans reflected patient care requirements and progress reports provided a clear account of the care provided.
- The patient care record was multi-disciplinary and we saw entries were made by the majority of clinical staff involved in the patient's care and treatment. Some consultants had been noted as reluctant or unable to access and enter their notes directly into the system and relied on hand written records. The hospital had implemented a 'work around' to address the potential risks of having two patient records and staff scanned the handwritten record onto the system. The minutes of the medical advisory committee (MAC) recorded the on-going discussions to resolve the issue and the risk register originally rated the risk as high but this had been reduced with the implementation of the work around.
- On discharge from the unit staff printed a copy of the completed documentation which was incorporated into the in-patient medical records.

Safeguarding

- A safeguarding adults policy which reflected national guidance was available to staff on the unit and was due for review in June 2016.

Critical care

- Staff completed annual safeguarding training as part of the mandatory training programme. We saw individual staff training records which showed staff had completed the training however they had not all fully completed the hospital electronic record to ensure the training was recorded centrally.
- Staff showed us how to access the safeguarding guidance and explained the process to raise concerns.
- Medical staff told us the use of the electronic alerting system had caused an increase in calls to the wards but had meant that deteriorating patients were seen and received interventions much earlier than previously.
- The unit monitored incidents of falls, pressure ulcers, venous thromboembolism (VTE), central venous catheter infections and catheter associated UTIs. The eight electronic patient records we looked at all included evidence that VTE assessments were completed daily on every patient.

Mandatory training

- There was a mandatory training programme which all staff had to complete annually and attendance was monitored and formed part of the core requirements for staff appraisal and pay awards. Sessions were available as e-learning programmes and some were formal attendance based.
- There was a clinical practice facilitator in post to coordinate all training and oversee practice development. A spreadsheet had been developed to record and monitor staff completion of training as the electronic system was not always up to date and could not provide the information in an easily accessible format to show the percentage of staff training completed.
- Staff told us they were given time to complete their mandatory training and received reminders when training was due.
- All designated nurses in charge in ITU had completed advanced life support training and were available to support the resuscitation team and attend emergencies outside of the unit.

Assessing and responding to patient risk

- The hospital used the national early warning system (NEWS) to monitor patients for signs of deterioration and the electronic alerting system triggered an alert to the RMO.
- The hospital did not have an outreach team but had established a resuscitation team contactable by emergency bleeps who assessed deteriorating patients. Team members were assigned specific roles daily and there was a test bleep every morning. In the event of the telephone system failing there were hand held radios available. The RMO in ITU and the nurse in charge were part of the team. All members of the team were trained in advanced life support (ALS).

Nursing staffing

- The provider's workforce planning tool was used to establish the number of nursing hours required per patient bed. In ITU nurse staffing levels were based on national guidance for providing level 3 critical care and there was a 1:1 nurse to patient ratio.
- The unit had an establishment of 22 full time nursing posts. There were 18 staff in post, one senior sister (band 7), four sisters/3.10 wte (band 6), four wte senior staff nurses (band 5) and eight staff nurses (band 4) supported by one health care assistant. Bank and agency staff were used to fill vacant posts.
- Staffing rotas were prepared one month in advance and reviewed daily against the expected patient activity at the daily hospital bed meeting and additional staff booked as needed.
- There were sufficient staff to meet the needs of patients. Staff rotas showed the numbers of staff scheduled to be on duty and the system was updated with the actual names and numbers required to meet the planned activity. We saw all patients received 1:1 registered nurse support. There was a designated supernumerary nurse in charge for every shift in line with the Standards for Intensive Care Services published by the Joint Standards Committee of the Faculty of Intensive Care Medicine and the Intensive Care Society (2013).
- The unit had a core group of bank and agency nurses that were used regularly to cover vacant shifts. Bank nurses were employed by the provider and completed all mandatory training and competencies to meet the needs of ITU. The senior sister had introduced additional checks and had interviewed the agency nurses to ensure they had the qualifications and skills required to work in ITU. There was a formal induction process for new staff and agency staff working in the unit for the first time.

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- There was a two tier nursing handover process at every change of shift. There was a detailed handover between the nurses in charge using the electronic record and incorporated a check of individual patient risk assessments and nursing documentation to ensure records were completed. Nurses handed over to each other at the patient bedside again using the electronic record to ensure all pertinent information was communicated.
- There were plans in place for a wide range of issues such as the loss of utilities, loss of staff, communications, IT and the emergency call system. In the event the unit needed to be evacuated alternative locations had been identified as suitable to accommodate level 2/3 patients.
- The fire exit for ITU3 was through a narrow fire door and up a staircase to the ground floor. Staff described the process to move patients out of the unit and this was as described in the evacuation plan.

Medical staffing

- There was a designated lead consultant responsible for providing clinical leadership to the medical and surgical staff overseeing patient care.
- There were three consultant intensivists all who also held NHS contracts working a one week in three rota to provide 24 hours a day, seven days per week cover. The consultant we spoke with confirmed they had no other clinical commitments whilst on call and physically attended the unit as a minimum, once a day with frequent telephone contact with the RMO on duty dependent on patient acuity. There was accommodation available close to the unit for the on-call medical staff and they were required to be able to reach the unit within 30 minutes.
- Six RMOs were employed to cover four fulltime posts and provide 24 hours a day, seven days cover. working 12 hour shifts for example 08.00am to 8.00 pm. The RMO's were interviewed prior to employment by the consultant intensivists and had suitable previous experience in the anaesthesia and critical care setting. These arrangements met the Intensive Care Society guidelines for ensuring there was immediate access to a practitioner who had skills in advanced airway techniques.
- There were structured handovers between the RMOs at shift changes and there was a daily multidisciplinary ward round held at 11.00am led by the consultant intensivist and involved the RMO, nursing and allied health professionals (physiotherapist, pharmacist, and dietician) and IPCN.

Major incident awareness and training

- Business continuity plans were in place to ensure the critical care unit could remain functional in the event of an incident. Staff were aware of the plans for the unit, and were familiar with the steps to be taken in the event of a threat to the service provision.

Are critical care services effective?

Good



Policies and guidelines had been reviewed to ensure they were in line with national guidance. The unit participated in some local and national audits as applicable to demonstrate patient outcomes. The unit submitted ICNARC data until June 2014; however more recent data had not been submitted. We noted there was no dedicated support to assist in the timely submission of data to ICNARC.

Staff told us they were supported by senior staff to undertake their roles and there was a structured programme to ensure clinical competencies were achieved during the employee's probationary period and then reviewed two yearly in line with guidance. Bank and agency staff competence was also assessed.

The number of substantive staff holding post registration qualifications in critical care was above the national guidance and all staff were supported to complete a foundation course in critical care. The bank and agency staff used regularly on the unit had a critical care qualification. Staff had an understanding of the Mental Capacity Act 2005 in relation to informed consent and deprivation of liberty safeguards. Staff were aware of and familiar with, the hospital restraint guidance and told us patient's best interests were considered when using sedation.

Evidence-based care and treatment

- There were patient pathways and protocols available for the most usual complex surgical admissions such as for the management of immediately postoperative cardiac patients, neuro surgical patients and upper gastro—intestinal surgery such as an oesophagectomy.

Critical care

- The selection of ITU clinical policies and procedures we reviewed all referenced relevant NICE and Royal College guidelines. Although the unit was not part of a critical care network, best practice guidance from the group was used to support changes in practice and were referenced in the documents.
- There were systems to identify high risk surgical patients pre-operatively, surgical pre-assessment processes were in place and patients were able to visit the unit prior to admission.
- The resuscitation outcome audit in ITU showed there had been 10 arrest calls between January and December 2014, nine had occurred in ITU2 and one in ITU3, The audit showed that four of the patients survived to discharge, four of the resuscitation attempts were unsuccessful and two of the patients had a do not attempt cardio pulmonary resuscitation (DNACPR) decision made following the call.
- Artificial Airway care documentation audits were carried out monthly and results for November 2014 to January 2015 ranged from 85% to 92.5%. In addition senior managers reported spot checks were carried out to check the length of the endotracheal tube (ETT) met revised clinical guidance.
- The most recent oxygen safety check showed ITU2 achieved 100% compliance and ITU3 97%.

Pain relief

- The patient records we reviewed showed that pain medication and sedation was continually monitored and documented.
- Patient's pain control was managed by the multidisciplinary team. Post-operative analgesia was prescribed by the anaesthetist and adjusted if needed in collaboration with the patient's primary consultant. We were told there was no dedicated pain team available and specialist pain advice was sought from a local NHS trust if needed.

Nutrition and hydration

- Patient records showed there were daily assessments of nutrition and hydration recorded for each patient.
- The patient's consultant in collaboration with the ITU multidisciplinary team led the assessment, implementation and management of appropriate

nutritional support for their patients. There was a dietician available who attended the unit daily and speech and language therapist support was available if required.

- We were told patients were referred to a gastroenterologist if they required long term nutritional support such as total parental nutrition (TPN).
- Patients who were able to eat and drink made choices from the hospital menu appropriate to their dietary, religious and cultural needs. Patients told us they were very happy with the menu choices and the standard of food provided.

Patient outcomes

- The unit submitted data to the Intensive Care National Audit and Research Centre (ICNARC) however there was no dedicated resource to ensure timely submission.
- The most recent ICNARC report included activity up to the end of June 2014. Data provided showed that mortality outcomes were three (2.1%), healthcare acquired infection rates were low and early readmissions to the unit were 1.5%, these outcomes were similar to other units with a similar case mix.
- The ICNARC data reporting period used to inform our findings covered July 2013 – June 2014, and showed 717 patients had been admitted to the unit, 26 were unplanned and eight were non –surgical.
- The majority of patients were admitted to the unit as part of their surgical pathway of care and transferred into the unit from the theatre recovery area. ICNARC data showed all admissions were undertaken in a timely manner once a decision had been made that the patient required critical care. The time to admission data showed that all patients were admitted within the four hour national standard.
- Quality of care indicators such as ventilator associated pneumonia (VAP) and catheter-related bloodstream (CVC) infection rates were measured by staff and outcomes were used to influence the quality of care. We saw the results of recent audits which showed 95% compliance with the care bundles.
- The unit was not eligible due the patient case mix to submit data to the majority of national audits relevant to critical care and were not invited to participate in the Critical Care Network to participate in benchmarking.

Competent staff

Critical care

- Of the core nursing staff on the unit 59% held a post registration critical care course, which complies with the national standards for nurse staffing in critical care which stipulates a minimum standard of 50%.
- The unit supported staff to complete a foundation course in critical care nursing based on the national competency framework prior to completing a recognised post graduate course.
- Permanent staff were supported to complete local training during their probationary period to undertake their role. The training included management of arterial line, management of chest drain, ventilation, enteral feeding, pain management and inotropic management.
- There was an intention to implement the National Competencies Framework for Critical Care Nurses and there was a corporate group working on the implementation. However, at the time of our inspection this had not occurred. Staff told us they had their competencies in these areas assessed by senior members of staff and they could approach senior staff for help and support.
- We saw six staff records which all showed evidence of the completed assessments and competency checks. Agency nurses completed an orientation booklet on their first shift and worked under the supervision of unit staff.
- We spoke with four bank and agency staff and they told us they had all been previous employees who wanted to maintain their critical care skills but wanted flexible working to meet their personal and family commitments.
- The unit manager told us that all permanent staff had received or were due to receive an appraisal. All staff appraisals were scheduled to be completed by May 2015 as the hospital's pay and reward scheme was dependant on the successful completion of mandatory training and appraisal. We saw appraisal records in the six staff records we looked at and staff confirmed they had dates arranged for their meeting with their appraiser.

