

King Edward VII's Hospital

Quality Report

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

Ratings

Overall rating for this location

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

King Edward VII's Hospital is an independent hospital located in central London, initially opened as a hospital for officers in the armed forces, it is now a hospital open for the whole public. The hospital registered as a charity in 1962 and has focussed most of its charitable efforts in providing subsidised private healthcare for veterans, serving personnel and their families.

The hospital employed 233 consultants under practising privileges and 67 qualified nursing staff. It has 55 beds including four level three critical care beds in their own department. The remaining beds were split over three wards with one ward being for day cases and the rest being mixed with surgery or medical patients. The hospital had two laminar flow theatres and one 4K integrated theatre for scope work. Other facilities included a therapies department with hydrotherapy pool, a radiology department with CT, MRI, ultrasound, general x-ray, fluoroscopy and mobile imaging and a breast care unit with separate consulting rooms, mammography and ultrasound. The hospital had a total of 11 consulting rooms in all areas for outpatient appointments.

The hospital provides surgery, medical care, critical care and outpatients and diagnostic imaging. We inspected all of those core services. We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on the 31st January 2017 to the 2nd February 2017.

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

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

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

Services we rate

We rated this hospital as requires improvement overall. Below is a summary of reasons broken down by core service.

We rated surgery as requires improvement because:

- We found that within recovery unit the medicines cabinet was regularly kept unlocked, the risk of 'poor medicines management, theft, fraud or harm especially in relation to management of controlled drugs' was on the departmental risk register.
- The difficult airways trolley in theatres was shared with the critical care unit (CCU) and we were informed that if the CCU required it, it would be taken down in the lift. When not in use, dust covers were placed on equipment.
- We had concerns that senior leaders did not have an adequate management strategy on incident investigations. We observed that there were 671 incidents not marked as complete with some awaiting investigation and some awaiting completion by senior staff.
- There was a lack of oversight of consultant's practising privileges, with 68 consultants not having the expected full standard of documentation in their files at the time of inspection.
- Four out of 11 records we reviewed contained an incorrectly completed VTE risk assessment.

However:

Summary of findings

- The environment was clean and fit for purpose and we observed staff complying with infection control and prevention guidelines.
- Staff were supported by managers, mentors and practice development nurses to deliver effective care and treatment, through meaningful and timely supervision and appraisal.
- Patients told us they felt supported and informed about their treatment. Patients and families we spoke with said staff explained their care and treatment to them and visited them regularly.
- There was a dementia champion that had arranged talks from dementia charities for the staff. A dementia integrated care pathway had also been created.
- Leadership was visible and supportive at all levels in the surgical services and staff told us they felt valued by the senior leadership team. They were able to contribute their views and felt new ideas were welcomed and listened to.

We rated medical care as requires improvement because:

- Most staff were aware of their responsibilities with regards to duty of candour, although some senior members of staff were not entirely clear that there had to be both a verbal and written apology.
- Advice regarding VTE prophylaxis as recommended by NICE was not always followed. However, the hospital had identified this in an audit in December 2016 and had taken some actions to address this issue by the time of inspection.
- Consultants did not always adhere to the “bare below the elbows” requirement for the prevention and control of infection. The hospital explained that a number of consultants visited patients to review them and would remove any inappropriate items prior to an actual examination taking place.
- Safeguarding training was provided by an external organisation and senior leaders said the company could not confirm in writing that training was to level 2 or 3.
- Entries in some patients' care records did not comply with professional standards for record keeping in that there were issues with legibility and the identification of staff entering information into the care record.
- Although numbers requiring end of life care were small, effective ceilings of care were not always established and patients were not always referred for palliative care early enough in the care pathway. Staff expressed the need for further training and supervision around how to support and care for dying patients. The hospital had identified this as an area for further staff training in a needs analysis for the next financial year.
- The requirements of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards were not always well understood and applied. DNACPR forms were not always filled out in enough detail.
- Discussions with patients and families were not evident in all of the notes that we examined, with often little detail of any difficult conversations.
- An audit of three records of patients living with dementia in December 2016 found that one did not have a full and proper assessment or application of care pathway, and two patients were not given any information or advice at assessment or admission. We found that the care plan was not fully explained or filled out in the two records of patients living with dementia that we looked at. There were no patient passports or ‘this is me’ care plans evident.
- There was no link nurse for patients with learning disabilities. There was no specific training or policy on caring for these patients.
- There was no clear, separate strategy in place to develop and improve end of life care services within the hospital.

Summary of findings

- The service did not participate in any national audits related to medical care or end of life care as the numbers of patients who would be eligible to be included was very small.
- The risk register was general with no specific risks for each ward environment or type of patient specified, and no clear mitigation in some cases.

However:

- Medicines were managed and stored appropriately. Staff told us the pharmacy services were easily available and pharmacists visited the wards daily.
- Nursing staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse. They knew how to escalate concerns.
- There were sufficient nursing and medical staff to ensure patient safety was maintained at all times.
- Hospital policies were current and referenced according to national guidelines and recommendations.
- Nursing and medical staff completed a variety of local audits to monitor compliance and improvement.
- Pain was assessed and well managed on the wards, with appropriate actions taken in response to pain triggers.
- In the Patient-Led Assessments of the Care Environment (PLACE) assessment in 2016, the hospital scored 97.3% overall for food and hydration, against a national average of 88.2%.
- Staff received annual appraisals on their performance, which identified further training needs and set achievable goals. Staff were satisfied with the quality of the appraisal process. The hospital was supporting nurses with the revalidation process.
- Patients were cared for in a caring and compassionate manner by staff throughout their stay.
- Patients were able to access care and treatment in a timely way. There were clear admission processes and no problems with flow or discharge throughout the hospital.
- The number of complaints in line with national average. When complaints were received they were used to identify learning and improve patient experience.
- Most nursing and medical staff thought that their line managers were supportive and approachable. They felt able to raise concerns.
- Feedback was sought from staff and the public to develop and improve the service.

We did not rate critical care overall as we found there to be insufficient evidence, however we did rate the well-led domain as requires improvement. We found the following areas of good practice;

- Staff were encouraged to report incidents and knew the process to follow if an incident occurred.
- Staff understood their roles and responsibilities with regards to safeguarding and could tell us how they would escalate any concerns.
- The environment was fit for purpose and we observed staff complying with infection control and prevention guidelines.
- Medications and controlled drugs were stored safely and appropriately.
- Mandatory training compliance was generally good.
- Policies and procedures were readily available to staff and referenced best practice guidance.

Summary of findings

- There was appropriate assessment of pain relief and nutrition for patients.
- There were minimal non-clinical transfers out of the CCU and only a few patients were discharged out of hours.
- ICNARC data demonstrated that patient outcomes including mortality and readmission rates, were as expected.
- There was appropriate seven day services provided by the ITU fellows and physiotherapists, as well as seven day access to investigations and scans.
- Staff treated patients with respect and we saw staff interacting in a friendly and professional way with patients.
- The unit provided compassionate care and patients were treated with dignity and respect.
- Friends and family test results were good with 99% of people saying they would recommend the service to others.
- The service provided a flexible number of level two and level three beds, which could be flexed according to patient need.
- There were no elective operations cancelled due to unavailability of CCU beds between January 2015 and January 2016.
- Whilst a number of services were not directly available within the hospital, such as psychology, the hospital could make referrals on an individual need basis.
- We saw good leadership within the unit and this was reflected in the conversations we had with staff. There was a positive culture across the service and staff spoke positively about the leadership team.
- There was evidence of staff and public engagement and changes being made as a result of feedback.

However;

- The vision was to increase the number of patients seen in critical care, however there was no formal strategy in place to say how this would be achieved.
- We had concerns, senior leaders did not have oversight on incident investigations. We saw no evidence that action plans had been developed and shared with staff.
- The risk register did not match the risks we found and identified within the service. The risk identified by the senior leaders as their biggest concern was not on the service's risk register.
- There was a general lack of audit and quality improvement work looking at adherence to national guidance and best practice.
- There was no dementia training and the dementia pathway had not been developed at the time of the inspection. Staff had a limited knowledge of how to treat dementia patients.
- Complaints were investigated at a more senior level within the hospital and critical care staff had no oversight of these.
- The provision of occupational therapists, dieticians and speech and language therapists was not sufficient to meet recommended standards.
- We had concerns that critical care nurses were not getting sufficient access to critical care patients to keep their skills up to date.
- Whilst staff demonstrated a good knowledge and understanding of the Mental Capacity Act we found no capacity assessments in any of the patient records that we reviewed.
- There was a lack of audit activity within the service.

Summary of findings

- We were not assured learning from incidents was disseminated amongst staff.
- The isolation room did not fulfil all requirements for an isolation facility.
- We were not assured there was appropriate consultant cover due to consultants working across two different hospitals at the same time.

We rated outpatients and diagnostic imaging as requires improvement because:

- The outpatient department did not maintain accurate, complete and contemporaneous patient records.
- Equipment list in diagnostic imaging was incomplete.
- Referral forms in diagnostic imaging were not accurate.
- Access to information was limited because the hospital did not keep any medical records of outpatients.
- There were no signatory lists that staff had read local rules and IRMER guidance.
- We did not see any special arrangements for patients with learning disabilities or living with dementia.

However,

- Staff were encouraged to report incidents and knew the process to follow if an incident occurred.
- Staff understood their roles and responsibilities with regards to safeguarding and could tell us how they would escalate any concerns.
- The environment was fit for purpose and we observed staff complying with infection control and prevention guidelines.
- Diagnostic imaging services were delivered in line with current evidence-based standards and legislation.
- Privacy and dignity of patients was consistently maintained and patient feedback results showed high satisfaction rates.
- Services were organised to provide same day diagnostics to patients whenever possible.
- The service actively sought patient feedback.

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

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Rating

Summary of each main service

Medical care

Requires improvement



The medical specialities were located in three wards mixed with surgery patients. The hospital also provided an endoscopy service from one of their theatres. We rated this service as requires improvement due to findings in safe and well-led, although it was good for effective, caring and responsive.

Surgery

Requires improvement



Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section.

Surgical patients were located across three wards mixed with medical patients. We rated this service as requires improvement in safe and well-led, although it was good for effective, caring and responsive.

Critical care

Not sufficient evidence to rate



Critical care service was mainly general critical care with more advanced patients being referred out. The hospital has a four-bed unit providing level three and level two care, with an outreach team providing assistance for critically ill patients across the hospital. There was insufficient evidence to rate the safe, effective, caring and responsive domains; however we rated well-led as requires improvement.

Outpatients and diagnostic imaging

Requires improvement



The outpatient department provided facilities for consultants with practising privileges to assess and examine patients and to provide clinical areas where minor procedures can be undertaken. The diagnostic imaging department provided general x-ray, CT, MRI, ultrasound, fluoroscopy and mobile imaging. The breast unit was recently opened which provided patients an all in one service with its own diagnostic services.

Summary of findings

We rated this service as requires improvement due to findings in safe and well- led although it was good for caring and responsive.

Summary of findings

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Requires improvement 

King Edward VII's Hospital

Services we looked at

Medical care; Surgery; Critical care; Outpatients and diagnostic imaging.

Summary of this inspection

Background to King Edward VII's Hospital

The King Edward VII's Hospital was opened in 1899 at the suggestion of the Prince of Wales, later King Edward VII. It was initially opened to treat the sick and wounded soldiers returning from the Boer War. In 1962 the hospital became a registered charity. Originally a hospital for officers it is now a private hospital for all service personal and the general public. It is located at Beaumont Street, Westminster, London. The hospital serves a demographic of privately insured, self-funding and charity funded patients. The majority of patients it serves are UK residents, however a small portion are from overseas.

The hospital provides 52 beds including 12 day case beds and four level three intensive care beds. The main

hospital is located in one building which houses all theatres, inpatient wards, outpatients and diagnostic facilities. The hospital also offers primary medical services such as GP appointments, this service was not inspected as part of this inspection.

The CQC has previously inspected this hospital on five occasions. The last occasion being a focussed inspection regarding their medicine management conducted in July 2014, the hospital met all standards in this inspection and there were no requirement notices. This current inspection will be the first that was carried out using the new methodologies with the aim to providing a rating.