Multidisciplinary working

- The daily consultant intensivist led ward round of all patients on the unit, which was attended by all members of the multidisciplinary team including the nurse in charge, the nurse caring for the patient, the

RMO, physiotherapist, dietician, pharmacist and the infection control nurse. We observed that all aspects of patient care was discussed and decisions to discharge from the unit were made at the ward round.

- Patients discharged from the unit were followed up on the ward by the ITU RMO. The patient's consultant and clinical nurse specialists involved in the patient's on-going care were able to refer the person psychological therapy if required.

Seven-day services

- There was a consultant available seven days a week, 24 hours a day.
- There were daily ward rounds and if required consultants were required to reach the unit within 30 minutes if they were called in an emergency and not on-site.
- There was a physiotherapy service available seven days a week.
- Pharmacy services were available Monday to Friday between 9.00 am and 6.00pm and 9.00am - 1.00pm on Saturdays. There was an on-call pharmacist for out of hours support.
- Radiology support was available seven days a week with on-call support for out of hours.

Access to information

- Staff were positive about the electronic patient record system in use. They reported there were no delays in accessing patient information. Patient medication was entered on to the system on admission and the prescription was checked by the pharmacist to ensure there were no errors in the transcription.
- The system did not interface fully with the ward based electronic record and staff told us they provided a printed copy of the patient record for inclusion in the patient medical record on discharge from the unit as part of the handover procedure.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- Staff told us patients were asked for their consent whenever possible before receiving any care or treatment, and staff acted in accordance with their wishes.

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- Staff understood their responsibilities under the Mental Capacity Act 2005 and its associated deprivation of liberty safeguards (DoLS). We were told that the unit had not made any DoLS applications in the last 12 months.
- We were told by staff that patients could be restrained using sedation medication to maintain their safety and the decisions were taken in conjunction with the patient's family. Staff were aware of the hospital restraint guidelines in place to support staff to act in the patient's best interest.

Are critical care services caring?

Good



Staff were caring; patients were very satisfied with the support and care provided to them and their relatives. Patient survey feedback was good although response rates were low. Patients and relatives were fully involved in all aspects of their care, relatives and carers were welcomed and encouraged to be involved during the person's stay in the unit.

We witnessed staff interaction with patients and relatives that was caring and compassionate. Communication and interactions between the unit team were unfailingly polite, professional and respectful.

Compassionate care

- Staff were polite and respectful in their interactions with patients, relatives and between all members of the unit team.
- We observed staff speaking to patients and their relatives in a caring and compassionate manner, providing reassurance and support. Some relatives were very familiar with the ITU team and greeted staff by name. They told us the staff were "excellent" and care and treatment was "second to none".
- We were provided with many examples of staff 'going the extra mile' to accommodate patient's individual wishes and needs. We heard of staff arranging an outing for a long term ITU patient with fluctuating care needs who wanted to go out whilst in a stable condition.
- The unit staff had implemented a short survey to capture patient feedback on the unit. The results for 2014 showed patients were very satisfied with the care

and treatment they received. Staff told us the number of returns were low however they were keen to promote its use and raise the number of returns to identify areas of improvement.

- We observed staff ensured patients' privacy and dignity, for example, by closing doors and blinds when providing personal care.

Understanding and involvement of patients and those close to them

- We observed staff explaining to patients and their relatives the care and treatment that was being provided, in order to reduce their anxiety. Patients told us they given sufficient information before their procedure to prepare them for their stay in ITU.

Emotional support

- The unit manager/nurse in charge visited all patients and relatives on the unit daily to assess if they had any concerns with their stay in the hospital.
- Spiritual support was available and staff could contact the chaplaincy service of a local NHS trust to arrange a visit. Staff also reported the embassy was able to arrange spiritual support for patients and relatives.
- Staff told us there were no specific services for emotional support for patients such as counsellors and bereavement support on the unit however they were able to access specialist support if needed.

Are critical care services responsive?

Good



The critical care services were responsive to and met the needs of patients. Patients were admitted to the unit in a timely manner but there was a higher than national average number of delayed discharges.

Patients received information about the service and their procedures prior to admission. One patient complaint had been received in the last 12 months and learning from this had been shared with staff and a new working practice had been implemented as a result.

Service planning and delivery to meet the needs of people

- The unit provided care and treatment primarily to adult patient's having complex elective surgery and some

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medical patients. The unit did not take emergency admissions from other hospitals or critical care units, although patients were able to be escalated to the critical care unit from wards in the hospital if unexpected complications occurred following planned surgery or their condition deteriorated.

- The service provided by the unit was planned in advance with the surgeons and the admissions office. Admissions/activity was reviewed daily on the unit and at the hospital bed meeting to ensure there was sufficient capacity to meet patient needs. Surgical lists were provided in advance which assisted with planning. In the event of an unplanned admission staff told us they would have some advance notice from theatre and were usually able to make suitable arrangements such as additional staffing.

Meeting people's individual needs

- Staff were not trained in the needs of patients or relatives living with dementia and reported that they had not had to care for patients who were living with dementia or who had a learning disability in recent years.
- Significant numbers of patients admitted to the unit were Arabic speaking and staff were able to access interpreting services at any time.
- There was written information available on the unit for patients and their relatives, this included general information about the unit, some condition specific leaflets and spiritual support information. Staff showed us that information in other languages was available on the provider's website and was easily accessible.
- Relatives were encouraged to visit and spend time with patients. The hospital offered overnight accommodation to relatives wishing to stay or arranged a hotel room close by. There were two dedicated relative rooms adjacent to the unit for families to gather and they were supplied with tea and coffee making facilities.

Access and flow

- The average bed occupancy rate in the critical care unit was below the national average of 85%. ITU 3 was opened as needed and staff reported a 70% average occupancy. Data provided showed 27.1% of patients required level 3 care and 72.9% required level 2 care.

- The average length of stay on the unit for surgical patients was less than three days and 25.7% of patients were ventilated.
- There were nine unplanned admissions and two re-admissions to the critical care unit between April and July 2014.
- There was one reported out-of-hours discharge in the period and staff told us patients were not usually discharged from the unit after 6.00pm however they could be discharged up to 10.00pm if necessary.
- There were arrangements in place to admit patients to the unit from the wards in an emergency. The decision to transfer was made on medical grounds and involved the ward RMO, the ITU RMO/consultant and the nurse in charge of the unit in consultation with the patient's lead consultant.
- We were told that there had been one non-clinical transfer out of the unit in the last six months. Between April and July 2014, there had been two transfers from ITU which was 1.4% of the total number of unit discharges; one was to a another critical care unit for treatment not provided at the hospital and the other for palliative care.
- Data submitted to ICNARC showed that 41% of discharges from the unit were delayed over four hours. Staff told us there were delays in patients vacating rooms on the wards to facilitate the timely discharge of patients off the unit.
- We were not provided with any data to show patients' surgery was cancelled due to the availability of ITU beds.

Learning from complaints and concerns

- Staff told us they tried to resolve any concerns patients or their families may have immediately and the details were entered into the electronic system. Patients were provided with information on how to raise concerns or complain as part of their admission information and there were television screens continuously showing patient information including how to raise concerns/complaints.
- Complaints were responded to in a timely manner. The critical care unit had received one complaint in the last 12 months, relating to communication between staff and relatives. The complaint response was sent out within 20 days after the initial complaint was acknowledged, which was in accordance with the hospital's complaint's policy.

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- Staff reported that following the complaint there had been a change of working practice with the Senior Nurse contacting relatives on a regular basis to give an update on on-going patient care and this is documented in the electronic nursing notes. Minutes of the monthly unit meeting showed complaints and concerns were discussed and learning shared with the team.

Are critical care services well-led?

Good 

There was identified clinical leadership and clear reporting lines for staff and managers in unit. Although there was no formal documented vision or strategy for the critical care service staff were aware of the role the unit played in meeting the hospital and corporate vision.

Staff reported that the senior management team were visible and accessible; department managers were described as supportive and approachable.

There was identification and management of risks in the unit but governance could be strengthened with the implementation of a unit wide meeting to review patient outcomes including mortality to improve practice.

Vision and strategy for this service

- There was no specific vision and strategy for the service, staff were aware of the role the ITU played in meeting the overall hospital vision and were proud of the unit and the service provided to patients and relatives.
- Staff were aware of the service priorities for the unit and these had been discussed in ward meetings.

Governance, risk management and quality measurement

- The critical care unit performance indicators and quality indicators were reported monthly through a variety of meetings such as the senior nurse forums and the Adult Clinical Governance meetings up to the hospital clinical governance meeting.
- Performance data such as activity and audit results and issues arising in the meetings were escalated and reported to the Clinical Governance Committee and the Medical Advisory Committee (MAC).
- The clinical lead for critical care represented the unit at the MAC which met quarterly and in addition to

reviewing clinical quality information, recommended consultants to be offered practicing privileges after reviewing their application including evidence of their GMC registration, medical indemnity insurance and current or recent employment in the NHS. We were told that specialist external advice was sought to support decision making particularly when consultants with very specialised skills and new treatments were proposed. The MAC minutes documented when external advice had been sought to support decisions.

- There were terms of reference for the MAC and minutes were distributed to the clinical leads that were responsible for cascading information to their colleagues.
- We saw the unit risk register listed the most current clinical and environmental risks identified such as agency nurse access to the electronic patient record and post cardiac surgery and ablation patient risk of requiring emergency chest re opening. There was a record of the controls put in place, the actual level of risk at the time of the entry and the target risk level to be achieved with a review date. There was an assigned person to manage the risk, usually the unit manager and entries were seen to be updated and closed when the level of risk was reduced. We saw the controls had been implemented in the unit, with temporary log in arrangements for agency staff and the availability of skilled staff and equipment to carry out the emergency procedure if required.
- There was no forum for unit staff including the RMOs to come together to discuss the unit performance, governance and review patient outcome data as a team to identify potential improvements in the service or to improve practice. The consultant intensivist told us they had plans to implement such a meeting in the near future but this had not occurred at the time of our inspection.

Leadership of service

- There was a lead intensivist and we were told they had oversight of the clinical management of the critical care unit and represented their speciality on the hospital's medical advisory committee (MAC).
- Staff spoke highly of the support the unit manager provided to the whole team, patients and relatives.

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- Every member of the unit team we spoke with told us they were supported and encouraged to report concerns and the manager would act on their concerns and keep them informed of the outcome.
- Staff told us they felt valued and their efforts were appreciated by managers. They said they saw senior managers regularly.

Culture within the service

- Staff told us they felt there was an open and transparent culture within the hospital. They were confident about challenging poor practice if necessary and were aware of the whistleblowing policy and procedure.
- Staff reported there was good communication in the unit and across the hospital. There were formal weekly sister's meetings and monthly staff meetings. Minutes were kept and were made available on the intranet for those who could not attend. There were also staff forums with the senior executive managers.
- Staff reported there were good working relationships between clinical and non-clinical staff. Where there were issues, these were escalated and dealt with by managers, an example of action taken included working with the RMO clinicians to address poor performance issues and communication.

Patient and staff engagement

- Patients or relatives were asked to complete a feedback form about their experiences in the critical care unit. Staff told us the response rate was low and the results showed the majority of people rated the care and treatment in the service as good or excellent.
- Staff reported there were regular opportunities to meet with senior managers in the hospital and they were visible around the hospital.
- Staff also told us the hospital had a good reputation amongst their circle of health professionals, it was a friendly place to work and there was a very approachable senior management team who provided excellent career opportunities and state of the art equipment to deliver exceptional patient care.

Innovation, improvement and sustainability

- The nurse in charge handover process incorporating the in-depth review of the electronic patient record was highlighted by staff as an innovative and proactive approach to patient safety.

Services for children and young people

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

Information about the service

The service is known as the children's hospital and specialises in congenital heart conditions, neurosciences and cancer treatments and also offers general paediatric services to children and young people up to 18 years. The service comprises of an 18 bedded paediatric ward and a 13 bedded paediatric intensive care unit (PICU) providing level 2 and 3 care. The service includes a four bedded high dependency unit (HDU) unit referred to as the progressive care unit. This unit was closed for refurbishment during our inspection. The haemato-oncology unit provides a dedicated suite of rooms, including facilities for haemato-oncology and stem cell transplant.

The children's day care unit has four chemotherapy chairs and five day care beds for children and young people having general medical and surgical procedures such as hernia repair and ear, nose and throat surgery. Outpatient appointments take place in specially designed paediatric consulting rooms in a nearby building which is open Monday to Saturdays.

In 2014 the service had 734 inpatient admissions with an average length of stay of seven days, and 1,219 day cases, of which half were children and young people having oncology treatments.

We visited all the areas where children and young people were cared for. Four parents and two children agreed to speak with us. We also spoke with 40 members of staff including nurses, play specialists, doctors, consultants, allied health professionals, administrative and domestic

staff. We observed care and treatment being provided. At the time of our inspection all children and young people being treated were private patients, there were no NHS funded patients.

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Summary of findings

Care was provided to children and young people in well maintained accommodation and the equipment we saw was clean. We observed systems in place to ensure appropriate response to deteriorating children. There was 24 hour paediatric medical cover on site and access to consultants at all times but no anaesthetic rota. Staff used an electronic incident reporting system and demonstrated that learning from incidents took place. There were high numbers of medication errors that had not reduced despite action being taken.

Most care and treatment pathways were based on national guidance and local audits were undertaken to assess compliance with these. Data was submitted to some national audits such as paediatric intensive care audit network (PICAnet) and central cardiac audit data (CCAD). Some key policies were overdue for review and updating and did not reflect current best practice, for example the safeguarding policy and the Do Not Attempt Resuscitation policy.

Children and their families were involved in the planning of their care and treatment and staff were receptive to their wishes and choices. Staff took care to make sure children and their parents understood their treatment.

Are services for children and young people safe?

Requires improvement 

Safety is not a sufficient priority. Staff understood and used the incident reporting process. Incidents were investigated and some learning took place to reduce the risk of a similar incidents reoccurring. However, there were high numbers of medication errors which despite retraining of nurses had not reduced.

The environment was clean. A range of equipment was available and had been tested for safety in line with the hospital's policy. Medical records were stored securely and were readily available to clinicians. Patient records were legible, in chronological order and included treatment plans.

Most medicines were securely stored, and stocks were checked. Vaccines were kept in two unlocked fridges, temperatures were not consistently recorded, in the children's outpatient building.

Nurse staffing levels met the service's demands, this included chaperones being available when necessary. There was no formalised paediatric anaesthetic rota in place. Most nurses had completed their mandatory training in line with the hospital's policy, however not all nurses had a children's qualification. Insufficient attention had been given to safeguarding. While staff had attended safeguarding training and understood how to recognise potential safeguarding issues. The safeguarding children policy did not reflect national guidance on Working Together to Safeguard Children which was published in March 2013.

Incidents

- Staff reported incidents through the centralised electronic reporting system. We were told that all incidents were reviewed by the management team and staff received feedback on the findings of the investigations with the aim to improve practice. For example the matron told us that following medication errors the nurses involved were re-trained in the administration of medication and their competencies

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assessed. We did not see evidence of the retraining. We observed a senior nurse reminding nurses of learning from a recent incident relating to the placement of naso-gastric tubes.

- The most common incident reported was medication errors - 24 incidents were reported between July and October 2014. An audit was carried out and showed 17 errors caused no harm these included some missed doses because the child was asleep or nil by mouth. The pharmacy report reported four near misses averted by pharmacy intervention. The number of errors in children's wards represented 35% of the total in the hospital during that period. Action had been taken to address this issue but it had not been effective.
- Management had responded to the level of error by reassessing the competencies of 10 nurses involved in these incidents and had reduced the use of bank staff. However, the number of incidents reported in the subsequent months had not significantly reduced. We were not informed of any additional actions taken to address the on-going number of drug incidents.
- There had been no serious incidents (SIs) in the previous year.
- Hospital morbidity and mortality meetings were not held and therefore reflecting and learning from complications, errors and patient deaths did not occur. The neurosurgeons told us that they reviewed their private paediatric neurosurgery patients at the NHS mortality and morbidity meetings at the NHS trust the paediatric neurosurgery team worked at. As these meetings did not take place at this hospital we were not provided with evidence of the learning from these meetings.
- There had been three deaths in 2014. The cases were discussed at the Medical Advisory Committee (MAC) and recommendations and action plans were developed. We did not see evidence of the monitoring of the delivery of the action plans or if changes had occurred. The hospital had reported the deaths to the Coroner and the Local Children's Safeguarding Board in line with national requirements.

Cleanliness, infection control and hygiene

- The ward areas were clean and well-maintained. Cleaners told us and we were provided with the cleaning schedules and checking processes in place to ensure standards of cleanliness were maintained throughout the paediatric department.

- All children and young people were cared for in individual rooms which reduced the risk of cross infection.
- There had been one case of methicillin-sensitive staphylococcus aureus (MSSA) in the last 12 months.
- We observed staff used personal protective equipment (PPE) such as gloves and aprons and disposed of them appropriately after completing patient care to reduce risks of cross infection.
- We observed the majority of staff complied with 'bare below the elbow' policy. However, we saw two interpreters wearing coats at children's bedsides in the intensive care unit. Staff did not challenge this, despite hospital policy requiring coats to be left on the coat racks provided. One resident medical officer (RMO) was also seen wearing long sleeves on a ward round.
- Each patient's room had a wash hand basin and hand disinfecting gel was available at the entrance to the PICU and the paediatric ward for staff and visitors to use.
- Hand disinfecting gel was not prominently displayed in the outpatient building to encourage visitors to clean their hands when attending appointments to limit cross infection.
- We saw the Haemato-oncology unit had been designed with hand wash basins outside the rooms, rather than inside. This arrangement was a potential infection control risk for nurses carrying out procedures.

Environment and equipment

- Resuscitation equipment was checked daily and records seen evidenced this. We noted that in the outpatient area a defibrillator had been signed as checked, but without printing the dated test strip to indicate that it had been turned on. Therefore it was not possible to confirm this check had taken place.
- We observed the resuscitation trolley on the paediatric ward did not have a functional suction unit. We drew this to the attention of staff who were uncertain where to obtain replacement tubing.
- Children had access to up to date diagnostic and imaging equipment on site, in the main hospital including MRI and CT scanning, digital x-ray and ultrasound.
- We saw in the public areas of the outpatient department the stairs were steep. Although there were infant stair gates at the top of the stairs there were no gates to prevent children climbing stairs from the ground floor, which was a potential safety risk.

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- We were told, and saw that the main door into outpatients from the street had a low level exist release button which a child could reach to leave the building. We were told that this was being replaced but this had not been done at the time of our inspection and the risk had not been mitigated.
- We saw a locked fire door in the basement consulting area. Three staff who were working in the building we spoke with were unaware of the location of the key to open this door. Following our inspection the senior managers informed us the door would automatically unlock in the event of fire but we did not see evidence that this had been tested in a recent fire drill and staff we spoke with were not aware of this.
- When we visited the hospital on 06 May 2015 we noted the lock on the fire door had been blocked to avoid confusion that a key was required to open this door. We were told that this change had been communicated to all staff and added to the local induction for new starter. We were not provided with evidence of this communicated to staff.
- Surgeons told us the patient lift was unreliable and had broken down three times in the last year which had occasionally led to procedures being cancelled and could contribute to problems in the event of emergency evacuation. The staff we spoke with were not aware of the actions being taken to mitigate this risk.

Medicines

- There were processes for checking medicines. Nurses checked controlled drugs daily and pharmacy audited these checks every three months. The audit showed 100% compliance in PICU, the paediatric ward and the children's day unit. All drugs we saw were in date, and the date of opening liquids was recorded.
- A computerised medicine prescribing system was used to support appropriate prescribing and minimise prescribing risks. There were facilities for aseptic preparation of cancer drugs to reduce the risk of cross infection.
- Most medicines were securely stored, and stocks were checked. We saw vaccines were kept in two unlocked fridges in the children's outpatient building. We saw there had been two working days when the temperatures of these fridges had not been checked. The temperatures were correct at the time of inspection

but we could not guarantee that the vaccines had not been subjected to higher temperatures on the days no checks had been made, so there was a risk that they might not be fully effective when administered.

- The six drug charts of children who were inpatients we looked at were accurately completed and any allergies were recorded. Three medication audits covered the content of the drug chart, namely admitted doses, medicines reconciliation and antibiotic stewardship.
- There were two designated paediatric pharmacists one for oncology and one for cardiac and general conditions. The paediatric pharmacists checked supplies and prescriptions to prevent errors in medication. We saw a record of any errors in prescribing was maintained, we saw most errors identified related to incorrect dosage or inappropriate duration of drugs being prescribed. These were identified in under 24 hours and prevented harm.
- The paediatric outpatients department and day unit held some pre-packed medication for children which avoided the need to collect these medicines from pharmacy. Parents were given written information about their child's medicines and they were also given an explanation on how to administer them when they returned home.

Records

- Nursing notes were clear and recorded electronically.
- The hospital permitted consultants to choose how they recorded their notes. Some doctors' notes were handwritten on the corporate provider's paperwork and were tidy and legible and contained clear, child-centred treatment plans. Other consultants maintained electronic records and uploaded these onto the hospital computer system. Both paper and electronic records contained a range of information. However, we noted that consultants and RMOs did not always print their names and roles in line with best practice.

Safeguarding

- The hospital safeguarding policy, a corporate rather than a local policy, had not been updated since November 2012. The existing policy did not reflect updated national guidance on Working Together to Safeguard Children published in March 2013. The policy did not contain details of the required paediatrician

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input where safeguarding concerns were raised. When we returned to the hospital on 6 May 2015 we noted the policy had been updated but the frequency of review of the policy was not stated.