Our inspection team

The team inspecting the service was led by CQC inspection manager, Michelle Gibney and included CQC inspectors, and specialist advisors with expertise in clinical governance, medicine, surgery, nursing care and critical care.

Why we carried out this inspection

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

Information about King Edward VII's Hospital

The hospital is registered for the following regulated activities;

- Diagnostic and screening procedures (12 January 2011).
- Surgical procedures (12 January 2011).
- Treatment of disease, disorder or injury (12 January 2011).

During the inspection, we visited all areas of the hospital including all inpatient wards, theatres, the critical care unit, all outpatient areas including the breast unit, the radiology department and therapies department.

We spoke with, 73 staff including: registered nurses, health care assistants, reception staff, medical staff, consultants with practice privileges, operating department practitioners, and senior managers. We spoke with 25 patients and relatives. We also received 76 'tell us about your care' comment cards which patients had completed prior to our inspection, these included

Summary of this inspection

eight cards completed by staff members. During our inspection, we reviewed 49 sets of patient records. We also conducted interviews with senior managers and focus groups with different staffing groups.

There were no special reviews or investigations of the hospital on going by the CQC at any time during the 12 months before this inspection. The hospital has been inspected five times, and the most recent inspection took place in July 2014, which found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (October 2015 to September 2016):

- In the reporting period October 2015 to September 2016, there were 4166 inpatient and day case episodes of care recorded at the hospital of these 0.5% were NHS funded and 99.5% were other funded.
- 5% of all NHS funded patients and 58% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 3,781 outpatient total attendances in the reporting period, all of which had a funding source other than the NHS.
- 233 consultants including surgeons, anaesthetists, physicians and radiologists worked at the hospital under practising privileges. The hospital had four full time equivalent (FTE) resident medical officers (RMO). 67 FTE registered nursing staff, 14 FTE operating department practitioners and health care assistants and nine other allied health professional staff. The accountable officer for controlled drugs (CDs) was the deputy matron.

Track record on safety:

- There were no never events.
- In the reporting period (October 2015 to September 2016) there were 181 clinical incidents. 91% incidents occurred in surgery or inpatients, 4% occurred in other services and 5% occurred in outpatient and diagnostic services
- Of the 181 incidents, 121 were categorised as no harm, 39 were categorised as low severity (minimal harm), 17 were categorised as moderate severity (short term harm) and 4 were categorised as a death.
- The hospital told us they reported any patient death as an incident; however, this did not correspond with the notifications made to the CQC. In the reporting period

(October 2015 to September 2016) the hospital notified the CQC of eight expected inpatient deaths and one serious incident, which was a venous thromboembolism as a consequence from surgery, resulting in death at another hospital.

- No incidents of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA).
- Two incidents of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA.)
- No incidences of hospital acquired Clostridium difficile (c.diff).
- No incidences of hospital acquired E-Coli.
- There were 14 complaints in the reporting period of which none have been referred to the Ombudsman or ISCAS (Independent Healthcare Sector Complaints Adjudication Service).

Services accredited by a national body:

- ISO 9001: 2008 – Quality Management System Standard accredited to the whole hospital.
- External accreditation to the ophthalmology network, MRI & CT Scanners and the cardiac CT network
- Investors in People – UK Commission for Employment and Skills
- Food Standards Agency Food Hygiene Rating ‘Very Good’ –highest achievement.

Service provided under a service level agreement:

- Ambulance transfer services
- Bariatric nursing services
- Biomedical services
- Blood transfusion services
- Continence services
- Courier services
- CSSD services
- Dietetic services
- Health and safety assurance
- Interpreting services
- Linen cleaning
- Pacemaker checks services
- Pathology services
- Podiatry services
- Radiation protection services
- Reflexologist services
- Security and alarm monitoring services
- Speech and language services
- Stoma services
- TPN and PCA production

Summary of this inspection

- Undertakers services
- Waste disposal

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

- The number of patient falls in the reporting period were high when compared to other similar services. However, the hospital explained that it routinely reported all types of fall, including near miss and low harm falls. The rates of falls where harm actually occurred was low. The hospital had a falls working group which reviewed all incidents to find any common themes. We saw evidence of appropriate root cause analysis (RCA) conducted for each fall.
- Consultants did not always adhere to the “bare below the elbows” requirement for the prevention and control of infection. The hospital explained that a number of consultants visited patients to review them and would remove any inappropriate items prior to an actual examination taking place.
- Advice regarding VTE prophylaxis as recommended by NICE was not always followed. The hospital had identified in an audit in December 2016 and had taken some actions to address this issue by the time of inspection.
- The outpatient department did not maintain complete patient records.
- The difficult airways trolley was shared between theatres and the critical care unit separated by a lift.

However

- There were sufficient staff to ensure patient safety was maintained at all times.
- Patients were assessed for a variety of risks on admission to the wards, using nationally recognised tools. Processes were in place to identify and control patient risks.
- The environment was clean and fit for purpose and we observed staff complying with infection control and prevention guidelines.

Requires improvement



Are services effective?

- Policies and procedures were readily available to staff and referenced best practice guidance.
- Pain was assessed and well managed on the wards, with appropriate actions taken in response to pain triggers.

Good



Summary of this inspection

- Staff received annual appraisals on their performance, which identified further training needs and set achievable goals. Staff were satisfied with the quality of the appraisal process. The hospital was supporting nurses with the revalidation process.
- Staff obtained and recorded consent in line with relevant guidance and legislation.

However;

- The requirements of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards were not always well understood and applied. DNACPR forms were not always filled out in enough detail.

Are services caring?

Good



- Patients and their relatives we spoke with were positive about the way staff treated and cared for them.
- We saw that patients were treated with dignity, respect and kindness.
- Patients told us they felt supported and informed about their treatment. Patients and families we spoke with said staff explained their care and treatment to them and visited them regularly.
- Patient privacy and dignity were well maintained.

Are services responsive?

Good



- Patients were able to access care and treatment in a timely way. There were clear admission processes and no problems with flow or discharge throughout the hospital.
- Within the menu there were many options to cater for those with different nutritional requirements.
- Translation services were readily available.
- Services were designed to be responsive to patient needs such as the organisation to provide same day diagnostics to patients whenever possible.

However;

- A dementia pathway had been established in the surgery core service this was not reflected in critical care or outpatients and diagnostics.
- Staff currently did not receive formal training in caring for people living with learning disabilities.

Summary of this inspection

Are services well-led?

- We had concerns that senior leaders did not have an adequate management strategy on incident investigation, learning and outcomes.
- We observed that there was a large number of incidents awaiting investigation or completion by senior staff.
- There was a lack of oversight of consultant's practising privileges.
- The local risk registers did not match the risks we found and identified within certain services.

However;

- There was a positive culture across the service and staff spoke positively about the leadership team.
- There was evidence of staff and public engagement and changes being made as a result of feedback.

Requires improvement








Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|------------------------------------|----------------------|-----------|-----------|------------|----------------------|----------------------|
| Medical care | Requires improvement | Good | Good | Good | Requires improvement | Requires improvement |
| Surgery | Requires improvement | Good | Good | Good | Requires improvement | Requires improvement |
| Critical care | Not rated | Not rated | Not rated | Not rated | Requires improvement | Not rated |
| Outpatients and diagnostic imaging | Requires improvement | N/A | Good | Good | Requires improvement | Requires improvement |
| Overall | Requires improvement | Good | Good | Good | Requires improvement | Requires improvement |

Medical care

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

Are medical care services safe?

Requires improvement 

Incidents

- There were no “never events” reported within the hospital in the 12 months prior to our inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Staff across the inpatient wards were aware of how to report and record safety incidents and near misses. All staff we spoke with were familiar with the electronic reporting system and how to navigate this. Staff that we spoke with said they were encouraged to report incidents. They were able to give examples of when they had used the system to report appropriate incidents.
- Between October 2015 and September 2016, the hospital reported 165 clinical incidents across surgery and inpatient settings. Of these, the hospital reported 1% of all incidents as ‘severe’ or ‘death’. The rate of clinical incidents in surgery and inpatients in this reporting period is lower than the rate of incidents in other comparable independent acute hospitals that the Care Quality Commission (CQC) hold this type of data for. The rate of non-clinical incidents was higher however, with 162 incidents of this type occurring in the same period.
- There were no serious incidents (SIs) reported across the medical service between October 2015 and September 2016. Senior staff told us that SIs were subject to a full root cause analysis (RCA) investigation and action plans were developed where areas for improvement had been identified. We saw evidence that 100% of appropriate senior staff had attended training on how to conduct an RCA, but there were no incidents from the last year in the service that met the threshold for investigation.
- Feedback and learning points from incidents were shared with staff across the service via team meetings. Minutes from the Non-Clinical Risk & Safety, Senior Clinical, and Patient Safety Group were provided to all departmental sisters and managers for feedback. Some nursing and pharmacy staff could provide examples of learning from local incidents. For example, a trend in prescription errors was recognised in relation to anticoagulants, so the drug charts were altered to make this less likely.
- We saw that 671 incidents had not been marked as complete on the hospital incident reporting system. Please see the core service report for surgery for further details.
- The hospital did not hold specific morbidity and mortality meetings, as a low number of deaths occurred within the hospital. Between October 2015 and September 2016, the hospital reported eight deaths to the CQC. Senior staff told us that any patient death would be discussed in the monthly patient safety group.
- Staff at all levels confirmed there was an expectation of openness when care and treatment did not go according to plan. Staff at all levels confirmed there was

Medical care

an expectation of openness when care and treatment did not go according to plan. Most staff were aware of their responsibilities with regards to duty of candour, although some senior members of staff were not entirely clear that there had to be both a verbal and written apology. However, we saw one example of a written apology to a patient following a fall, which met the requirements. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents' and provide reasonable support to that person. We saw posters displaying the key principles of the duty of candour regulations in the clinical areas that we visited.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The hospital was not required to use the NHS Safety Thermometer as they are an independent healthcare provider. This is a tool which measures harm to patients which may be associated with their care. However, the hospital monitored incidents of patient falls, pressure ulcers, catheter acquired urinary tract infections and venous thromboembolism (VTE). There were 'hot boards' on each ward that displayed the data relating to performance in these key safety areas. These boards indicated how many days had passed since the last incident of each of these types.
- Between July 2016 and September 2016, 97% of inpatients were risk assessed for VTE on admission, rising from 95% (April – June 2016). Between October 2015 and March 2016, no data was provided by the hospital. Between October 2015 and September 2016, there were two cases of VTE or pulmonary embolism (PE) reported. A VTE prophylaxis (preventative measure) audit conducted by the hospital in December 2016 found 59% overall compliance with measures, with 70% having recommended mechanical prophylaxis, such as anti-embolism stockings, implemented as per NICE guidance. In addition, 60% of patients had been prescribed recommended medication where appropriate, such as anticoagulants, as per NICE guidelines. The audit also found that 40% of assessments had been updated every third day, or as the condition changed. This audit showed a slight improvement from August 2016, when overall compliance was found to be 53%. The hospital had taken a proactive approach to these audit findings. The policy and risk assessment document relating to VTE was under review and awaiting approval by the medical committee. Changes had also been made to the drug chart in response to these findings
- Between October 2015 and September 2016, there were no reported cases of catheter-related UTIs during the course of hospital admission. The hospital audited ten cases of catheter care against a number of measures in October 2016, scoring 98% overall compliance. There was one case of incorrect fluid balance recording, where the amount of liquid consumed by a patient had not been recorded.
- Between October 2015 and September 2016 there were 28 reported falls, which was high when compared to other similar services. Of these six were near misses, five were no harm and 17 were low harm, the hospital provided evidence to show there had been learning from these incidents and mitigating actions put in place. We saw evidence of a thorough root cause analysis (RCA) conducted for each fall. Of these 28 reported falls, we were told that 50% belonged to surgery and the other remainder belonged to the medical core service.
- In the same period, 98.7% of patients were assessed for risk of falls on admission. The falls working group reviewed these incidents to find common themes. As a result, they developed an information book on how to prevent falls for high risk patients and the hospital invested in safe mats for patients with short term memory loss. These mats alert their allocated nurse (via a bleep) to let them know when the patient is getting up from their bed or chair so that they can attend and ensure they are safe.
- Between October 2015 and September 2016, the hospital reported no pressure ulcers of grade 3 or above acquired after admission to hospital. In the same period, 98% of inpatients were assessed for risk of pressure ulcers on admission. We confirmed that these risk assessments were mostly completed and regularly reviewed in the 12 patient records that we looked at. There was a pressure care working group to discuss training needs and changes in practice.