- We were told staff had been made aware of the updated safeguarding children policy but the evidence provided did not demonstrate this communication.
- The hospital had a named doctor and a named nurse for safeguarding. Staff we spoke with were aware of how to contact these individuals.
- Nursing staff knew the process for raising safeguarding concerns both in and out of hours, and could explain what might constitute a safeguarding concern.
- We were told all staff on the ward had completed level 3 safeguarding children training. Staff we spoke with confirmed they had attended this training. Training records for the hospital showed that 88% of clinical staff had completed level 3 safeguarding children,
- When we returned to the hospital on 06 May 2015, we were told that 83.3% of RMOs in paediatrics and between 83% and 100% of nursing staff had completed level 3 safeguarding children training. However, the evidence provided to demonstrate this, two emails, related to the cancellation of safeguarding training and the date of the next training, the second provided the date and time of training and asked managers to encourage staff to attend. This was not evidence of the attendance at this training.
- The provider's safeguarding training contained links to up to date national documents and information sources. The paediatric matron told us she was working towards level 4.
- Paediatric staff attended the Private Patients Forum run by the Central London Clinical Commissioning Group which provided a means of keeping up to date with developments in safeguarding nationally and locally. This group was not mentioned in the policy and we were not provided with evidence of any changes that had occurred as a result of learning from attending this group.
- The manager told us that all RMOs working in children's services had attended level 3 safeguarding children training and that records of this were retained by the chief executive's assistant. However, we were not provided with evidence to support this or that there was a process to ensure the 67 consultants listed on the website as having practising privileges for delivering

care to children had attended level 3 safeguarding children training. We were later told by the provider that 32 out of 33 consultants actually providing care to children had attended level 3 safeguarding of children training.

Mandatory training

- Mandatory training included first aid, fire, infection control, basic cardiopulmonary resuscitation and patient evacuation techniques. The level and range of mandatory training for clinical and non-clinical staff depended on their role.
- Staff attended mandatory training, and updates at the specified intervals. We did not receive paediatric specific information and therefore could not confirm how many paediatric staff had completed their mandatory training relevant to their role.
- The three consultants we spoke with were aware of their mandatory training requirements and reported they were up to date and that records were kept centrally. However, we were not provided with evidence to confirm this.

Assessing and responding to patient risk

- The consultant had primary responsibility for assessing the individual patient's risk before surgery or treatment. We noted not all children attended a pre-assessment appointment at the hospital because they lived overseas and were flown to the UK for surgery.
- We were told that for most children the parent either completed an online pre-assessment form or received a telephone call from the pre-assessment nurse. A parent confirmed that they had completed a pre-assessment form before their child came to the hospital which covered their child's medical history, allergies and drugs they were taking.
- A checklist was completed by nurses before a child was taken to theatre for any procedure, this included a check of the child's identity, that the child had not eaten or drunk anything and allergies had been flagged. We found inconsistent use of these checklists when staff handed the child over to theatre staff. For example on one pre-procedure checklist the receiving staff in theatre had not signed to double check the theatre readiness of the child. This was not in line with the hospital policy.
- We observed a briefing for a child going to theatre. All relevant staff were present. They discussed the background and operating plan in accordance with best practice principles, and carried out sign in with the

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parent present. There was time out before the actual surgery and there was a sign out at the end to check everything had been done and accounted for, and a debrief involving all staff at the end, in line with the Five Steps to safer surgery in the World Health Organisation (WHO) Surgical Safety Checklist. We were told an audit of 10 WHO checklists took place monthly.

- Nurses we spoke with understood all the observations that made up the Paediatric Early Warning Score (PEWS) and the escalation processes. The hospital used an electronic system for recording clinical observations on an electronic observation chart, this was linked to the individual child electronic medical record. Risk was automatically calculated and escalated if necessary.
- If observations showed deterioration of a child the paediatric RMO would attend. A PEWS score above four was automatically sent to the RMO's iPod and triggered a bleep to which the doctor had to respond within 15 minutes. Scores of five or more were sent as an alert to the iPod of the doctor in the Paediatric Intensive Care Unit (PICU). Alerts at this level were also received by the child's consultant, who also carried an iPod. The system enabled the consultant to receive real time information on their patients when away from the hospital. Doctors spoke highly of the alerting system.
- Risk assessment in relation to the risk of falls or pressure ulcers and the use of bed rails or cots were undertaken for all children. We saw that if a child was at risk of falling, the risk was signalled to staff by a Humpty Dumpty sign placed on the door to a child's room. Non slip socks were provided for the child. When risks were identified appropriate action was taken and included in the patient notes.
- We were told if a child was receiving palliative care the consultant would record that the PEWS protocol should not be followed. This was in line with the hospital policy on PEWS. There were no children receiving palliative care during our visit. We were told an end of life pathway for children was being developed with support from the palliative care team at a local NHS trust but we were not told when this was due for completion.
- We observed the daily process for ensuring prompt response to cardiac arrests. Staff met specifically to review any child or young person considered to be at risk of deteriorating, and each staff member was allocated a specific role if an emergency occurred.
- After a cardiac arrest a debrief session involving the staff on shift at the time of the emergency took place to

reflect on and review the response and identify any learning. Staff we spoke with demonstrated that an incident that had occurred the previous day had been promptly and effectively managed.

Nursing staffing

- There were 73.8 whole time equivalent (WTE) nurses working in children's services. 30 WTE staff worked on PICU and 17 staff on the paediatric ward. The remaining staff worked in the different day services and almost all were permanent staff. There were six whole time equivalent nursing vacancies in the ward and PICU establishment of 48.5 WTE staff. These vacancies were covered by the corporate provider's bank staff. As bed occupancy had been below 50% over the previous five months the full complement of staff was not currently required.
- Staff numbers for each shift were assessed by the shift leader based on the clinical needs of the children such as frequency of observations or intravenous infusions.
- Nurses told us there were enough staff to meet the needs of children, both on the ward and in the PICU. Parents confirmed this, and said any requests for help or care were responded to promptly.
- The nurse in charge was not always supernumerary if there were fewer than four children inpatients.
- Children in the PICU who needed level three care were cared for on a one to one basis, while those requiring level two or level one care were cared for by one nurse to two children as recommended nationally.
- When a shift was short of staff, gaps were filled either by permanent staff changing their rota or by the corporate provider's bank staff. Nurses said no agency staff had been used in the previous six months.
- Managers were aware of the possible impact of reduced activity on staff competencies, to address this we were told that training updates were being arranged during the current quiet period. Staff told us about recent training they had attended on the use of equipment for blood purification.
- We were told that the majority of nursing staff held a children's nursing qualification. However, some nurses were employed in the children's service without this and we were not provided with evidence to confirm how many did not hold a qualification in children's nursing.
- All shift leaders we spoke with confirmed that they had completed advanced paediatric life support (APLS)

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training in line with the hospital's policy, and the matron told us this was a requirement for becoming a shift leader but training data to support this was not provided.

- There was a system for induction, supervision and mentoring for staff providing the shift leader role to ensure they were aware of and competent in this position and shift leaders we spoke to said that the training for this role had been valuable.
- Nurse handovers took place at each shift change, the nurse in charge handed over to the nurse in charge and the individuals handed over the children they were caring for at the bedside. After this a short group meeting took place to discuss more general issues, such as training opportunities, expected admissions that day and reminders of checks to be undertaken that day. We saw that nurses had written handover notes in line with good practice.
- There were two clinical nurse specialists, one for oncology and the one for cardiac services who provided specialist knowledge of treatments as well as support and leadership to other nurses as required.
- An entry on the risk register indicated that care on the paediatric intensive care unit did not meet neonatal intensive care standards. However, we were told by a paediatric consultant that babies admitted for cardiac treatment were all full term babies, even though sometimes admitted for surgery when only a few days old. Such babies did not require neonatal care of the type provided in a NICU. The ward team could contact the neonatal link nurses in one of the corporate provider's other hospitals if they needed additional advice on caring for new born babies.
- There had been high staff turnover in some paediatric areas in the previous year, notably the oncology unit which had a 91% turnover during a period when there had been no matron. In the last six months staffing was reported to have stabilised. We asked for exit interviews to review the reasons staff left the service but these were not provided with this information.

Medical staffing

- Medical care was consultant-led. Three permanent paediatric trained resident medical officers (RMOs) provided 24 hour seven days a week cover and worked 12 hour shifts. To ensure adequate cover paediatric bank RMOs from the corporate provider's bank were

used. All these doctors' qualifications and competencies had been assessed during the recruitment process. An associate specialist for paediatrics, who reported to the head of paediatrics, led the RMO team.

- The 67 paediatric consultants holding practising privileges at the hospital covered a wide range of specialities, such as paediatric neurosciences, endocrinology, oncology, imaging, neuro-oncology and other sub-specialisms.
- There were twice daily RMO handovers. Therapists such as dieticians and physiotherapists held a separate handover.
- Consultants reviewed their patients daily. In an emergency, consultants were expected to be able to attend within 30 minutes. The protocol was that the RMO would take charge until the consultant arrived and meanwhile have telephone contact with the consultant. We were not provided with evidence to demonstrate consultant's response times were audited.
- We were told there was access to a paediatric anaesthetist 24 hours a day. However, there was not a formalised anaesthetic rota. The hospital maintained a list of paediatric anaesthetists who could be contacted in an emergency. It was the responsibility of the nurse or the RMO looking after the child to contact staff on the list. We saw from the April 2014 MAC minutes that there had been a delay in getting an anaesthetist for a 10 year old at 2.00 am. One consultant who worked regularly at the hospital said he would be reassured by having a formal rota as in the NHS.

Major incident awareness and training

- The hospital had a major incident plan. Each service had been analysed using a business continuity planning tool to assess preparedness for an incident and ensure a contingency plan.
- Each ward had a plan for evacuating patients safely in the event of an incident with major incident action cards in each paediatric area for the nurse in charge. Staff told us procedures for major incidents such as fire had been tested in the recently opened paediatric out patients department.

Are services for children and young people effective?

Services for children and young people

Good



The majority of services were available 24 hours a day seven days a week. Children had access to diagnostic facilities on site. Care and treatment pathways were evidence-based. There were systems to ensure children had pain relief when required and nutrition and hydration was monitored.

Staff were competent and most had received specialist training as appropriate. Children's treatment was regularly discussed by a multidisciplinary team to ensure a holistic approach to the child's medical, nutritional and psychological needs where relevant.

Consent was sought from parents, and older children as appropriate, and involved interpreters as necessary, before any medical or nursing interventions. Written consent was obtained appropriately before surgery or other significant treatment. We were told that older children were involved in the process of consent if they were assessed as competent to do so but the arrangements did not reflect the law on Fraser competences.

Evidence-based care and treatment

- We reviewed a range of clinical care pathways which reflected national evidence based guidelines. Consultants told us that they used the same protocols at the hospital as they used in their NHS practices.
- Staff said that care and treatment plans occasionally varied dependent on the individual consultant as not all consultants used the same protocol or treatment plan in the same situation. However, we saw from ward meeting minutes that it had been determined that, as the service was consultant-led staff should follow the consultant's recommendations.
- We noted some policies relating to children had not been updated by their expected review date. The paediatric Do Not Attempt Resuscitation policy was written in 2005, and was due to be reviewed in January 2013. The out of date guidance did not reflect the joint guidance from the British Medical Association, Resuscitation Council (UK) and the Royal College of Nursing in October 2014, and the form used did not record the child's capacity or involvement in the

decision process. The senior paediatric nursing manager was unaware this was out of date and could not provide an explanation why this review had not taken place.

- When we returned to the hospital on 06 May 2015 we noted the DNA CPR policy had been updated and now included a specific form to record the child's capacity or involvement in the decision process. It was unclear if or how this policy had been circulated to staff.
- The majority of local audits were corporately determined such as nursing records, patient discharges, blood transfusion, Human Tissue Authority audits (relating to consent, storage and traceability) and infection control. A few local audits were carried out on topics selected by the hospital such as monthly paediatric pressure ulcer prevention audit which had been introduced in response to an incident.