Cleanliness, infection control and hygiene

Medical care

- The hospital had an infection prevention and control (IPC) policy and all staff received mandatory training relating to this as part of their annual clinical update, which 100% of inpatient nurses had completed. Each ward had an IPC link nurse. Link nurses act as a link between the ward and the infection control team. Their role is to increase awareness of infection control issues and motivate staff to improve practice. There was also a lead IPC nurse for the hospital, who staff were aware of and knew how to contact if necessary.
- The wards and communal areas we visited were visibly clean and tidy. The wards' main entrance and corridors were clean and uncluttered. Personal protective equipment (PPE) was available for staff to use. All wards had antibacterial gel dispensers throughout the corridors and in patient rooms. Green 'I am clean' stickers were in use throughout the wards to inform colleagues at a glance that equipment or furniture had been cleaned and was ready for use.
- Across the hospital, fabric curtains were used in all rooms. We randomly inspected curtains in three rooms and all were clean and stain free. All heavy curtains on the wards were dry cleaned twice per year (during Easter and Christmas holidays), as well as after every isolation discharge.
- The Infection Prevention and Control team (IPCT) met every quarter and discussed any outbreaks of communicable diseases, compliance with processes such as water testing and relevant IPC audit results. An IPC audit conducted in July 2016 found 89% compliance with all measures across the hospital. This noted a number of areas for improvement, which we found had been actioned when we conducted the inspection.
- Staff on the wards we visited wore appropriate PPE such as gloves and aprons and utilised effective hand-washing techniques. However, not all staff adhered to the bare below elbow (BBE) dress code whilst on the wards, with three consultants observed wearing wristwatches. The hospital explained that a number of consultants visited patients to review them and would remove any inappropriate items prior to an actual examination taking place. Hand hygiene audit results for clinical staff varied between 95% (October 2016) and 99% (July and April 2016). For housekeeping and catering staff, results varied between 91% (April 2016) and 100% (October 2016).
- All of the inpatient rooms were single occupancy on the wards we visited and therefore additional isolation areas were not required. There was appropriate signage on these doors. Staff of all levels knew of measures they should take to reduce the risk of healthcare-associated infections.
- Between October 2015 and September 2016, the hospital did not report any cases of hospital-acquired MRSA. MRSA is a bacterium that can be present on the skin and can cause serious infection. In the same period, there were also no cases of E. Coli or Clostridium difficile infection (a bacterium that can infect the bowel and cause diarrhoea, most commonly affecting people who have been recently treated with antibiotics). There were two incidents of Meticillin Sensitive Staphylococcus Aureus (MSSA). MSSA is a type of bacterium that can live on the skin and develop into an infection, or even blood poisoning.
- In the Patient-Led Assessments of the Care Environment (PLACE) assessment in 2016, the hospital scored 100% for cleanliness, against a national average of 98.1% (based on 1,291 assessments across 287 organisations). The assessment of cleanliness covered all items commonly found in the healthcare premises including patient equipment, baths, toilets and showers, furniture, floors and other fixtures and fittings.
- We observed safe systems for managing waste and clinical specimens during the course of inspection. Staff used sharps appropriately; the containers were dated and signed when full to ensure timely disposal, not overfilled and temporarily closed when not in use. However, the waste disposal audit covering January 2016 – January 2017 (based on volume reports supplied by the waste disposal company) found some issues with domestic waste being disposed of in clinical waste stream and with sharps containers not being dated and signed. The hospital audited the use of sharps bins annually to ensure that any issues were addressed. In the 2016 audit, 62 sharps bins were seen across the hospital, with five being found not properly assembled and 29 not having the temporary closure in place when not in use. These issues were addressed with staff on the wards concerned. We found no issues with the disposal of sharps on inspection.

Environment and equipment

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- Throughout our visit, we found the wards to be clean and well-lit with appropriate equipment. In 2016, the hospital received a PLACE score of 99.7% for condition, appearance and maintenance, against a national average of 93.4%. This assessment included various aspects of the general environment, such as decoration, condition, tidiness, signage, lighting (including access to natural light), linen, access to car parking, waste management, and the external appearance of buildings and maintenance of grounds.
- Equipment used on medical wards was clean and labelled to indicate it was disinfected and ready to use. All portable equipment we checked had been recently serviced and labelled to indicate the next review date. Disposable equipment was easily available, in date and appropriately stored. In the sluice of each ward, bed pans were not labelled with 'I am clean' stickers. Nursing staff told us that they were cleaned but stickers were not placed on them for hygiene purposes.
- Resuscitation equipment was available on all the wards we visited and tamper seals were in place. Emergency drugs were available and within the use by date. Nursing staff carried out daily and weekly checks to demonstrate that equipment was safe and fit for use, with appropriate actions recorded to report any missing or expired items. When checks were missed, senior staff followed this up directly with the staff involved.
- The hospital used infusion pumps for delivering measured doses of pain medication, including at the end of life, as there were so few deaths on the wards. These conformed to national safety guidelines on the use of continuous subcutaneous infusions of analgesia (pain relief medication delivered via a needle or soft cannula under the skin). The infusion pumps had in-date annual maintenance checks and/or corrective maintenance in line with the manufacturer's recommendations. These had preloaded syringe cartridges to reduce the risk of administration errors. Guidelines for these were set by the pharmacy, with advice from consultants. Across the hospital, 94% of nursing staff were trained in the use of infusion pumps. The remaining 6% were due to be trained but had started work in the last six months.

- Arrangements were in place for the safe handling of endoscopes and the segregation, decontamination, and storage of endoscopes. Endoscopes were sent out to a neighbouring hospital for decontamination.

Medicines

- Nursing staff told us the pharmacy services were easily available and pharmacists visited the wards daily. Bank pharmacy staff were used on an ongoing basis, but the same people were used to minimise impact. A bank pharmacy technician worked one day a week (fixed term) and an additional bank pharmacist worked two days a week. This was in addition to four whole time equivalent (WTE) staff.
- Medicines were managed and stored appropriately on most of the wards. Staff kept medicines and intravenous (IV) fluids in locked cupboards or rooms with restricted access to ensure security. All drugs that we checked were within date, with stickers used to indicate those nearing expiry. The waste disposal audit covering January 2016 – January 2017 (based on volume reports supplied by the waste disposal company) found evidence of hazardous medicines being disposed of in yellow lidded sharps containers and orange clinical waste bags. We found that clear signage and instructions had been added to bins for the disposal of medication.
- Controlled Drugs (CDs) were stored in a locked cupboard, which the nurse in charge held keys for and were checked twice a day. The nurse in charge, along with a qualified nurse, checked drug stock daily and a spot check of the register confirmed levels were correct. The hospital was inspected by the Home Office in November 2016, and had received confirmation of the renewal of their Controlled License for Controlled Drugs. In an audit conducted in November 2016, there were some issues picked up in record keeping, but the audit noted that this was mainly in theatres.
- Medication fridge temperatures were monitored electronically, with the pharmacist and senior nurses receiving alerts if these were out of range. Records of the three months prior to inspection were provided and appropriate actions were taken when these were out of normal range. We saw that drugs in Ward 3 had been moved to Ward 2 when a low reading had been noted

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on 31 January 2017. The ambient room temperatures of each treatment room were also monitored centrally to ensure temperatures did not exceed recommendations for the safe storage of medicines.

- The pharmacy team aimed to carry out medicine reconciliation within 24 hours of admission across the wards. Medicine reconciliation is the process whereby the patients current medications are reviewed to ensure the most up-to-date prescriptions are used. In an audit of 10 records in May 2016, there was 65% compliance overall in relation to medicines reconciliation, with only 20% with GP details on the discharge summary. In addition, only 13% (not all cases were applicable) of discharge summaries had any explanation of any new medicines started whilst in hospital. The pharmacy had flagged that the discharge summary process needed review and circulated reminders to nursing staff and consultants.
- We looked at the prescription and medication records for 11 patients. All charts documented VTE assessments and the allergy status of patients. Appropriate arrangements were in place for recording the administration of medicines. Each chart had separate sections for different types of medications. Records were clear and fully completed in most cases. They showed people were usually given their medicines when they needed them and any reasons for not giving people their medicines were recorded. An audit of 10 records in May 2016 showed 94% compliance with prescription guidelines. However, in only 50% of records was the discontinuation of medicines clearly marked with line through and signed and dated. No late or missed doses were found on any of the charts.
- Incident reports were filled out in cases of medication administration errors. Between January and November 2016, there were 45 medication incidents, with the key themes being identified as administration errors (19), 'other' (14) and prescribing errors (8). Seven of the incidents, occurring between June and November, were related to patient's own CDs not being locked away or an incorrect amount of CDs after the daily count. The remainder of the errors were isolated and addressed with individual staff, who were asked to complete a reflection form after an investigation by their line manager. All incidents were discussed in the quarterly drugs and therapeutics committee, along with audit results and changes to policy. The pharmacy manager had delivered training at ward level to nursing staff where mistakes had occurred. Some of this took the format of an informal scenario test, where historic trends in mistakes of the prescription or administration were added to prescription charts and staff were asked to highlight them.
- An audit pharmacist interventions took place in October 2016, finding 62 errors over the course of two weeks. Out of 341 take home medication prescriptions, there were found to be 17 errors (5%). This accounted for 23% of all interventions recorded, and pharmacy reminded all prescribers of the requirements for writing prescriptions. Out of 1430 ward medication prescriptions, 14 (1%) contained errors, including the drug not being prescribed on the chart, missed doses and no administration signatures. This accounted for 27% of all interventions recorded, and staff were reminded to report these omissions as incidents. There were seven errors (0.05%) with the dispensing of 517 prescriptions in pharmacy, with half being related to a supply problem. Dispensing involves producing labels, selecting the correct medication from the pharmacy shelf and assembling the prescription medications in accordance to a prescription. A near-miss log had been introduced to reduce dispensing error occurrence.
- The hospital had an adult antimicrobial guideline for the use of antibiotics, which was due for review in March 2017. This was in line with national guidance. An antibiotic prescribing compliance audit of 10 records in September 2016 found 99% overall compliance with guidelines, with only one chart missing a start and stop date. This showed improvement from May 2016, where 50% (5) of all charts were missing this, with additional issues around prescribing antibiotics according to sensitivities (50% compliance), reviewing cultures when available (50%), contacting a microbiologist for prescription of restricted antibiotics (67%) and review when 2 or more antibiotics were prescribed (67%). This improvement followed a change in July 2016, where a new service-level agreement allowed doctors to contact a microbiologist for advice via a call centre.

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- Medicines were usually available to facilitate timely discharge of patients who were going home. An audit conducted covering 44 medications in March and April 2016 showed that the average turnaround time per prescription was 15 minutes and 27 seconds.