Pain relief

- There was a children's pain relief and sedation policy. Senior staff told us the policy had been communicated to staff through the clinical practice facilitators, at daily handovers and unit specific meetings but were unable to provide evidence of this.
- Children were prescribed pain relief by their consultant anaesthetist after surgery. Pharmacists were available to provide advice to nursing staff on the administration of these drugs. Staff we spoke with had a good understanding of pain management and guidelines for pain control in children. Parents said children's pain relief was well managed.
- Children requiring medication for pain were provided with this on discharge.
- We were told that the policies for both pain relief and sedation were under review. It was unclear what policies staff were using at the time of our inspection.
- Play therapists were used to assist in preparing children for painful procedures, and said they used distraction techniques and relaxation to help children manage their pain.

Nutrition and hydration

- We observed in children's and young peoples' records that they had been weighed and measured on admission and weighed weekly thereafter.
- Children's nutritional status was assessed on admission and was monitored by the dietician.

Services for children and young people

- Dieticians ensured specialist dietary requirements were met if children had allergies or other special dietary needs.
- The catering department could provide a variety of food and drink outside mealtimes to meet individual's needs.

Patient outcomes

- The hospital did not participate in the majority of children's national audits because the number of patients having specific procedures was too small. The hospital did submit data where the volume of patients was higher. For example in the intensive care unit where data was submitted to the Paediatric Intensive Care Network Audit (PICANet), a national audit on all children admitted to intensive care units across the UK. This data showed the unit's performance was in line with expected levels.
- National Congenital Heart Disease Audit Report for 2010/13 found that the hospital had a 97.9% survival rate which was slightly better than the expected predicted survival rate of 97.2%.
- Patient data was also submitted to the British Paediatric Neurosurgery Group (BPNG) audit and to the National Institute for Cardiovascular Outcomes Research for Critical Coronary Artery Disease (NICOR/CCAD) in relation to paediatric congenital cardiac data.
- There had been four unplanned readmissions to hospital within 28 days in 2014, three cardiac cases and one oncology because the patients had become unwell. There had been one cardiac unplanned return to theatre because of bleeding. These incidents were reviewed by the Medical Advisory Committee although we did not see evidence of actions made in response to these.
- We were told there was no other comparative data regarding patient outcomes available. The majority of children came from overseas so follow up in this country was not always possible.

Competent staff

- To assess whether staff had the necessary skills, all RMOs and nursing staff worked a three months' probation before they were provided with a permanent contract. New staff shadowed another staff member for a week, undertook initial mandatory training to familiarise themselves with the hospital's policies, procedures and ways of working.

- We were told that a four to six month preceptorship programme was provided to all new nurses which offered structured support and study days. However, we did not meet any nurses on or who had completed this programme during our inspection.
- There was support through supervision and mentoring for staff moving into new roles. Several staff spoke positively about career progression within the hospital.
- All staff had participated in an appraisal within the last year. Staff told us pay awards were linked to satisfactory performance and completion of relevant training. Training needs were discussed as part of appraisal.
- Permanent staff could access a range of training opportunities such as foundation courses on cardiac or oncology nursing, and training days at other children's hospitals.
- All paediatric consultant surgeons working at the hospital were also employed by local NHS trusts. Their appraisal and revalidation with the General Medical Council was managed by the NHS trust. We were told that the individual provided the hospital with evidence of their appraisal and revalidation and a record was maintained that this had been submitted and of Disclosure and Barring Service (DBS) checks. However, we were not provided with evidence to demonstrate this.
- Those paediatricians who did not hold NHS contracts, had their appraisal and revalidation undertaken by the hospital's corporate organisation.

Multidisciplinary working

- The RMO conducted a daily ward round accompanied by the nurse looking after the child but not routinely accompanied by other professionals.
- Dieticians, physiotherapists, pharmacists, pathologists and other health professions were involved in scheduled multidisciplinary meetings as appropriate. These meetings were recorded in the child's record.
- Second opinions could be obtained as necessary, including through international multidisciplinary team working. For example the hospital provided second opinions for those children whose surgical procedure was for correction of failed treatment.
- Psychological support was provided to children and their families. The importance of play therapy was recognised especially for helping young children through daily treatments such as radiotherapy. Art and music therapy was also used to support children.

Services for children and young people

Seven-day services

- A rota of RMOs provided inpatient cover 24 hours a day, seven days a week.
- Consultants visited the children they were responsible for daily. We were told that there were arrangements in place for when a consultant was working in an NHS trust or on leave. Consultants made their cover arrangements themselves with a colleague. This was part of their practising privileges contract. Consultants told us the hospital was informed about who was providing cover at any time, and that cover was always in place for children. Nurses and RMOs said the system worked effectively but we were not provided with evidence that it was monitored.
- Seven day service for pharmacy, radiology and physiotherapy teams out of hours were available through on call rotas.
- Diagnostic imaging including ultrasound, CT scans, magnetic resonance imaging (MRI) and nuclear medicine imaging was available seven days a week with on-call support for out of hours.
- Outpatient appointments were available six days per week between 08.00 am and 8.00 pm on weekdays and 08.00 am to 2.00 pm on Saturdays.

Access to information

- Nursing staff and doctors had ready access to up to date treatment guidelines on the intranet. Nurses demonstrated to us how to find information on the electronic system.
- We saw that wards were sent information updates from pharmacy when there was a change of drug supplier or when national guidance changed, for example when guidance was produced that codeine should no longer be prescribed for children.

Consent

- Consent for care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004.
- We were told parents provided informed, written consent for the treatment their child received and that older children were encouraged to participate in decision- making. We saw signed surgical consent forms in children's records.
- Parents told us they had been given enough information to understand the expected benefits and possible complications of treatment to enable them to make an informed decision.

- Some drugs prescribed and administered were not licenced for use in children. In these cases these were only administered once information about the benefits and side effects had been explained to the parents and they had given their consent for the drugs to be used.
- We observed that verbal consent was obtained from the child or parent before some nursing or medical interventions such as blood sampling took place.
- We were told decisions 'not to resuscitate; children and young people were made by the consultant and the family. But these discussions and the involvement of the parent and young person were not recorded on the DNA CPR forms in line with best practice.

Are services for children and young people caring?

Good



Staff provided care to children and young people that was compassionate and respectful. Staff were committed to providing holistic, family centred care to both children and their families.

Parents and children spoke positively about the hospital and were pleased to be asked for their feedback after treatment. They were complimentary about the engagement and responsiveness of their consultants.

Compassionate care

- A child and parent said the permanent nurses were kind and caring and "very good".
- One parent commented that some temporary staff seemed 'less professional', but children and their relatives were invariably treated with dignity and respect.
- Parents said nurses always knocked and waited before entering children's rooms.
- Parents praised the care provided by their child's consultant and frequency they reviewed the child, stating "that is the reason we came here".
- Consultations took place in private rooms to promote the child's privacy and dignity.
- Children and their parents were both invited to complete questionnaires 24 hours before discharge. The results of these questionnaires provided during our

Services for children and young people

inspection showed that children who were inpatients were positive about their time on the ward and the nurses. The questionnaire results were shared with staff quarterly.

Understanding and involvement of patients and those close to them

- Parents of children receiving inpatient care and those attending outpatient appointments both reported consultants explained the risks and benefits of different treatment options and involved them in decisions about treatment choices.
- Parents said they were encouraged to be involved in their child's care during their hospital stay.

Emotional support

- Complementary therapies, spiritual and psychological support were available. Families said they valued the additional support services, particularly from psychologists and play therapists for children who were anxious or depressed. Therapy sessions were also offered to siblings and parents.
- As a number of children lived outside the UK a mothers' group supported them during their stay, there were also periodic mothers' and fathers' meetings. Both these meetings were facilitated by a consultant clinical psychologist.
- For children receiving a course of treatment, such as radiotherapy, appointments were arranged if possible, with the same staff to provide continuity of care.
- We were told that additional practical support for families with children who had long term conditions and living temporarily in London could be provided. This included staff working with the embassy to meet individual families' needs.
- A multi-faith chaplaincy team was on call and ward staff were aware of how to contact members of this team. We saw leaflets explaining this service to families, including bereavement support. As this leaflet was more appropriate for bereaved British families, the provider's international patient centre would support overseas families together with the relevant embassy.

Are services for children and young people responsive?

Good



The service met the needs of the children and their families. We saw numerous examples of the way the service was able to meet the complex medical needs of children and young people as well as their diverse cultural needs. Interpreting services were available on demand, and parents could be with their child at all times. Accommodation was arranged for families if a child needed to be in hospital for a long time

Service planning and delivery to meet the needs of people

- The majority of children attending the hospital for day case procedures or outpatient appointments were mainly from the UK. For UK patients, inpatient admission was arranged through the child's consultant and with the hospital admissions office.
- Around 60% of children who were inpatients and almost all complex inpatient cases came from overseas. For complex patients from overseas, the provider's overseas offices arranged the referral process from pre-admission, including if necessary visas, to follow up care.
- A medical report from a doctor in the child's home country with a provisional diagnosis was provided in advance of the child being admitted.
- Interpreters were employed by the hospital and available at any time according to patient requirements.
- Arabic and Russian were the main languages spoken by children and their families. We saw some signs in the wards in these languages but not information leaflets specifically written for children or parents in their own languages.
- The hospital's website had downloadable leaflets about the various services and parents told us they were sent information in advance of admission. Topics covered included radiotherapy processes, so parents knew what to expect when their child came to the hospital.

Access to information

- Written information was given to parents about their child's medication on discharge and about the level of post hospital care required.

Services for children and young people

- In some cases medical follow up care was planned to take place outside the UK, in these cases a fitness to fly document and the relevant information about medicines being out of the country was provided the child's medical team.
- Training and written information was provided to parents of children receiving cancer treatment about their child's treatment programme, using an interpreter if necessary. These parents were provided with hand held records that included future appointments and treatment plans. They also included information about the importance of seeking prompt medical attention if their child became unwell during a course of chemotherapy.

Access and flow

- During our inspection there were only seven inpatients: three children in the intensive care unit, two of whom were long term patients, and three children on the inpatient ward, and one day case patient. Managers said current economic and political situation had reduced the number of children coming for treatment from certain countries.
- Children were assessed, diagnosed and treated promptly. Due to low bed occupancy rates, beds were readily available on the paediatric ward and in the PICU, therefore consultants could arrange complex surgery without delay.
- Parents in the inpatient and outpatient departments confirmed they had been able to arrange treatment at a convenient time for the family.
- At the time of our inspection some children remained in the intensive care unit after they had been considered fit for discharge by their consultant as there was no step down facility and the level of care they required could not be provided on the children's ward.
- Staff told us there was pressure from funding authorities such as embassies to keep intensive care episodes short, and patients should be transferred to the ward as soon as they were clinically fit to do so.
- The majority of children's surgery was planned in advance and there were only a few cases when urgent surgery took place.
- Children who had been inpatients in the past year, such as oncology, neurology or neurosurgical patients were sometimes brought directly to the ward by their parents if they became unwell, despite advice to take them to

A&E in an emergency. In response to this the ward was developing a protocol to manage unplanned admissions but at the time of our inspection this was not in place.

- At the time of inspection a child presenting in an unplanned way was examined by the RMO who would telephone the child's consultant to discuss whether to admit or discharge the child. The RMO would clerk the child for admission if this was agreed.
- There were issues transferring children arriving by ambulance who required to be taken directly to theatre because there was no designated ambulance parking outside the Harley Street Clinic entrance nearest to theatres. The local authority had designated ambulance parking spaces outside the main hospital entrance in Weymouth Street but not in Harley Street. The hospital management was in discussion with the local authority to identify ways to resolve this issue.
- The imaging service was used by both children and adults. The facilities were not specifically designed to be child-friendly, but we were told children rarely had to wait in the department.
- Dedicated paediatric ultrasound sessions and paediatric anaesthetists were present when a child needed sedation for scanning. Results were given to doctors and parents promptly. For cardiac MRI (magnetic resonance imaging, a scan to create pictures of the inside of the heart) a cardiologist would be present at the time of the scan. Most other scans were analysed by radiographers remotely, but staff reported minimal delay in obtaining results, and families confirmed this.
- Parents could arrange general paediatric consultations with consultants' secretaries, and appointments were made to fit in with the family's needs. Follow up appointments for children who had been inpatients could also be arranged in this way.
- There was no designated ambulance parking outside the Harley Street Clinic entrance nearest to theatres. The ambulance had to stop at the nearest point to the entrance so the transfer from the ambulance sometimes took place on the street pavement. The local authority had designated ambulance parking spaces outside the main hospital entrance in Weymouth Street but not in Harley Street. The hospital management was in discussion with the local authority about this issue.

Services for children and young people

Meeting people's individual needs

- The playroom on the paediatric ward had a range of age-appropriate amusements for children and teenagers, a sensory room and an enclosed outdoor play area. There was also a play area in the outpatients building and amusements for younger children in the consulting rooms. Play therapists supported children in all paediatric areas.
- We asked staff could they meet the needs of children with learning difficulties. We were told very few children with learning disabilities were seen in the hospital but the psychosocial staff knew how to support children with a range of needs. There was no evidence that the hospital monitored how many children with learning difficulties attended and therefore it was unclear if this was an area of the service that needed to be developed.
- Early morning and evening outpatient appointments, as well as Saturday appointments were available to meet the needs of working parents. Parents told us they had been able to arrange an appointment within a few days.
- While some children were inpatients for long periods of time we noted there was no education available for such children.
- Parents could accompany their child to the anaesthetic room prior to surgery and remain until the child was asleep, in line with good practice.
- A range of parent facilities were available including a sitting room which overlooked the outdoor play area, and refreshments were available on request. A parent or carer could also sleep in the room with their child or teenager.
- One parent mentioned the smaller rooms did not offer the most comfortable environment for a child with neutropaenia who had to remain in isolation in their room, as a precaution against infection. While staff explained that a small room would only be used at times when all other rooms were occupied, this was not the situation during our inspection.
- Families were given information about hospices as an alternative place of care for children requiring palliative care. However, we were told these facilities were not usually wanted by overseas based families for whom the concept was unfamiliar.
- Children whose treatment affected developing teeth had access to dental treatment through the hospital.

Learning from complaints and concerns

- There was a formal policy setting out timescales for complaints handling and complaints were discussed at weekly Quality meetings. Patient feedback was also discussed at other meetings, but we did not see examples of changes made in response to complaints.
- Staff told us they generally tried to resolve concerns raised by families informally to prevent formal complaints being made. All complaints, formal and informal, were logged promptly.
- If someone wanted to make a formal complaint they received information about the procedure. The procedures followed the Code of Practice set out by the independent sector complaints adjudication service.
- The children's hospital had seven formal complaints, made in the previous year. Complaints tended to be about food and accommodation services, and communication. We were not provided with evidence to demonstrate what action had been taken to address these issues

Are services for children and young people well-led?

Requires improvement



Nurses reported they felt supported by the local leadership within the paediatric areas. Staff understood their roles and responsibilities and reporting lines were clear. Staff were aware of expansion plans for paediatrics but they were not clear about the timescale for change or the specific details.

Paediatric managers considered they were aware of the key risks for their service, but had not identified risks associated with safeguarding and DNA CPR found during this inspection. Middle managers and senior staff were aware of the priorities for their service areas and departments and shared the hospital and corporate vision. Medical staff and senior nurses considered the senior management team were accessible and supportive. Nursing staff were less involved with managers and management decisions.

Vision and strategy for this service

- Members of the management team told us there was a strategic objective to expand the paediatric services. In

Services for children and young people

anticipation of increasing numbers of patients, particularly in day surgery and the paediatric outpatient service an education programme for staff had begun to develop skills.

- The clinical lead for paediatrics was planning some overseas visits to promote the care available at the hospital. At ward level staff were not clear about the development plans or the timescale. They saw their objective as providing excellent care and all understood the focus on high quality care and the importance of family satisfaction with the service.
- Staff were aware of the corporate provider's values of integrity, respect, equality, appreciation, compassion and honesty, and we observed that these values were reflected in the way staff responded to children and their families.

Governance, risk management and quality measurement

- Several consultants had worked at the hospital for a number of years, and a small number such as the clinical leads for paediatric surgery and paediatric medicine were involved in hospital management. At ward level staff did not consider they were involved in governance and that this was 'for managers'. Senior nurses we spoke with told us they felt they were kept updated on key quality and safety through their line managers.
- The matron held weekly operational meetings with the senior sisters, the associate specialist for paediatrics and the canteen manager at which current issues such as expected admissions and skill mix needed were discussed. These meetings were not minuted.
- Every two weeks paediatric services meetings were held, involving the associate specialist for paediatrics, paediatric matrons and senior sisters, therapists and counsellors, pharmacists, paediatric intensivist and the dietician. These meetings considered learning and development, a pharmacy report, a dietician report and guidelines reviews.
- Once a quarter the paediatric service's meeting became a formal clinical governance meeting. The infection control manager attended these meetings which focused on audit reports, risks and incidents.
- Paediatric managers were aware of the key risks for their service, and significant risks were discussed at the quarterly clinical governance meetings where plans to mitigate risks were developed. Mitigations were added

to the risk register with a named person responsible for action and reporting back to the next fortnightly meeting. Only risks directly affecting ward practice were cascaded to staff.

- Ward nurses we spoke with were not aware of the risk register. If staff identified a risk on the ward they told us they would escalate it by recording it as an incident on the recording system.

Leadership of service

- Nursing leadership for the paediatric inpatient department was provided by a matron who reported to the chief nursing officer. There was also a matron for paediatric oncology.
- The medical lead for paediatrics was a paediatric surgeon who was also a member of the MAC. Paediatric cardiac services were led by a consultant paediatric cardiologist. The associate specialist for Paediatrics managed the RMOs.
- Medical staff said that the management team were approachable and responsive. Nurses said matrons were visible and in regular daily contact with them.
- Some ward staff we spoke with questioned the involvement of the corporate office and their involvement in local issues such as ward staffing, as they could not see the rationale for this.

Culture within the service

- Nursing and other health professionals reported good support from consultants.
- Nurses said the atmosphere was friendly and teamwork and day to day communication was good. They were proud of the care they were able to give children with complex needs.
- Nursing staff did not feel fully involved in service developments. We were told a staff committee was being set up, to meet monthly, to facilitate improved sharing of information within the organisation
- There had been some staff turnover during the previous year, this had been over 90% in the oncology unit. We were told exit interviews were held with staff to identify their reasons for leaving, but despite asking we did not see examples of these.
- Staff we spoke with told us they could raise issues with their manager but most were not aware of the ethics line for reporting concerns.

Services for children and young people

Child and family engagement

- Staff told us they received regular feedback from family and patient questionnaires but were also directly aware of feedback from the families they were working with.
- Parents we spoke with said they felt the service was efficient, caring and centred around their child's needs

Innovation, improvement and sustainability

- A one stop hernia service for children had recently been introduced. It provided same day diagnosis and treatment, reducing the number of appointments and facilitating early intervention.
- The electronic remote monitoring system for sick children on the wards linked to the monitor on the ITU nurses' station was highlighted by consultants as an innovative approach for identifying and responding to deteriorating children.

Outpatients and diagnostic imaging

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

Information about the service

The outpatient and diagnostic imaging department at The Harley Street Clinic (THSC) provide outpatient clinics and diagnostic imaging services to private patients from overseas and from the UK. Outpatients and diagnostic imaging services includes all areas where patients undergo diagnostic testing, receive diagnostic test results, are given advice or provided care and treatment without being admitted as an inpatient. The Outpatients & Diagnostic Imaging departments at the THSC provided a service to a total of 66,780 patients in the financial year 2013/2014.

THSC outpatient department held clinics for a range of different specialities including orthopaedics, plastic surgery, ophthalmology, cosmetic surgery, gastroenterology, ENT, gynaecology, general surgery, cardiac surgery, vascular surgery, dermatology, rheumatology and oral surgery. The diagnostic and imaging services offer Computerised Tomography(CT), Magnetic Resonance Imaging (MRI), X-Ray, Positron emission tomography, Digital Mammography and Ultrasound.

The outpatient services are provided from various locations within the Harley Street vicinity. There are 97 consulting rooms. As part of this inspection we visited all outpatient locations and diagnostic areas. We spoke with 26 patients and their relatives, 12 staff and departmental managers. We observed care and treatment and looked at care records. Information provided by the hospital before the inspection was also reviewed. We did not look at outpatient services for children; this service is reported under the children's services section of this report.

Summary of findings

Staff demonstrated an awareness of the process for identifying and recording patient safety incidents. Where serious patient incidents had occurred we found there were processes to investigate the incident and where actions were identified they had been taken.

Complaints were investigated and where necessary clinical and administrative practice had changed to prevent recurrence. Diagnostic and imaging staff followed national guidance and equipment was appropriately cleaned, tested and maintained. Radiation regulations were followed and staff received the necessary training and competency assessment to ensure patient safety.

We saw that staff were caring and maintained patient's privacy and dignity at all times. Patients understood their treatment options and their plan of care. Patients were able to choose the time of their appointment to suit their needs and there were no delays in booking appointments and some investigation results were available within an hour.

There was evidence of effective multi-disciplinary team working across the services with shared responsibility for care and treatment. Patients were positive about the staff and the quality of the care and treatment they received.

Outpatients and diagnostic imaging

There was a vision for the development of outpatient and diagnostic imaging services and identified local leadership. The outpatient and diagnostic imaging department strived for continuous improvement.

Are outpatients and diagnostic imaging services safe?

Good



There were effective systems in place, supported by resources to enable the department to provide high quality care to patients attending for outpatient consultations. The majority of staff considered staffing levels to be appropriate to meet patient's needs.

The equipment used in the outpatient and diagnostic imaging department was visibly clean and appropriately maintained. Equipment was readily available and staff were trained to use it safely. Resuscitation equipment was in place to deal with emergencies and medicines including controlled drugs were stored securely. Staff adhered to infection prevention and control policies and procedures. There were facilities available in all areas for staff to maintain appropriate hand hygiene practices. All staff participated in mandatory training and annual performance appraisals.

Incidents

- The hospital used an electronic incident reporting system and all staff we spoke with were familiar with how to report incidents using this system and gave examples of reported incidents such as missed pre medication, missed appointment and drug errors.
- Staff were confident that the incident reported would be investigated and gave examples of learning and changes made as a direct result of learning from incidents. These examples included two nurses checking drugs and reminder phone calls for patient with appointments to avoid non-attendance.
- The outpatients manager stated that following an incident relating to patient identification, a checklist was introduced to check and confirm patient identity before treatment was administered.
- The outpatients manager said all incidents were investigated using a root cause analysis tool, taking into account contributory factors such as stress, workload, language barriers and personal development which may have affected nurses, healthcare assistants and administrative staff. This was corroborated by the senior sister at the outpatient clinic.