Records

- Data protection training was mandatory for all staff working at the hospital, and 100% of nursing staff had completed this within the last year. There was a quarterly information governance group to discuss any audit results or concerns.
- Hospital staff used paper based patient records to record patients' needs and care plans, medical decision-making and reviews, and risk assessments. Nursing records and medical records were kept together in a lockable cupboard by the nursing station.
- We looked at 12 sets of patients' records. Most notes were dated, signed and followed the hospital's note writing protocol, apart from some entries by medical staff, which were not signed and were illegible. This was also found during the DNV International Accreditation Standard for Hospitals inspection in May 2016. All records we looked at included details of allergies, a daily treatment care plan and risk assessments. However, discussions with the patient and family were not always well documented.
- The hospital conducted documentation audits to ensure staff complied with agreed standards. In a nursing documentation audit of 10 records carried out in September 2016, there was 87% overall compliance (falling from 95% in May 2016). Out of those audited, there were some minor record keeping issues such as illegible entries and missing details of next of kin or GP. Pressure care documentation scored 93% overall compliance, with two patients not being given written information and 11% of assessments not being filled out correctly. Manual handling assessments scored 94% overall compliance, with problems with comprehension identified and documented in only eight cases, and additional instructions not being clear in one case. Falls assessment scored 85% overall compliance, with one record not containing a total score or level of risk, or being updated daily or as condition changed. Only 63% of patients were given patient information. The action plan from this audit included training nursing staff in falls risk assessment. Training records showed that 100% of inpatient nurses had attended training on slips, trips and falls.
- In an audit of 30 records in October 2016, doctors' documentation was found to be 82% compliant with agreed record keeping standards (rising from 40% in July 2016). Issues in the most recent audit included: no referral letters in notes (32%), consultants not stating time (73%) or printing their name legibly (46%), not stating their job title (53%), resident medical officers (RMOs) not stating their name (36%) and the lead consultant not writing in the notes every full day of hospital stay (16%). The action plan stated that the hospital would write to individual consultants concerned to address any issues.
- Although the numbers of patients requiring end of life care was small, all end of life care plans were documented in the same manner as other interventions. This meant that there was no validated assessment tool for staff to utilise and document that care at the end of life was consistent.
- We reviewed four do not attempt coronary pulmonary resuscitation (DNACPR) forms during the inspection. The reason not to resuscitate was not filled out with an appropriate clinical reason in two of these forms. In all but one case, there was no detailed record of the discussion with the patient or family on either the DNACPR form itself, or the corresponding entry in the patient record. The hospital did not currently audit DNACPR forms.

Safeguarding

- Staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse. Staff had access to the up-to-date safeguarding policy on the intranet and flow charts for the escalation of concerns were available. Safeguarding was part of the hospital's mandatory training, with data indicating that 100% of staff were compliant with level 2 safeguarding children and adults training. Additionally, 12 senior staff were trained to level 3. However, safeguarding training was provided by an external organisation and senior leaders said the company could not confirm in writing that training was to level 2 or 3.

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- Both medical and nursing staff at all levels knew who to contact if they wanted further advice and told us that the matron supported them when they needed support or guidance. Between October 2015 and September 2016, the hospital did not report any safeguarding concerns to the CQC. The hospital was in the process of reinstating the safeguarding working group, but any issues were discussed at clinical governance meetings and senior clinical team meetings.
- All patients were assessed on admission using national risk assessment tools in nutrition, falls risks, manual handling needs and skin integrity. We saw evidence that initial assessments were completed within 24 hours of admission, with the aim to identify any factor which the patient may need support with and to identify a baseline condition. We observed from the records that consultants reviewed all patients within 12 hours of admission, which was in line with agreed national standards.

Mandatory training

- Staff received mandatory training on a rolling annual programme which was provided through a mix of classroom based sessions and e-learning. Topics included: medical gases, incidents, clinical update, pressure areas/nutrition, intravenous (IV) medication, personal safety and conflict, risk assessment, bullying & harassment, equality & diversity, stress management, diabetes, VTE and dementia. Mandatory training completion rates for staff varied between 90% (pressure areas/nutrition) and 100% (risk assessment), against a hospital target of 100%. All permanent resident medical officers (RMOs) were required to undertake mandatory training, which was monitored by the matron.
- There were reliable arrangements in place for supporting and managing new nurses, including a comprehensive induction and a supernumerary period during which senior staff assessed their clinical competencies. One newly qualified nurse told us that she felt very supported in the ward environment and able to ask for help if required.
- There was a sepsis protocol in place at the time of the inspection. However, the hospital had no sepsis lead and did not provide staff with any training in this area.
- Patients clinical observations such as pulse, oxygen levels, blood pressure and temperature were monitored in line with National Institute for Health and Care Excellence (NICE) guidance CG50 'Acutely ill-Patients in Hospital.' A scoring system based upon these observations known as a national early warning score (NEWS) system was used to identify patients whose condition was at risk of deteriorating. In a nursing documentation audit of 10 records carried out in September 2016, an initial assessment was not carried out within 20 minutes on three patients, seven did not have vital signs recorded frequently enough, and one had not been graphed. However, NEWS scores that were out of range had been actioned in 100% of cases. Training was underway in familiarising staff with the newly designed NEWS chart. The chart also included a sepsis pathway chart that staff could refer to each time they checked the patient observations. The pathway included a step-by-step guide of escalation in the event of patient sepsis.
- The hospital had an outreach team made up of staff from critical care, who were available 24 hours a day. The team visited deteriorating patients so that they could be observed closely, allowing for timely intervention if required. There was a daily resuscitation team meeting to agree team responsibilities and identify potential patients of concern. Nursing staff told us that the team were responsive to bleep calls when they were concerned a patient was deteriorating. All RMOs held an advanced life support qualification. Across the hospital, 98% of all nursing staff had completed basic life support training and 100% of those required (30) had completed intermediate life support training. Staff also completed scenario training in cardiac arrests.

Assessing and responding to patient risk

- We saw the hospital admissions policy, which had clear exclusion and inclusion criteria. Patients with a known terminal illness, severe psychiatric illness or women past 16 weeks of pregnancy were excluded. Patients who were grossly obese, with suspected acute heart conditions or with multiple traumas or head injury, required a risk assessment by the relevant consultant prior to admission. Access to the wards was via a consultant only.

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- Pathways were in place for the referral and transfer of patients to neighbouring NHS hospitals if this was required. There were eight unplanned transfers of patients to other hospitals between October 2015 and September 2016.
- Endoscopy currently took place in the main theatres. Staff there used the WHO safety checklist, which involves briefing, sign-in, timeout, sign-out and debriefing. The use of the WHO safety checklist ensures patient safety throughout the perioperative journey. The National Patient Safety Agency (NPSA) advocates it for all patients in England and Wales undergoing surgical procedures to reduce errors and adverse events, and increase teamwork and communication in surgery. The mandatory steps of the WHO checklist were fully embedded in practice in theatres. The hospital audited the use of the WHO surgical safety checklist every month. In October 2016, the service achieved 99% compliance against standard measures.
- Patients at the end of their life were not always being identified in a timely way. This meant that effective ceilings of care were not always established and patients were not always referred for palliative care early enough in the care pathway. Patients receiving palliative and end of life care were cared for on the wards, with advice and support from an on-call palliative care consultant. Data provided by the hospital demonstrated that three patients were referred to the palliative care consultant in the year preceding the inspection. In these three cases, involvement occurred a maximum of eleven days before the death of the patient. It was evident in the notes we examined on inspection that some clinical interventions were not always discontinued in a timely manner to allow for a peaceful death. For example, diagnostic tests and feeding by tube continued until the last few days of death in two cases.

Nursing staffing

- Planned staffing levels were appropriate for the acuity and dependency of patients. Most nursing staff were registered nurses, with lower numbers of healthcare assistants (HCAs). The hospital's staffing standard was one qualified nurse for every five patients. In addition, there was one HCA per shift, as well as the nurse in charge of the ward who did not take patients. Staffing skill mix was reviewed daily against patient numbers, patient level acuity and dependency across the hospital

at the bed management meeting. Where patient dependency required 1:1 care, this could be provided. Between July and September 2016, 3% to 4.7% of planned shifts were left unfilled. Nurses worked either day or night shift patterns, with only newly employed nurses working a mix of both.

- Use of bank and agency nurses in the hospital inpatient departments was lower than the average of other independent acute hospitals that CQC holds this type of data for (October 2015 to September 2016). In this period, bank and agency usage varied between 10% and 20.9% for registered nurses. Only three HCAs were employed by the hospital at the time of inspection, with each ward only having one HCA working at any one time. The small number of HCAs employed by the hospital meant that between 8.3% and 39.2% of HCAs working in the hospital were bank and agency in this period (even rising above this to 59.7% in one month). Senior staff told us that they tried to use the same bank and agency staff where possible, so that they were familiar with local protocols and procedures. We observed that agency staff were supported by a member of permanent nursing staff to ensure they felt comfortable and oriented, with one agency nurse confirming that she felt, "part of the team". All agency nurses were assessed prior to being able to administer medication.
- Between January and December 2016, nursing staff sickness rates varied 3% and 9% across all inpatient areas, with the highest figures on Ward 3. In the same period, staff turnover rates fluctuated between 0% and 7%, remaining at 2% since June. In December 2016, there was one whole time equivalent (WTE) vacant nursing post in Ward 2, 1.8 WTE vacancy in Ward 2 and two WTE vacancies on the night shift. Senior staff told us that nursing staff were flexible and would work in different wards and departments to meet demand. We observed this on inspection when staff from the day unit were redeployed to other areas when patient numbers were low. Each ward also had a supernumerary senior member of staff, to allow flexibility in case load in the case of last minute sickness. They also provided support, direction and leadership to junior members of staff and supervised the clinical care of patients.
- We attended two nursing handovers and observed they were well structured and comprehensive, with a

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thorough discussion of each patient. Staffing and patient levels were discussed, with additional needs such as accompaniment to diagnostic tests considered. Referrals to and input of other members of the multidisciplinary team were also discussed. The hospital had developed handover documentation for each member of staff to refer to, which focused on the necessary information needed to provide care for each patient.

Medical staffing

- Consultants worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. Consultants were invited to join the staff at the hospital following identification of suitability via the consultant selection & review committee (CSRC) with approval required at the medical committee, before the medical director sent a formal letter of invitation. Most consultants with practising privileges had their appraisals and revalidation undertaken by their respective NHS trusts. Consultant anaesthetists were each sponsored by a consultant and also operated under a practising privileges agreement.
- All patients were admitted under the care of a named consultant. Lead consultants were available on admission and usually reviewed their patients at least once a day during their hospital stay. The consultants communicated any changes or concerns with the resident medical officer (RMO). There was 24-hour on-call cover available for consultants in cardiology, general medicine, infection control, haematology and palliative care. RMOs and nursing staff told us they received a good level of support from the consultants. Consultants made themselves available when required, either on site or on the telephone.
- There were four RMOs within the hospital. The wards had arrangements for 24 hour, seven days a week, RMO cover. RMOs worked 24 hour shifts, with supervision in place to ensure that they were adequately rested and able to work. RMOs were appropriately experienced, with training in advanced life support. This meant they met the requirements of the Quality Standards for Acute Hospitals. There were comprehensive and structured handovers between the RMOs at shift changes to ensure continuity of patient care.

Emergency awareness and training

- The service had a contingency business plans in place in case of an emergency. Staff had awareness of what actions they would take in the event of a major incident, including a fire. Across the hospital, 100% of staff had completed fire safety awareness training as part of their annual clinical update. The last fire safety drill was held in January 2016.

Are medical care services effective?

Good 

Evidence-based care and treatment

- Hospital policies were current and referenced according to national guidelines and recommendations. These were accessible electronically for all staff that had access. All policies sampled were up to date. The medical committee (MC) and clinical governance committee (CGC) reviewed patient outcomes and policies and advised on effective care and treatments.
- There was a quarterly clinical audit group that discussed outcomes, improvement plans and actions around local audit outcomes. We saw examples of recent local audits that had been completed on the wards. These included cleanliness and documentation audits, as well as clinical topics such as catheter care. Results of these audits and any learning were shared with staff in team meetings and emails.
- The hospital did not routinely admit patients for end of life care but recognised that patients may deteriorate whilst an inpatient and require end of life care. An end of life care policy which referenced the five priorities of care (One Chance To Get It Right, 2014) was available to staff to guide them in caring for patients at the end of life. This included guidance for medical staff on prescribing anticipatory medication.

Pain relief

- The hospital used a variety of tools to assess pain, depending on the needs of the patient. The numeric rating scale (NRS) was most commonly used, with patients asked to score their pain from zero to 10 each

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time their vital signs were taken. In this scale, zero meant no pain and 10 was extreme pain. An adapted pain scoring tool was available for those who did not speak English, or had communication difficulties.