Outpatients and diagnostic imaging

- The managers we spoke with confirmed information relating to reported incidents was collated and discussed by the management team at their monthly quality team meetings. Minutes we saw confirmed that incidents were discussed and action points shared with staff via staff meetings and email bulletins.
- The service had not reported any Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) events in the last 12 months.

Cleanliness, infection control and hygiene

- Staff working in the outpatients and diagnostic imaging department understood their responsibilities in relation to cleaning and infection prevention and control. Clinical staff participated in cleaning audits, the audit results available in the department showed that all the clinical and non-clinical areas were compliant with the hospital's cleaning regime.
- The majority of staff we observed at the outpatients clinic complied with policies and guidance on the use of personal protective equipment, such as gloves and aprons.
- There were enough hand washing facilities including hand wash basin and hand gel sanitizers within the clinics and imaging suites and we observed staff were complainant with appropriate hand hygiene practises between patients.
- Nursing staff were responsible for cleaning clinical equipment after each patient use and at the end of their shift. We saw that there were checklists in place and these were completed to demonstrate the checks had been complete. The equipment had green labels to indicate that it had been cleaned and was ready for use.
- There were disposable curtains in all the treatment and consulting rooms with a date on when they were put up and when they were due to be changed.

Environment and equipment

- The outpatients and diagnostic imaging department was uncluttered, and well maintained. Patient waiting areas were clean with sufficient seating for patients and their relatives. The diagnostic and imaging department and the treatment rooms were noted to be visibly clean and tidy.
- The resuscitation equipment at the outpatients and diagnostic imaging department was in line with national

resuscitation council's recommendation; we noted that it was recorded as checked daily and ready to be used. We saw records of these daily checks and were accurate at all times.

- All equipment seen had been appropriately checked, cleaned and maintained. Portable appliance testing (PAT) was up to date. There was a contract for annual portable appliance testing and a record was maintained of all equipment tested.
- There was sufficient safety equipment in the diagnostic imaging department including resuscitation equipment to deal with emergencies.
- The imaging department manager told us all x-ray equipment such as computerised tomography was compliant with national guidelines and IR(ME)R 2000 regulations and that there were local rules in place to ensure safety standards were maintained.
- The radiation protection supervisor informed us that radiation audits and risk assessments were undertaken to ensure appropriate doses were not exceeded. The audits report seen demonstrated staff were compliant with the pre-treatment regime for radiological examination and treatment.
- We saw documentation check list which showed that daily checks such as calibration and physical cleanliness on all imaging equipment's had been completed.
- Examination couches were cleaned and checked daily before clinic. We saw records of those checks available in each consulting room.
- There were working emergency call bells in each consulting room that could be used to obtain assistance when necessary.

Medicines

- Staff we spoke with were aware of medicine management policies and the systems in place to monitor stock control and report medication errors. Medication audits were undertaken by the pharmacist, these showed minimal drug errors and staffs were trained in medicines administration. We were told that learning from these audits was shared with staff at team meetings and we saw minutes of meetings which confirmed this.
- All medicines seen were in date and stored securely in a locked cupboard. A record was maintained of all

Outpatients and diagnostic imaging

medication administered to patients during minor procedures in the treatment rooms, this included the name of the patient, the medication used and dosage. All entries were noted to be fully completed and signed.

- Medicines, including those requiring cool storage, were stored appropriately. Records showed that they were kept at the correct temperature so that they would be fit for use. Safe temperatures for fridges were recorded and a log of medication contents in the fridge was maintained.
- Controlled drugs (CD's) were stored and managed appropriately. The CD register confirmed that CDs were always checked and signed for by two nurses in line with the hospitals policy.
- Medications and contrast media required during diagnostic imaging procedures were administered appropriately using approved patient group directives (PGD's). The use of PGD's enabled registered healthcare professionals other than doctors to supply and /or administer medicines to patients without doctors prescription. PGD is a written instruction for the supply and / or administration of a named licensed medicine for a defined clinical condition by specific healthcare professionals to improve patient care.

Records

- At the time of inspection we saw patient personal information and medical records were managed and stored securely. All nursing and diagnostic imaging records were electronic and stored on the hospital's computer system, which were accessible to clinical staff using individually issued secure passwords.
- Staff we spoke with could not recall an occasion where medical records had not been available for a clinic, or when a patient could not be seen because their records were not available.
- Any new patients attending the outpatient appointment for radiological examination or treatment had a risk assessment completed which covered areas such as mental capacity assessments prior to undergoing radiological examination or other invasive procedures.
- Information governance training was mandatory for all staff to ensure compliance with the Data Protection Act. The mandatory training records we saw showed that all staff had completed Data Protection training.
- The records management policy stated that any breaches of data protection would be discussed at the managers meeting and actions taken to remind staff of

the importance of data protection. We were not provided with evidence to demonstrate that there had been any breaches of data protection in the last 12 months.

Safeguarding

- The majority of staff working in the outpatient clinics and diagnostic imaging department had completed level one mandatory adult safeguarding training, they demonstrated an awareness and knowledge of safeguarding and were able to show us the hospital's up to date adult safeguarding policy on the intranet (grapevine).
- The outpatient matron provided us an example of when staff had followed the hospital's safeguarding policy and made an appropriate referral to the hospital safeguarding lead.
- The chief nursing officer was the safeguarding lead for the hospital.
- There was a chaperone policy and we saw posters throughout the outpatient clinic and diagnostic imaging department advising patient how to access a chaperone should they wish to do so.
- All staff spoken with were aware of the hospital's whistleblowing policy, known as the ethics policy. They told us that they would feel happy using this policy to raise concerns if necessary.

Mandatory training

- There was a mandatory training policy that detailed which training staff were required to attend. The training included resuscitation, safeguarding, data protection, basic life support, risk assessment and health and safety training. The training records showed attendance at training was monitored and non-attendance was flagged and managers were required to take action to ensure that the staff member under them attended all mandatory training.
- The manager told us that all staff had completed the required mandatory training and completion of mandatory training was linked to the appraisal system. The training record maintained by the department, provided during our inspection confirmed this. The central records maintained by the hospital showed that 76% of staff had completed the required mandatory training.
- We were told medical staff with practising privileges at the hospital completed mandatory training at the

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hospital they spent most of their time at. For example those working mainly at an NHS trust would complete this training at their respective trusts and were required to submit copies of their training record to the hospital management team. However, we were not provided with evidence to demonstrate this occurred.

Assessing and responding to patient risk

- There were emergency assistance call bells in all patient areas including consultation rooms, treatment rooms and the x-ray suite. Staff we spoke with told us when the call bells were used they were answered immediately.
- There were clear procedures in place for the care of patients who became unwell. Staff we spoke with told us about emergency procedures and escalation process for unwell patients. However they stated these had not been used often as the department did not often have acutely unwell patients.
- Staff we spoke with were aware of their role in a medical emergency. Staff provided an example of a patient who had become acutely unwell during a clinic appointment where a cardio-respiratory resuscitation (CPR) team had been called to assist the patient.
- We were told by the radiographer that the radiation protection monitoring at the hospital was in line with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) requirements.

Nursing, physiotherapy and diagnostic imaging staffing

- The outpatients and diagnostic imaging department had a team of registered nurses, healthcare assistants, radiographers, medical laboratory assistants, physiotherapists, radiologists, receptionists and administration staff.
- The nurse in charge of the outpatient clinic was responsible for ensuring staffing levels always met patient needs. Staffing levels were based on the number of patients expected to attend the department on a daily basis, taking into account the type and complexity of clinics to be held to ensure there were enough staff to meet patient needs.
- The senior sister told us there were adequate staffing levels to enable the clinics to run effectively. Staff told us the department did not use agency staff and any staff

shortage due to sickness and annual leave were either covered by bank staff or staff employed by the provider who worked across several of their hospitals to cover staff shortages.

Medical staffing

- There were approximately 806 consultants with practising privileges, however not all of them regularly saw patients in outpatient clinics. We were not given information regarding the number of consultants who worked in the outpatients clinic and diagnostic imaging department.
- All clinics were consultant led, the consultants agreed clinic dates and times directly with the bookings and reservation team.
- There was a process in place for granting practising privileges, via the medical advisory committee (MAC). This process included interviewing, obtaining references and DBS checks on all applicants.
- Staff told us that the most of their consultants attended promptly for their clinics and could be easily contacted if they needed advice.

Major incident awareness and training

- The hospital had a business continuity management plan which had been approved by the management team. The plan established a strategic and operational framework to ensure the hospital was resilient to a disruption, interruption or loss of services.
- The hospital major incident plan covered major incidents such as loss of electricity, loss of frontline system for patient information, loss of information technology systems and internet access, loss of staffing, and loss of water supply.
- Staff we spoke with were aware of the hospital's major incident plan and understood what actions to take in the event of an incident such as a fire. Most staff we spoke with had attended major incident awareness training in the last two years.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

Evidence based assessment, care and treatment was delivered in line with National Institute for Health and Care

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Excellence (NICE) guidelines by appropriately trained and qualified staff. Radiation guidelines, local rules and National Diagnostic Reference Levels (DRL's) were available for staff references. There were assigned Radiology Protection Adviser and Radiology Protection Supervisor.

A multi-disciplinary team approach was evident across all the services provided from the outpatients and diagnostic imaging department. We observed a shared responsibility for care and treatment delivery.

The outpatients department did not operate seven day services, however they had extended opening hours and support services such as pharmacy and radiology were available when needed.

The diagnostic imaging service manager monitored the radiology turnaround times for reports, which were shared with all staff during staff meetings. The diagnostic imaging department had effective systems in place for monitoring radiation levels administered for diagnostic treatments, interventions and patient outcomes.

Evidence-based care and treatment

- Staff told us they participated in local audits, for example, documentation and film reporting audits. We saw evidence that when audits identified areas for improvement actions was taken, these included staff training to improve the completion of diagnostic request forms.
- Safety alerts were received by the outpatient and diagnostic imaging managers and all relevant alerts were cascaded to staff via email, displayed in the staff office and discussed at team meetings.
- We were told by the diagnostic and imaging manager that there had been improvements in quality assurance checks in the imaging department. These included checks on radiation exposure levels to safeguard patients. Most of the staff we spoke with confirmed that.

Pain relief

- The imaging department had a stock of pain relief and local anaesthetic for use when invasive procedures were being carried out. We saw that pain relief was discussed with patients during their consultation or treatment and analgesia was prescribed as necessary and dispensed by the hospital's pharmacy.

Patient outcomes

- National guidelines for radiological reporting and the clinic's own quality standards for radiology practice were followed in relation to radiology activity and reporting. This included all images being quality checked by radiographers before the patient left the department.

Competent staff

- Managers and staff told us performance and practice was continually assessed during their mid-year reviews and end of year appraisal. Staff we spoke with confirmed they received regular appraisals and we saw evidence that the appraisal completion rate for outpatients and diagnostic imaging staff was 100%.
- Nursing and imaging staff we spoke with confirmed they were encouraged to undertake continuous professional development and were given opportunities to develop their skills and knowledge through training relevant to their role. This included completing competency frameworks for areas such as the administration of medicines, cannulation and venepuncture. They were also supported to undertake specialist courses.
- Medical consultants with practising privileges had their appraisals and revalidation undertaken by the medical director if they did not work at an NHS trust. For those with NHS contract their appraisals and revalidation were done at their employing trust and a copy provided to the hospital. There were processes in place to ensure all consultants were up to date with their revalidation. However, we did not review this evidence to demonstrate that all doctors had participated in an appraisal in the last 12 months.
- Managers told us they had procedures in place for the induction of new staff and all staff, including temporary staff completed local induction and training before commencing their role. We saw evidence that attendance at these induction sessions had been completed by all new staff.

Multidisciplinary working

- Multi-disciplinary team (MDT) working was evident throughout the department with the majority of MDT meetings including consultants, nurse specialists, allied health professionals, administrative staff and managers in attendance.
- We observed nursing staff worked well together as a team and providing support to ensure that care and treatment was managed effectively.

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Seven-day services

- Seven day a week outpatient services were not provided. The outpatient service, including radiology was provided Monday to Friday 8.00am to 8.00pm. There was an ad-hoc Saturday clinics as and when required.
- The radiology department provided 24 hours on-call services.

Access to information

- All staff had access to policies, procedures, NICE guidance and e-learning on the hospital's intranet.
- All clinic rooms had computer terminals enabling staff to access patient information such as x-rays, blood results, medical records and physiotherapy records via the electronic system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with were aware of the Mental Capacity Act 2005 and its implications for their practice. We were told that level one adult safeguarding training included elements of the Mental Capacity Act 2005. Information provided demonstrated that 94% of out patient staff had completed Mental Capacity Act (MCA) training.
- Staff told us they were aware of the hospital's consent policy. Consent was sought from patients prior to the delivery of care and treatment. In the diagnostic imaging department, radiographers obtained written consent from all patients before commencing any procedure.

Are outpatients and diagnostic imaging services caring?

Good



Staff delivered compassionate care. Staff ensured patients understood what their appointment, care and treatment involved. Patients and relatives commented positively about the care provided from all outpatients and diagnostic imaging staff.

Staff listened and responded to patients' questions positively and reassured them. Patients were provided with information about their care and were involved in discussing and planning their treatment, enabling them to make informed decisions.

Compassionate care

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

Understanding and involvement of patients and those close to them

- We saw staff spent time with patients, explaining care pathways and treatment plans. All patients we spoke with told us they fully understood why they were attending the hospital and had been involved in discussions about their care and treatment.
- Patients told us they were given time to make decisions and staff made sure they understood the treatment options available to them.
- The hospital collected patient views using a patient satisfaction questionnaire and there was an action plan in place to address issues raised by patients. But there was limited information relating to outpatient and diagnostic imaging department.
- The 26 patients we spoke with were satisfied with the overall experience of visiting the outpatients and diagnostic department. Patient had positive feedback to share with us regarding the doctors and other staff who they saw while in the imaging department and at the clinics.

Emotional support

- Nursing staff provided practical and emotional support to patients in all of the clinics. Staff told us how they supported patients who had been given bad news about their condition, and offered them sufficient time and space to come to terms with the information they were given.

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- Patients and relatives we spoke with told us they had been supported when they were being given bad news about their condition, and the nurses provided them with help and support.
- Patients reported that if they had any concerns, they were given the time to ask questions. Staff made sure that patients understood any information given to them before they left the clinic.

Are outpatients and diagnostic imaging services responsive?

Good 

The outpatients and diagnostic imaging services was responsive to the individual needs of patients, arranging appointments that met their individual needs. Patients were seen in a timely manner for all appointments by their chosen consultant and clinics were rarely cancelled at short notice.

Systems and processes were in place to ensure the service was able to meet the needs of individuals such as those with physical disability or those whose first language was not English. There were systems and process in place to manage complaints. Staff understood the complaint's process and received regular feedback on complaints.

Service planning and delivery to meet the needs of people

- Services were planned and delivered to meet patients' needs, providing flexibility, access, choice and continuity of care that met the needs of both patients from the UK and patients from overseas.
- Consultants liaised with the booking and reservation department to book appointments for their patients and arrange the use of the consulting rooms as required. We were told by the consultants that the hospital's booking system was flexible to accommodate their preferred consulting times for clinic and the use of the minor treatment rooms.
- The main reception desk was easily accessible and the design facilitated patients to have private conversation. Patients told us that staff in the reception area were always available to give directions when required.

- Signage around the outpatient and diagnostic imaging department was in English only. We saw staff stopping to ask patients and visitors if they required assistance or directions if they saw them appearing to be lost.

Access and flow

- Patients we spoke with said they were informed of how to book an appointment at the clinic and were provided with sufficient notice of their appointment. Referral and access to other services such as blood test and x-ray were considered to be appropriate by patients we spoke with.
- We were told waiting times, delays and cancellations were rare, and if there were any delays, these were minimal and managed appropriately. We were not given any data on cancelled clinics or waiting times. The receptionist's ensured patients were informed of any delays to their appointments or treatment as soon as they arrived if there were any.
- Consultants provided consultations for direct referral patients and post-operative follow up appointments and we were told patients could be seen within hours or days for most outpatient appointments and radiological diagnostics. Patients confirmed this and told us they had timely access to endoscopy, cardiac investigations and minor treatment within a few days of their appointment at the hospital.
- We were told and also observed that there was minimal waiting times in clinics and most patients were seen as soon as they arrived.

Meeting people's individual needs

- All posters and written information were in English and Arabic.
- We were told that translation services could be accessed through language line for people whose first language was not English. However, there were no posters or written information available to inform people of this service.
- There was a range of patient information leaflets in all consulting suites and imaging department. There was also a MacMillan information Centre in the outpatient department which provided patients with specific information relating to cancer and support services for those patients diagnosed with cancer.
- The clinic had a disabled access facility to enable patients with limited mobility or wheelchair users to access the clinic.

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- There was water, teas, coffees, books and magazines in the waiting rooms for patients or their relatives who were waiting.

Learning from complaints and concerns

- Complaints and comments were reviewed and discussed by teams at monthly staff meetings. We saw minutes of meetings which demonstrated that complaint themes and learning was shared with staff. Complaints made included parking and medication to take home issues. There was evidence that action had been taken to improve the timely dispensing of medication to take home.
- Staff described how they would resolve patients' concerns informally in the first instance, but would escalate to senior staff if necessary.

Are outpatients and diagnostic imaging services well-led?

Good



Staff considered their line managers to be approachable and supportive. Staff understood the vision of the hospital and they could demonstrate how this was implemented in practice. Staff told us they enjoyed their work and felt that it made a difference to how patients felt about the hospital.

Staff in all outpatient and diagnostic imaging areas stated their managers were visible and provided clear leadership. Staff and managers told us there was an open culture and they felt empowered to express their opinions and felt they were listened to by the management.

Vision and strategy for this service

- All staff were aware of the corporate provider's vision and values that included care being delivered with compassion, dignity, respect, and equality. Staff stated quality was a key priority for the hospital.
- A member of staff told us the hospital was expanding and improving and spoke passionately about the service they provided and were proud of the facilities. However we were not given any details or plans for this expansion.

Governance, risk management and quality measurement

- There were quarterly clinical governance meetings attended by senior sisters, matron and service managers. Comments, compliments and complaints were a standing item at these meetings. We were told by the matron that audit results and quality improvement programs were discussed at clinical governance and quality meetings. Minutes of the clinical governance meeting confirmed this, and discussions about audits and quality improvement was a standing agenda item.
- There were regular team meetings to discuss issues, concerns and complaints. Staff were given feedback at these meetings about incidents and lessons learnt by their line managers.
- We were told the hospital had a risk register and managers were responsible for updating the register with their departments' risks. Managers told us they were aware of the risks in their departments and were managing these. However we were not provided with any risk associated with the outpatient and diagnostic imaging department, the majority of risks on the risk register were hospital wide and not service specific. The managers of outpatient and diagnostic imaging department were unable to provide us with specific outpatient and diagnostic imaging risks.

Leadership of service

- There were clear lines of accountability and responsibility within the outpatients and diagnostic imaging department. Staff in all areas stated that they were well supported by their managers, that their managers were visible and provided clear leadership.
- Staff told us the hospital management team were accessible and visited their departments frequently.
- Supervisors and team leaders in the outpatients and diagnostic imaging department stated the main challenges to delivering care were appropriate skill mix and the recruitment of suitably qualified staff.

Culture within the service

- Staff we spoke with said that they felt listened to and respected by the recently appointed chief nurse.
- Staff told us the outpatients and diagnostic imaging department had an open culture. Staff told us they were encouraged to report concerns, record incidents and take part in team meetings. They told us managers were open to comments and suggestions for improvements from staff.

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- Staff said that there were good working relationship between clinical and non-clinical staff.

Patient and staff engagement

- Patients were asked to complete a comment card following their appointment about the service they had received and areas for improvement. The result were analysed and shared with staff at team meetings.

However, we were not provided with evidence to demonstrate any themes that had been identified from this feedback or if changes had been made in response to this feedback.

- The department actively sought patient feedback. We were told staff regularly spoke with patients waiting to be seen by their consultant to gather their feedback. However, we did not see this taking place during our inspection.

Outstanding practice and areas for improvement

Outstanding practice

- The electronic national early warning score (NEWS) to identify deteriorating patients by monitoring patient observations automatically calculated the level of risk which when a certain level was reached the registered medical officer (RMO) on call was automatically informed and reviewed the patient.
- The falls programme including the introduction of a falls assessment tool to identify patients at risk, posters to remind staff of the nine key points to consider such as the environment, call bells to hand and foot wear, signs in patient rooms to remind them to call for assistance stating 'call don't fall' were having an impact on the number of falls.
- Staff were caring and compassionate and focused on meeting individual patient needs.
- The multidisciplinary team (MDT) meeting discussed complex care and management plans for cancer patients requiring surgery and a range of other treatments.

Areas for improvement

Action the hospital MUST take to improve

- The hospital must ensure all policies reflect the latest national and professional guidance.
- Ensure all intravenous fluids are stored in locked cupboards to prevent unauthorised access.
- The hospital must ensure that the process for amending medication prescriptions out of hours when the consultant is not present is in line with national professional guidance.
- The hospital must ensure that there is evidence that the vaccinations are consistently stored at the recommended temperature and fridges used to store vaccines are appropriately monitored and maintained.

Action the hospital SHOULD take to improve

- Ensure that the process in place for contacting consultant in unplanned situations should be explicit.
- Implementation effective systems to monitor, review all patient death with independent input and disseminate the learning from these reviews.

- The critical care unit should implement a periodic multi-disciplinary team meeting to review unit performance, governance and review patient outcome data to identify potential improvements in the service.
- The hospital should review the need for dedicated support for ICNARC data collection and submission to ensure the data submission is timely.
- The hospital should ensure that there is a written plan including timescales for the replacement of the lift and all staff are aware of the actions being taken to mitigate the risks prior to the completion of this work.
- The hospital should ensure that all staff have completed the appropriate level of safeguarding training.
- Implement a dementia policy and training to ensure patients living with dementia are identified and receive appropriate care.
- The pre-operative checklist including theatre handover sheet used by nurses prior to taking children to theatre should be completed and used in all cases.
- The hospital should ensure the needs of patients with learning disabilities are assessed and met.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

The provider did not have suitable arrangements to store and prescribe medications.

- Not all intravenous fluids were stored in locked cupboards to prevent unauthorised access.
- The cold chain was not maintained and fridges used to store vaccines are fit for administration.
- The process for amending medication prescriptions out of hours when the consultant was not present is in line with national professional guidance.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse

The provider did not have an up to date children's safeguarding policy in place that reflected national guidance.

Regulated activity

Regulation

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

The provider did not have an up to date 'do not attempt cardio pulmonary resuscitation' policy in place that reflected national guidance.