- We reviewed 12 patient records that showed that appropriate actions were taken in relation to pain triggers to make patients more comfortable. We saw examples in the records of pain control managed with PRN (pro re nata or administered as required) pain relief. Complementary therapies such as reflexology were also available to patients to help manage symptoms. Patients that we spoke with were generally satisfied that their pain was well controlled.
- Patients were encouraged to complete a patient satisfaction survey following their visit, which included their views of pain management. Between October and December 2016, 88% of the 197 patients surveyed believed that the nursing staff had done everything they could to control their pain. A further 11% believed they had done 'a fair amount', with only 2% expressing dissatisfaction in this measure.
- We saw some evidence in records that the service strived to meet the needs of those suffering from symptoms in the dying phase of life or because of their illness. In the last days and hours of life, we saw regular review of both PRN and regular medication in view of changing symptoms.
- The hospital ran two week-long residential multidisciplinary pain management courses for armed service personnel veterans with severe pain. The course was inclusive of input from pain specialist consultants, nurses and psychologists. Patients received regular consultations for at least a year following the residential course, with 17 patients in treatment in autumn 2016. The courses tried to deal with issues surrounding pain management, which was one of the biggest barriers for veterans when trying to find meaningful employment, the hospital found. The hospital was planning a third course as demand was high, with 150 applications for the second course.

Nutrition and hydration

- All patients were screened on admission to ensure they were not at risk of malnutrition. A tool based on the MUST (malnutrition universal screening tool) was used to identify the risk level of each patient and this was

documented in each set of notes we reviewed. Nursing staff were able to refer patients to dieticians or speech and language therapists (SALTs), who were employed by the hospital through a service-level agreement. We also saw dietary supplements prescribed by RMOs in the notes we reviewed.

- The service conducted quarterly records audits to ensure that required standards for the assessment and management of nutrition and hydration were being met. In September 2016, the service found 67% overall compliance with agreed standards in the 10 records audited (falling slightly from 68% in May). Issues were found with completeness of assessment in around a third of cases, with additional 50% not being referred to the chef if appropriate, and only 67% (four out of six) patients with an elevated assessment score (greater than 12) being referred to a dietician. In addition, some fluid balance charts were incorrectly filled out, with no running totals and only 29% of charts being calculated every 24 hours. This meant that only 14% of results were being communicated to a doctor. Similar issues relating to fluid balance documentation were found on the DNV International Accreditation Standard for Hospitals visit, in May 2016. The results of such audits were discussed in the quarterly nutritional working party. As a result, further in house training was planned for staff and fluid balance forms were redeveloped to be simpler to use. Patients we spoke to all reported being adequately hydrated throughout their hospital stay.
- Protected mealtimes were in force, to ensure patients felt comfortable and safe to be able to eat their meals without any interruptions.
- In the Patient-Led Assessments of the Care Environment (PLACE) assessment in 2016, the hospital scored 97.3% overall for food and hydration, against a national average of 88.2% (based on 1,291 assessments across 287 organisations). Food and Hydration includes a range of organisational questions relating to the catering service, for example, the choice of food, 24-hour availability, meal times and access to menus. An assessment of food services at ward level and the taste and temperature of food was also completed.

Patient outcomes

Medical care

- The service did not participate in any national audits related to medical care or end of life care as the numbers of patients who would be eligible to be included was very small.
- Between October 2015 and September 2016, there were 24 unplanned readmissions within 28 days of discharge. These readmissions were due to various reasons, from pain and nausea to chest infections, medical assessments and patients being generally unwell.

Competent staff

- The hospital reported that 100% of nursing staff and health care assistants had had an annual appraisal in the current year and staff we talked with confirmed this. Staff reported they were generally happy with the appraisal system and process, which allowed them to identify their continuing professional development (CPD) needs.
- A programme of 'lunch and learn' sessions were held bi-monthly for heads of department and supervisors. These sessions were held over lunch and designed as peer learning and sharing in topics such as employment law, HR policies and best practice within the hospital.
- The nurse in charge of each shift checked the skill mix and competencies of their team before allocating work at handover. We observed this at the two handovers we attended. Agency nurses worked under the supervision of unit staff and received an orientation on their first shift.
- Nursing revalidation is the new process by which registered nurses are required to demonstrate on a regular basis that they are up to date and fit to practice. The hospital had helped nursing staff through this process by offering workshops, guidance and support. The monitoring of nursing staff registration had been identified as an issue during DNV International Accreditation Standard for Hospitals, in May 2016. The management of the process had passed back to the matron's office as a result and the database was updated.
- All consultants with practising privileges at the hospital had their GMC registration checked on an annual basis as part of the clinical governance process. Consultants were appraised through their NHS Trust and had to provide a copy of this to the hospital each year. An

external organisation carried out the appraisals of those without other significant practice. Doctors also usually revalidate with the organisation where they carry out the majority of their clinical work. If a doctor needed to revalidate with the hospital, this was the responsibility of the revalidation officer (who was also the medical director). The hospital reported 100% completion rate of validation of professional registration for doctors working under practising privileges between October 2015 and September 2016. However, during the course of inspection, we found some issues with this. Please see the surgery core service report for further details.

- An additional study day was available to staff in the management of diabetic patients. This covered topics such as blood glucose monitoring, dietary advice, patient education and how medication helped those with the condition. At the time of inspection, 86% of inpatient nursing staff had attended this training.
- There was no specific training available in caring for patients at the end of life at the time of inspection. However, nursing staff were able to discuss how to care for a patient in their dying phase in terms of physical health and family support, for example. Senior staff told us that they followed guidelines from a neighbouring NHS trust and took advice from the palliative care consultant on an individual basis. Some staff expressed the need for further specialist training and support around end of life care. The hospital were aware of this and it had been flagged in the training needs analysis for the next financial year.

Multidisciplinary working

- Relevant professionals were involved in the assessment, planning and delivery of patient care. The care records that we examined confirmed involvement from health professionals such as physiotherapists and dieticians, where necessary. Dieticians would attend to assess a patient within 24 hours of referral. We saw examples of referral letters from GPs and responses from the hospital, including previous discharge summaries.
- For general medical patients, informal MDT meetings would take place when there was a complex discharge. In this case, professionals involved in the care of the patient would meet up to discuss discharge and ensure the necessary arrangements were in place.

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- Doctors and nurses were complimentary about the support they received from one another and the wider team. One nurse described the RMOs as “excellent”, with pharmacists being praised as “fantastic” by another nurse.
- There was a SLA in place to transfer deceased patients from the hospital to a designated local undertaker. Staff confirmed that there were no issues with these transfers.

Seven-day services

- All patients were admitted under the care of a named consultant who provided consultant level cover in case of absence. Consultants were supported by RMOs 24 hours a day, seven days a week. A consultant-led ward round took place every day.
- Pharmacy services were available 8.30am – 6.30pm on weekdays. An on-call pharmacist was available out-of-hours only in an emergency but the duty nurse and RMO could obtain access to the inpatient pharmacy store using a dual access procedure. An escalation procedure was available if the medication was not available in the hospital pharmacy. Medical and nursing staff were happy with these arrangements, but some expressed the need for a partial weekend service at times.
- There was access to diagnostic imaging and tests, 24 hours a day, seven days a week. There was an on-call radiographer providing general diagnostic imaging support, as well as an on-call neuro-radiologist.
- The physiotherapy service was available seven days a week. Both speech and language therapist (SALTs) and dieticians were available on call.

Access to information (medical care only)

- There were sufficient computers available on all of the wards we visited, which gave staff access to hospital information, protocols and policies.
- Medical and nursing staff felt they had easy access to the relevant information in order to provide effective care and treat patients in an individualised and timely manner. This included diagnostic results such as blood tests and imaging. Staff accessed results of diagnostic investigations via digital services. If required, hard copies could be printed off and added to the patients’

medical records. The medical records department was located within the main hospital, with paper records being scanned electronically after the patient had been discharged.

- Do not attempt coronary pulmonary resuscitation (DNACPR) forms were located at the front of the paper patient records for easy access.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There were systems in place to obtain consent from patients before carrying out a procedure or providing treatment, which we saw evidence of in patients’ notes. We observed staff gaining consent from patients before giving routine care and treatment, such as washing. All of the notes we looked at included fully completed and signed consent forms where appropriate. The hospital had an up-to-date consent to treatment policy, which staff followed.
- Not all staff were able to give clear explanations of their roles and responsibilities under the Mental Capacity Act 2005 (MCA) regarding mental capacity assessments and Deprivation of Liberty Safeguards (DoLS). Some staff seemed unclear regarding the threshold of referring a patient for a capacity assessment. There were no registered DoLS cases in the hospital in the 12 months prior to inspection, but in notes we saw two examples of patients questioned as lacking capacity where no formal assessment of capacity was undertaken. There was no rationale for the decision not to undertake an assessment and no further indication that this had been considered. Across the hospital, 74% of staff had completed training specifically related to the MCA, and 100% had covered this topic in their annual clinical update.
- We looked at four DNACPR forms whilst at the hospital. There was a section relating to mental capacity on each DNACPR form, which was filled out by the doctor completing it in all four forms we looked at.

Are medical care services caring?

Good 

Compassionate care

Medical care

- The five patients we spoke with all provided positive feedback about the treatment and care they received from the hospital staff. They were treated as individuals and spoken to with respect by staff at all levels. Patients felt listened to and that nursing staff were “patient” and “very helpful”, working as a team to provide compassionate care. Patients told us that nursing staff made sure they were comfortable and their needs were met. One patient told us that they thought it was “the finest hospital in the world”. We observed that call bells were usually answered promptly, in line with the feedback we received from patients.
- In the Patient-Led Assessments of the Care Environment (PLACE) assessment in 2016, the hospital scored 74.3% overall for privacy, dignity and wellbeing, against a national average of 84.2% (based on 1,291 assessments across 287 organisations). The assessment of privacy, dignity and wellbeing included infrastructural/organisational aspects such as provision of outdoor/recreation areas, changing and waiting facilities, access to television, radio, computers and telephones. It also included the practicality of male and female services such as sleeping and bathroom/ toilet facilities, bedside curtains sufficient in size to create a private space around beds and ensuring patients were appropriately dressed to protect their dignity. The hospital scored below the national average in this measure due to the historical design of the building, which was not purpose built.
- Whilst on inspection, we found no issues with the privacy and dignity of patients. The ward environment ensured privacy as there were only single occupancy rooms. Staff consistently treated patients with dignity and respect. Nurses and doctors introduced themselves to patients and sought permission to enter their rooms. As per policy, staff checked how patients preferred to be addressed and documented this in their notes. Between October and December 2016, 96% of 229 patients surveyed felt they were always treated with dignity and respect.
- Patients were asked to complete a questionnaire on discharge about their experience, either via paper form or ward based tablet. The hospital used the Friends and Family Test (FFT) question to assess patients’ overall experience. Between April and September 2016, the hospital’s FFT score ranged between 95% and 100%,

which was in line with the England average (apart from April, where it was higher). The hospital's response rates were below the England average of NHS patients across the same period, ranging between 19% and 29%.

- Out of the 76 "tell us about your care" comment cards we received, 74 of them were very positive about care that patients received at the hospital.

Understanding and involvement of patients and those close to them

- Patients told us they felt involved in planning their care, and in making choices and informed decisions about their future treatment. They felt that doctors explained things in a language they could understand and gave them sufficient information about different treatment options. All patients felt able to ask questions of those caring for them and felt listened to by their doctors and nurses. Between October and December 2016, 91% of 229 patients surveyed felt they were definitely involved as much as they wanted to be in decisions about their care and treatment.
- We observed staff involving patients and those close to them during assessments on the ward giving them time to ask questions or clarify comments. Staff told us that they would give patients verbal information, supplemented with written information. Written information leaflets were available for patients about a range of treatments and procedures. Patients were provided with contact information for the appropriate hospital department to contact if worried, printed on the discharge envelope. Between October and December 2016, 90% of 229 patients surveyed felt they were completely confident in who to contact if they were worried about their condition or treatment after they left hospital.
- However, discussions with patients and families were not evident in all of the notes that we examined, with often little detail of any difficult conversations. We saw little documentation to reflect these observed interactions, particularly by doctors.
- The hospital provided information and support with the payment of fees through the admissions office, which patients could contact during office hours. There was written information available on how to pay for treatment.

Medical care

Emotional support

- The matron visited the wards daily and spoke to patients and relatives on the unit to assess if they had any concerns with their stay.
- Patients had access to psychological support and counselling services, provided through a service-level agreement with the hospital. Psychological support was discussed routinely in handovers.
- Most patients we spoke with were very positive about the support they received from members of the MDT. Staff had a good understanding of the emotional issues patients could face and described how they might give extra support to the most vulnerable patients, such as those with no family.
- Staff were aware of the procedures to follow in the event of a bereavement of a patient. A leaflet entitled 'coping with dying' was available across the hospital. Staff told us they would provide support to friends and family following the death of a patient, offering advice and signposting them to external agencies and services as appropriate.
- Patients had access to multi-faith spiritual support. Staff could contact local spiritual leaders from Jewish, Muslim, Catholic and Church of England backgrounds.
- The hospital had a number of volunteers that made patient's feel comfortable and talk to them to help prevent loneliness and isolation while in hospital.
- The hospital had a pet policy to allow patients to see their pets if they are hospitalised for a long time.
- The hospital provided birthday cards and homemade birthday cake to any patients that have their birthday in the hospital.
- The hospital had a dedicated Christmas party every year for any patients and relatives that were using the hospital at that time.

Are medical care services responsive?

Good 

Service planning and delivery to meet the needs of local people

- New services were developed in line with the hospital's business plan, incorporating comments from patients and consultations with consultants. Consultation had taken place on plans to expand the hospital and redevelop the building across the road from the main entrance.
- The hospital did not have accommodation on site for relatives. However, staff told us that relatives were able to stay overnight to spend time with their loved ones at the end of life, or if very unwell. There was a daily guest menu available for visitors at an additional cost.

Access and flow

- There were 4,166 inpatient and day case episodes of care recorded at the hospital in the reporting period (October 2015 to September 2016). Of these, 0.5% were NHS funded and 99.5% were funded privately or by other means. A further 5% of all NHS funded patients and 58% of all other funded patients stayed overnight at the hospital during the same reporting period.
- Between October 2015 and September 2016, the hospital reported eight deaths to the CQC. The hospital did not currently audit the number of patients dying in their preferred location.
- There were daily bed management meetings attended by senior staff to plan patient admissions, transfers and discharges. We attended one of these meetings and found it to be structured and comprehensive, with staffing levels and activities planned to suit the needs of patients.
- There were no 'wait times' for treatments or services at the hospital, as such. Instead, we were told that the booking system was based on elective bookings and patient choice. Patients were usually offered treatment within two weeks of wanting or needing treatment, and spoke positively about the ease of access to services. Diagnostic waiting times were not currently audited by the hospital, but staff reported no issues with accessing these, even at weekends.
- Staff across the hospital told us they could usually discharge patients promptly due to the nature of the client group, who did not usually require complex discharge arrangements. Discharge was discussed routinely at handovers. The medical lead nurse helped to coordinate any discharges that needed planning.

Medical care

Between October and December 2016, 91% of 229 patients surveyed felt that the discharge process was 'very organised'. A discharge planning audit conducted on 10 records in October 2016 found 93% overall compliance (falling slightly from 94% in July). Some issues were found around sending a GP summary within 24 hours and offering a copy to the patient (44% of eligible cases) and completing the notes to indicate discharge (80%), with a completed discharge checklist (80%). However, we found that these were complete in the records that we looked at.

- There were no discharges out-of-hours, unless requested by the patient.
- A total of 43 endoscopy procedures were undertaken in hospital theatres between October 2015 and September 2016. Patients requiring endoscopy only were admitted to the day case unit. When inpatients required endoscopy, they were collected from the ward by the lead endoscopy nurse and a porter and taken up to theatres. Once recovered, they were brought back down to the ward and discharged home from there.

Meeting people's individual needs

- The hospital had a patients' charter, which set out the patient's rights and the standards of service they could expect to receive. The hospital pledged to respect privacy, dignity and religious and cultural beliefs at all times and in all areas. For example, if a patient wished to be cared for by staff of the same gender, the hospital was able to accommodate their wishes.
- The hospital did not admit a great number of patients from overseas, but staff told us that interpreters were readily available when required. Staff were aware of how to access an interpreter and told us that a number of staff could also speak second languages. However, patient information leaflets were not standardly available in languages other than English. The hospital planned to obtain Arabic/Pictorial communication sheets.
- The hospital had access to multifaith chaplains, through an on-call system with spiritual leads in the local community. Staff told us that they could always get hold of someone when needed.
- Patients gave positive feedback about the range and choice of food available. Within the menu there were

many options to cater for those with different nutritional requirements. Different menu items catered for those with food allergies and provided halal, kosher, vegetarian and vegan options. The chef would visit patients with special dietary needs to discuss the menu if needed, which one patient told us had happened during their stay.

- In the Patient-Led Assessments of the Care Environment (PLACE) assessment in 2016, the hospital scored 87.8% overall for caring for those with a disability, against a national average of 78.8% (based on 1,291 assessments across 287 organisations). The disability assessment focussed on issues of access including wheelchair, mobility (e.g. handrails), signage and provision of such things as visual/ audible appointment alert systems, hearing loops, and aspects relating to food and food service. The items included in the assessment focussed mainly on buildings/environment related aspects. We found environments to be suited to those in wheelchairs or with mobility issues. There were notices on patient rooms to alert staff to those with hearing difficulties or poor vision. A bariatric nurse practitioner was available. The hospital also supplied bariatric commodes.
- In the same PLACE assessment in 2016, the hospital scored 93.5% in the dementia assessment, against a national average of 75.3% (1,047 qualifying sites nationally). The dementia assessment focussed on flooring, décor and signage, but also includes such things as availability of handrails and appropriate seating and, to a lesser extent, food. We found that the premises were suitable overall for those patients living with dementia. Clocks were available to place in patient rooms to keep people living with dementia oriented. The newly employed medical lead was a dementia champion and had reviewed the dementia policy and integrated care pathway (ICP) in line with National Institute for Health and Care Excellence (NICE) guidance. Nursing staff currently did not receive training in caring for people living with dementia, but a one day Dementia training course was provided by the Alzheimer's society to 32 staff from various departments within the hospital. This training was undertaken by the medical lead nurse, who planned to share this training with staff in shorter sessions at ward level. An audit of three records in December 2016 found that one did not have a full and proper assessment or application of care pathway and

Medical care

two patients were not given any information or advice at assessment or admission. We found that the care plan was not fully explained or filled out in the two records of patients living with dementia that we looked at. There were no patient passports or 'this is me' care plans evident.

- There was no link nurse for patients with disabilities. There was no specific training or policy on caring for these patients. The service told us that provisions were decided upon and organised on a patient individual basis.

Learning from complaints and concerns

- Information on how to make a complaint was available in the service information book, which was available in each patient's room. Patients were advised to make any complaints to the nurse in charge, who escalated these to the matron as appropriate. Nursing staff told us that the service would aim to resolve the complaint informally immediately.
- Formal complaints were by handled by the matron and the chief executive. There was an up-to-date complaints policy available on the intranet. The hospital aimed to acknowledge all formal complaints within 48 hours. A target of 20 working days was set for a full response.
- The hospital as a whole received 14 complaints between October 2015 and September 2016. Of these, 11 were from inpatients. All complainants were sent responses by the hospital within the 20-day target. Complaints varied from dissatisfaction with fees or standards of nursing care to challenges of existing policy. The assessed rate of complaints (per 100 inpatient and day case attendances) is similar to the rate of other independent acute hospitals that the CQC hold this type of data for.
- Learning and action points from any complaints were discussed in one-to-one meetings with individuals involved or through wider discussion at working party meetings or appropriate committees. Heads of department were asked to bring learning from complaints back to their team for discussion and implementation. All complaints were reviewed at quarterly clinical governance meetings and senior management team meetings. Staff showed us boards on the wards which displayed some actions taken in response to patient comments and complaints. Belts on

nursing uniforms had been replaced to make nurses appear more presentable, as well as blankets in the rooms being changed as they were too thin. Heating had been checked by estates, and sleep masks and ear plugs had been provided to patients.

Are medical care services well-led?

Requires improvement 

Leadership and culture of service

- There was a clear senior management structure within the hospital. The hospital employed a medical lead nurse in October 2016, who oversaw all of the medical patients in the two inpatient wards and day case ward. He also took the lead on complex discharges and dementia and were introducing new initiatives in these areas. He reported to the clinical operations manager (COM), who reported to the matron. The chief executive officer (CEO) managed the running of the hospital overall.
- During our inspection, we noticed senior staff were visible on the wards and knew ward staff across the service. Staff of all levels, from catering staff to consultants, confirmed that their line managers were approachable and easy to talk to. Matron was also known to get involved with aspects of clinical care when appropriate. All staff sat together at lunch in the communal canteen, as meals were provided by the hospital.
- We observed good team working amongst staff of all levels. The medical team worked well together, with consultants being available for RMOs to discuss patients and to give advice. Staff told us that they were proud to work at the hospital and liked the matron-led style of management. New staff felt part of the team and welcome to make suggestions for change.
- We observed information leaflets on the unit encouraging staff to speak up (whistle blow) if they saw something was being done wrong. There was an up-to-date whistleblowing policy, which outlined how to escalate any concerns.

Vision and strategy for this this core service

Medical care

- The medical service had employed a lead nurse in October 2016. The eventual aim was to develop a medical unit within ward three. The medical lead nurse planned to build relationships with consultants to encourage further medical admissions gradually. They had taken a proactive approach in their role thus far and were aware of the planned vision for the growth of the medical service.
- The hospital's vision was 'to be recognised as a highly regarded private hospital, with a charitable conscience, delivering clinical excellence within a culture of kindness'. Staff aimed to deliver these by adopting a set of values, which were to be professional, provide excellent quality care, respect one another's views, to ensure safety is a number one priority and to work as an effective team ('PQRST'). All of the staff we spoke with were aware of these and described how their views had been collected prior to the vision and values being decided upon. Senior staff told us that this was important as everyone across the hospital needed to buy into it.
- The hospital was planning to expand and develop a building across the road from the main hospital to provide more space for existing services. An additional 28 consulting suites and a new diagnostic imaging centre were planned in the new building. In the main hospital, there were plans to increase the number of theatres, as well as the size of one of the existing ones. Work was planned to commence soon, with the whole development programme taking about two years. The hospital also planned to reopen the endoscopy suite once renovations had been completed. A lead nurse was in post to oversee this development.
- Although small numbers of patients were admitted at the end of life, there was no clear separate strategy in place to develop and improve end of life care services within the hospital.

Governance, risk management and quality measurement (medical care level only)

- Clinical governance meetings were held on a quarterly basis. The clinical governance committee (CGC) discussed incidents, complaints and patient outcomes. There was also a risk and quality governance committee, in which the senior management team (SMT) reviewed the hospital's risk register and quality

performance key performance indicators (KPIs). The patient safety group reviewed all patient safety incidents and delegated actions. These meetings reported back to the medical committee that met quarterly, comprised of the medical director, the chair of the CGC and the chair of the audit committee. The medical committee oversaw clinical governance issues, key policies and guidance and monitored patient outcomes.

- Learning from these meetings was shared by providing verbal progress reports and minutes of meetings to heads of department and other committees. We saw minutes from a meeting on Ward 2, which discussed incidents and complaints with the wider group of staff.
- The hospital had an audit calendar, which was used to monitor services and compliance against national and local standards, where possible. Nursing staff participated in local audits relating to documentation, medicines management and various other factors relating to patient care. There was an audit committee that met quarterly to oversee both external and internal audits. However, the hospital did not take part in any national audits taking place specifically relating to medical or end of life care due to the small number of patients in the service.
- There were no separate risk registers for each ward. Instead, the hospital risk register contained risks relating to all inpatient wards, such as risk of injury from manual handling, to the care of bariatric patients. These risks were very general and although the level of risk was recorded in most cases, the mitigating actions were often vague. Of the 140 risks, there were 51 with no date, time or responsible person included. Issues with the risk registers were also found in the DNV International Accreditation Standard for Hospitals visit, in May 2016. They recommended one central system for coordinating and prioritising risk, which had been implemented. The hospital provided staff with clear guidance of the complete risk assessment process and to train managers to write risk assessments, although this had not yet remedied the situation completely.
- There was a lack of oversight of consultant's practising privileges, with 68 consultants not having the expected full standard of documentation in their files at the time of inspection. Please see the surgery core service report for full details.

Medical care

- Refer to the surgery section of the report for incident management, governance and practicing privileges management.

Public and staff engagement






- The service collected feedback from staff via annual surveys. The last one of these in November 2016, surveyed 123 (52% of) employees and found that 72% of staff surveyed felt positively about working for the hospital. The report included comparisons with external benchmarks (from 70 organisations) and found that this was in line with the average from other organisations. 73% of employees surveyed rated management positively, compared to the external benchmark of 58%. However, 62% of employees surveyed stated that they believe the hospital is committed to equal opportunities for all staff, against a benchmark of 77%. 34% of staff surveyed rated the hospital as providing them with good career prospects, against an external benchmark of 48%. The improvement of equal opportunities for all staff was identified as the single most important factor to improve.
- Staff were invited to attend regular unit meetings and working groups to contribute their ideas for improvement and development of processes and procedures within the hospital. A suggestions box was available in the canteen, as well as open forums with the CEO. Feedback from consultants was gathered by way of the medical committee and the annual general meeting (AGM).

- Patients were provided with a patient survey on discharge from the wards to gather their feedback. Survey results were collected and considered by the service to improve patient experience across the hospital. As a result of patient suggestions, additional TV channels had been added, and the room cooling systems were being reviewed. The hospital had found it difficult to set up a patient forum due to the wide geographical patient base, with no specific catchment area.

Innovation, improvement and sustainability

- Plans were underway to increase appeal to the younger market and to explore the international market, in order to grow and sustain the business. Meetings were underway to discuss the patient journey using modern techniques, in order to attract the next generation of patients.
- The hospital planned to reopen the endoscopy suite in the near future. A lead nurse had been recruited and was in post to ensure that the hospital met the minimum standards for JAG accreditation when the unit was opened. The JAG Accreditation Scheme is a patient centred and workforce focused scheme based on the principle of independent assessment against recognised standards. The scheme was developed for all endoscopy services and providers across the UK in the NHS and independent sector.

Surgery

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

Are surgery services safe?

Requires improvement 

Incidents

- There were no “never events” reported within the surgical service in the 12 months prior to our inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- All staff were aware of the hospital expectation to speak up when things went wrong. Staff of all levels were aware of the principles behind the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of ‘certain notifiable safety incidents’ and provide reasonable support to that person. Most staff we spoke with were aware of their responsibilities with regards to duty of candour, although some were not entirely clear that there had to be both a verbal and written apology.
- Senior ward staff informed us of a patient needle-stick injury that went through the duty of candour process. The staff explained the process of informing the patient and how practice changed to ensure it would not happen again.
- We observed three duty of candour letters that were sent to patients. The letters contained an apology and a

clear explanation of the incident that took place. The consultant or surgeon that was involved provided input and the patient was provided with the opportunity to respond.

- We found reliable systems and processes in place to keep people safe and free from harm. Staff across the wards and theatres were aware of how to report incidents and could explain the instances in which an incident needed to be reported. The hospital used an electronic system and staff were aware of how to log incidents on this. Senior staff understood the investigation process and how to support staff who had been involved in incidents. Between October 2015 and September 2016, the hospital reported 165 clinical incidents across surgery and inpatient settings. Of these, the hospital reported 1% of all incidents as ‘severe’ or ‘death’. The rate of clinical incidents in surgery and inpatients in this reporting period is lower than the rate of incidents in other comparable independent acute hospitals that the Care Quality Commission (CQC) hold this type of data for.
- In the same reporting period, there had been no serious incidents. A serious incident requires investigation and can be identified as an incident where one or more patients, staff members, visitors or member of the public experience serious or permanent harm, alleged abuse or a service provision is threatened.
- Staff on the surgical wards told us they received feedback and learning from incidents through learning grids, via email and at nursing handovers. Theatre staff informed us that there was an incident involving anaesthetists using the same ampule of medication for more than one patient. This incident had been communicated as bad practice to staff and there were posters across the service warning against this.

Surgery

- As a low number of patient deaths occurred within the hospital, morbidity and mortality meetings (M&Ms) were not held. Between October 2015 and September 2016, the hospital reported eight deaths to the CQC. Senior staff informed us that these cases were discussed and learning was disseminated to all staff via handover and emails. Staff on the wards informed us that learning from deaths was an important part of their role. Senior staff told us that any patient death was discussed in the monthly patient safety group.
- There was a backlog of 671 incidents awaiting investigation by senior staff. Please see the well-led domain of this report.
- In the same period, 98.7% of patients were assessed for risk of falls on admission. The falls working group reviewed these incidents to find common themes. As a result, they developed an information book on how to prevent falls for high risk patients and the hospital invested in safe mats for patients with short term memory loss. These mats alert their allocated nurse (via a bleep) to let them know when the patient is getting up from their bed or chair so that they can attend and ensure they are safe.
- There were six pressure ulcers reported in the same period, of which two were grade two and four were grade one. In the same period, 98% of inpatients were assessed for risk of pressure ulcers on admission, with 98.7% assessed for falls. In the same period, 98% of inpatients were assessed for risk of pressure ulcers on admission, with 98.7% assessed for falls.

Clinical Quality Dashboard

- The NHS safety thermometer is an improvement tool to measure patient “harms” and harm-free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheter-associated urinary tract infections. The hospital was not required to use the NHS Safety Thermometer as it was a private healthcare provider. The hospital did however measure rates of thrombosis, falls, physiotherapy input, pressure ulcers and pain. These were all recorded in the patient’s notes.
- We saw that day case patients had their risk of falls and pressure ulcers noted in their short stay Integrated Care Pathway (ICP).
- There were ‘hot boards’ located on each ward. These displayed data relating to performance in key measurable areas, for example, patient falls, friends and family test results and infection control statistics.
- The hospital audited ten cases of catheter care against a number of measures in October 2016, scoring 98% overall compliance.
- Between October 2015 and September 2016 there were 28 reported falls, which was high when compared to other similar services. Of these six were near misses, five were no harm and 17 were low harm, the hospital provided evidence to show there had been learning from these incidents and mitigating actions put in place. We saw evidence of a thorough root cause analysis (RCA) conducted for each fall. Of these 28 reported falls, we were told that 50% belonged to surgery and the other remainder belonged to the medical core service.

Cleanliness, infection control and hygiene

- The hospital had an infection control link nurse. The role of the link nurse was to act as a link between the wards and the infection control team. This nurse went to infection control meetings every month and sat on the infection control committee. The Infection Control committee met every quarter and discussed incidents, communicable diseases screening and clinical waste issues amongst other things. Learning from these meetings was shared with staff via the daily handovers and email.
- The hospital took part in the annual Patient-Led Assessments of the Care Environment PLACE survey. Between February 2016 and June 2016 the hospital achieved 100% for cleanliness (based on 1,291 assessments across 287 organisations). This was just above the England average of 98%.
- Between October 2015 and September 2016, there were two surgical site infections (SSIs). One of these SSIs was the result of knee surgery and was therefore reported to Public Health England (PHE). The other SSI was the result of the patient picking at the wound area.
- We observed posters in theatres, recovery and on the wards displaying hand washing technique, however we did not observe any “World Health Organisation, 5 moments of hand hygiene” posters to indicate to staff when they need to decontaminate their hands, which is in line with Infection Control good practice standards. However, the service completed hand hygiene audits every month. In the month of October 2016, the theatre

Surgery

staff achieved 100% compliance with good hand hygiene practice. There were dispensers with hand sanitising gel located in appropriate places throughout the service. We observed staff using both the gels and basins before and after interacting with patients. Patient rooms also contained wash basins.

- There were adequate supplies of personal protective equipment (PPE), for example gloves and aprons, on the wards and in the theatre areas. Some rooms contained PPE for staff. Both junior and senior nurses could accurately and confidently describe the instances where PPE was necessary.
- On the wards, sluice rooms were clean and well organised and the cleaning staff kept cleaning rotas. There were colour coded linen skips in the sluice room. We observed green 'I am clean' stickers being used by cleaning staff and we saw these stickers were up to date. In theatres, there was a cleaning log that contained step-by-step instructions on what needed to be cleaned and when. Staff signed this log on a daily basis. We viewed this log whilst on inspection and found it to be fully completed and up to date.
- We observed that the decontamination pathway in the theatres was clear and followed by all staff. We observed a sound scrub technique throughout the inspection. Surgeons and theatre staff were scrubbing their hands both pre and post operatively, in line with the World Health Organisation (WHO) and the Association for Perioperative Practice (AfPP). If there was a last minute list, the theatre staff could fast track the cleaning of equipment to be completed within 24 hours. Progress of this could be tracked on an online system.
- In the 12 months prior to our inspection there were zero cases of MRSA. MRSA is a bacterium that can be present on the skin and can cause serious infection. There was a hospital wide policy that stated that all patients should be screened for MRSA prior to admission.
- There was one incident of hospital acquired *Clostridium Difficile* (C.Diff). C.Diff is a bacterium that can infect the bowel and cause diarrhea and most commonly affects those people who have been recently treated with antibiotics.
- There was one incident of *Escherichia Coli* (E.Coli) as a result of surgery. E.Coli is a bacterial infection that can cause severe stomach pain and diarrhoea.

- There were two instances of meticillin sensitive staphylococcus aureus (MSSA). MSSA is a type of bacterium that can live on the skin and develop into an infection or even blood poisoning.
- If a patient was infected with any communicable disease, such as those above, they would be scheduled as the last operation of the day. The patient then recovered in theatre to maintain some form of isolation.
- During our inspection, we observed that infection control policies were readily available in wards and within theatres. The policies relating to MRSA, hand hygiene and aseptic technique were in date and comprehensive.

Environment and equipment

- Both wards, theatres and the recovery area were clean and well-lit with natural light. On the wards, there were wide corridors and all inpatients had single rooms with televisions and sometimes, a sofa bed. Rooms were not identical sizes but all were en-suite with walk-in showers. All rooms contained a safety checklist that ensured each room was equipped with up-to-date, clean equipment. Nursing staff maintained this list.
- Resuscitation equipment was stored securely in designated trolleys and was readily available, on both wards and within theatres. We checked all trolleys and found all equipment to be in date. Audits kept with trolleys displayed that staff had checked them both daily and weekly. The difficult airways trolley in theatres was shared with the critical care unit (CCU) and we were informed that if the CCU required it, it would be taken down in the lift. When not in use, dust covers were placed on equipment. Please refer to the critical care report for more information.
- On the wards, the blood pressure machine was safety tested and regularly checked in line with the hospital policy. All portable equipment we checked had been recently serviced and labelled to indicate the next review date. Disposable equipment was easily available, in date and appropriately stored. In theatres, all equipment was safety tested regularly and was all in date.
- The theatres were reached via a secure access. On the theatre floor, equipment was stored along the corridor. This restricted space in the environment. Each of the three theatres had its own anaesthetic room. Anaesthetic equipment was adequately stored in these rooms. An anaesthetic equipment audit of 10 records

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from November 2016 found that whilst the anaesthetist checked the equipment prior to all surgeries, only 50% of patients (5) possessed a record of such a check within their medical records. In addition, 90% of cases had a completed and signed log book entry. The lessons from these audits were shared with all theatre staff to ensure that they understood the importance of signing all relevant logs. During our inspection, we observed fully completed log book entries.

- On the theatre floor, there were clear pathways for the collection and drop-off of equipment. All staff were aware of the processes for the collection of equipment due to the clear guidelines provided.
- The arrangements for the management of waste products and clinical specimens were appropriate for keeping patients and staff safe from harm. Sharps bins were used correctly and sluice areas included bins that were adequately labelled and classified to ensure segregation of waste. The sluice area contained 'I am clean' stickers on all equipment and tools, besides the bed pans. When questioned about this, staff informed us that the bed pans were cleaned, but stickers were not placed on them for hygiene purposes.
- The hospital took part in annual PLACE survey. Between February 2016 and June 2016 the hospital achieved 100% for condition, appearance and maintenance. This was above the England average of 93%.

Medicines

- There were two whole time equivalent (WTE) pharmacists – this included the pharmacy manager. There was also one WTE pharmacy technician and one WTE pharmacy assistant. There was no out-of-hours pharmacy rota but a pharmacist was available if needed. If the nurses in the ward required medicines out of hours, the matron and the Resident Medical Officer (RMO) could gain access. There was a standard operating procedure (SOP) in place for this process.
- Controlled drugs (CDs) were securely stored in a cabinet that was accessible via two keys. There was also an emergency controlled drugs cupboard accessible by a key that was kept under a personal identification number (PIN) system. The PIN system tracked the date and time that the key to the CD cupboard was requested. It also noted the user who took the key. Medicines in the pharmacy were checked every three months to ensure

they were within expiry date range. If a drug was due to expire in the next three months, it was removed and placed in pharmaceutical waste. An external company destroyed the waste.

- In an internal audit of CDs in August 2016, the hospital scored 100% in most measurable outcomes. For example, in 100% of cases (10), CD receipts and supplies had been recorded accurately in the CD register and pharmacy CD register. We observed this process whilst on inspection. The pharmacy department ensured that the CD journey was continuously recorded.
- The pharmacy team usually carried out medicines reconciliation within 24 hours of patient admission. This process ensured that the drugs the patient was admitted with were in date and appropriate. We reviewed an audit of 10 records from December 2016 and found that there was 67% compliance with internal standards. For example, only 30% of records possessed GP details.
- Fridge temperatures throughout the wards were attached to an online system. The matron and pharmacist were emailed if the fridge temperatures fell out of range. The ambient room temperatures of each treatment room were monitored centrally to ensure temperatures did not exceed recommendations for the safe storage of medicines.
- Within theatres, a dedicated pharmacy technician also checked the accuracy of any prescriptions. Theatres kept their own stock of 95% of vital drugs, but if a drug prescribed was not in stock they contacted the pharmacy.
- Within theatres, the medicines cabinet was unlocked and open during the inspection. A recovery nurse informed us that they kept the cabinet open when there were staff in the unit. The risk of 'poor medicines management, theft, fraud or harm especially in relation to management of controlled drugs' was on the departmental risk register.
- Staff had access to copies of the British National Formulary (BNF), in addition to policies relating to medicines management (including the antimicrobial formulary), via the trust intranet. Staff understood and demonstrated how to report medicine safety incidents. Learning from these incidents was then fed back through various channels such as emails, nursing handovers and monthly meetings.

Records

Surgery

- Paper records were used throughout the service. These were kept in lockable units at the nursing stations. A ward clerk always manned the stations. Over the course of the inspection, we reviewed 11 sets of patient records and found them to be complete, legible and up to date. All of the reviewed showed that a doctor saw all patients within 12 hours of admission. All records also contained signed consent forms and records of signed and dated patient observations. Consultants had signed and dated records but their signature was not always legible.
- VTE risk assessments were part of the paper-based notes. Ten out of 11 records we looked at contained a complete VTE risk assessment. Four out of 11 records we reviewed contained an incorrectly completed VTE risk assessment.
- An audit of 10 records undertaken by the hospital in September 2016 found that records were 87% compliant with internal markers, including legible entries, completion of GP details and signing of notes. Pressure care documentation filled out by nurses scored 93% overall compliance. Of the nine applicable patients, 100% had their initial pressure sore assessment completed within three hours of admission and had their level of risk identified. Manual handling assessments achieved 94% overall compliance, with all 10 patients audited having received a manual handling assessment within three hours of admission. All 10 patients also had their level of risk identified by nurses in their records. Patient risk of falls documentation scored 85% overall, with 90% of patients (9) receiving an initial assessment within three hours of admission and 100% of patients (10) being reviewed daily.
- An audit of 30 patient records in October 2016 found that documentation by doctors scored 82% overall compliance with regard to operation/procedure notes. All patients undergoing a procedure had signed and filed consent forms and an operation summary in their notes.
- Anaesthetist documentation we reviewed clearly instructed staff on how to contact the consultant anaesthetist if necessary.
- Information governance was part of the mandatory training programme, which all staff were required to attend. Within the surgical service, 100% of staff had attended this training, against a target of 100%.
- The matron was the safeguarding lead and was trained to level 3. All other staff were provided with safeguarding training taught by an external organisation and senior leaders said the company could not confirm in writing that training was to level 2 or 3.
- All staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. Staff on the wards understood safeguarding procedures and how to report concerns. Safeguarding policies were up to date and readily available on all units. Staff knew how to access both the hard copy stored on the ward and the copy kept in the policy library on the intranet.
- Both junior and senior nurses were aware of whom the safeguarding lead was and the escalation process if they had any concerns. The Matron was the safeguarding lead.
- There had been no reported safeguarding incidents to the CQC in the 12 months prior to inspection.
- Data provided demonstrated that 100% of inpatient staff and 78% of theatre staff were safeguarding trained. However, senior leaders could not confirm the level of the training that had been provided.

Mandatory training

- Staff received mandatory training on a rolling annual programme that consisted of both e-learning and classroom courses. The mandatory training programme included: bullying and harassment, data protection, equality and diversity, hazardous substances, health and safety, risk assessment, safeguarding and slips/trips and falls. Compliance with mandatory training ranged from 42% (risk assessment) to 86% (data protection). The mandatory training target for all topics was 100%.
- There were reliable arrangements in place for supporting and managing new nurses, including a comprehensive induction and a supernumerary period during which senior staff assessed their clinical competencies.
- Inpatient nurses also attended clinical updates, the aim of which was to update staff on key training areas. Data demonstrated that 100% of inpatient nurses had attended this update in the 12 months prior to our inspection.
- Managers were responsible for ensuring staff were up to date with their mandatory training. Staff were provided with protected time each year to ensure that mandatory

Safeguarding

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training and competencies were up to date. Surgical staff were offered additional modules to study, as an incentive, once they had completed their mandatory training.

- Data provided by the hospital showed that 24 consultant's files showed no up to date evidence of mandatory training.

Assessing and responding to patient risk

- We saw the hospital admissions policy, which had clear exclusion and inclusion criteria. Patients with a known terminal illness, severe psychiatric illness or women past 16 weeks of pregnancy were excluded. Patients who were grossly obese, with suspected acute heart conditions or with multiple traumas or head injury, required a risk assessment by the relevant consultant prior to admission.
- The service had a pre-operative assessment team for all patients that provided advice and information to patients prior to their surgery. The service tested all patients for MRSA and offered patients the opportunity to clarify any details of their surgical journey. Patients who were not physically assessed would be assessed over the phone. The pre-assessment team consisted of two full-time nurses. These nurses informed us that they assessed patients for learning difficulties, dementia and other complex needs. If a patient suffered from any of these conditions, the service informed the ward and the dementia champion (who worked on the wards).
- 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. This checklist was developed to reduce errors and adverse events, and increase teamwork and communication in surgery. We observed that the mandatory steps of the WHO checklist were fully embedded in practice. The service used all five steps of the checklist. We observed three of the steps which included the sign in, time out and sign out. We observed the whole theatre team were involved and staff stopped what they were doing to participate. The service audited the use of the WHO surgical safety checklist every month. In October 2016, the service achieved 99% compliance with the use of the five steps. Upon our review of medical records, three of the 11 records we looked at did not have a fully completed WHO checklist as the 'sign out' stage had not been completed in all three cases.

- Patients were assessed for the risk of hospital acquired venous thromboembolism (VTE) at preadmission and on admission prior to surgery. Between April 2016 and September 2016, 96% of patients were risk assessed for VTE.
- Patients' clinical observations were recorded and monitored in line with the National Institute for Clinical Excellence (NICE) guidance 'Acutely Ill-Patients in Hospital.' The hospital used the National Early Warning Score (NEWS), which is a scoring system that identifies patients at risk of deteriorating, or needing urgent review. The nurses documented each patient's NEWS in the paper-based nursing notes. The service used a score of between one and two to escalate to the nurse in charge and a score of more than three to escalate to the resident medical office (RMO) and outreach team. We saw staff on the surgical wards and in recovery recording patient observations such as heart rate, respirations, blood pressure, temperature and pain. A documentation audit of 10 records carried out in September 2016 found that out of range NEWS scores were actioned in 100% of cases.
- Across the hospital, 98% of all nursing staff had completed basic life support training and 100% of those required (30) had completed intermediate life support training. Staff also completed scenario training in cardiac arrests.
- There were clear guidelines and policies for the management of suspected sepsis based on NICE guidelines. The patient NEWS chart also included a sepsis pathway chart that staff could refer to each time they checked the patient observations. The pathway included a step-by-step guide of escalation in the event of patient sepsis.
- There was a cardiac arrest team that met twice daily in the critical care unit (CCU). The team was comprised of clinical staff throughout the hospital, with each member of staff taking on a different responsibility in the event of an emergency.

Nursing staffing

- Due to the size of the inpatient wards, the hospital was able to allocate staff in advance, based on demand. The Royal College of Nursing (RCN) recommends a nurse to patient ratio of 1:8 (RCN 2012). This meant one registered nurse (RN) for eight patients. At the time of our inspection, the service maintained a ratio of one

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registered nurse to 4.5 patients. One Healthcare Assistant (HCA) worked each shift, as well as the nurse in charge of the ward, who was supernumerary and was not allocated patients.

- The Association of Perioperative Practitioners (AFPP) Safe Staffing guidelines were used to determine safe staffing levels in the perioperative environment. The AFPP guidelines recommend a minimum of two scrub practitioners, one circulating staff member, one anaesthetic assistant practitioner and one recovery practitioner for each operating list. We observed three operating lists and found them all to comply with AFPP standards. Between July and September 2016, between 3.7% and 4.7% of shifts were left unfilled across the hospital.
- Theatres had 10 open vacancies at the time of our inspection, this was equivalent to a 27% vacancy rate. There were three vacancies for scrub nurses, two ODP vacancies, two recovery nurse vacancies and three HCA vacancies. At the time of our inspection bank and agency usage in theatres was on average 19% to mitigate against the vacancy rate. When questioned about this, staff informed us that they used regular bank and agency staff to ensure continuity. Between October 2015 and September 2016, inpatient usage varied between 10% and 20.9% for registered nurses. Agency staff were provided with a 'buddy' to ensure they could address queries to a permanent member of staff. Agency nurses also received a thorough induction of the hospital and the clinical area they would be working in. We spoke with one agency nurse who was on shift during the inspection who confirmed she had received an orientation and induction to the hospital and the ward.
- Between October 2015 and September 2016, sickness rates for theatre staff were less than 1% (except for September 2016 when the rate was 3.3%). In inpatient areas, the sickness rate varied between 3% and 9% in the same period.
- Between October 2015 and September 2016, the rate of turnover of inpatient nurses was 9.3%. In the same reporting period, the rate of theatre staff turnover was 11.6%.
- Senior nurses told us that staffing throughout the inpatient areas was flexible. During quiet months, the hospital frequently closed down the day unit and

sometimes one of the wards. The staff from those areas would be redeployed elsewhere. Staff said that this worked well and that they could sometimes take holiday if needed.

- Nursing handovers within surgery were carried out at the beginning of each shift. Surgery handovers consisted of a full briefing of all patients on the ward that day. Handovers were also used as a communication tool to discuss incidents and learning.

Surgical staffing

- Surgeons worked under a practising privileges agreement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. The Consultant Selection & review Committee (CSRC) was responsible for approving practising privileges. This was done on an invitation only basis. Consultants that were granted practising privileges had their appraisals and revalidation undertaken by their respective NHS trusts.
- All patients were admitted under the care of a named consultant. The service was consultant-led and 141 surgeons had practising privileges within the service at the time of inspection.
- There were four resident medical officers (RMOs) within the hospital. The RMOs looked after both medical and surgical patients. RMOs performed 24-hour shifts and were available 24 hours a day, seven days a week.
- Anaesthetists stayed with their patients post-operatively, until they were transferred to the wards. There was on-call anaesthetic rota for emergency returns to theatre. This was in line with the Royal College of Surgeons (RCS) and Association of Anaesthetists of Great Britain (AAGB) guidelines.

Emergency awareness training

- We were informed by the hospital that 100% of theatre staff were trained in major incidents. The mandatory training programme included fire training, in which 100% of staff were trained. The last fire safety drill took place in January 2016.
- Supervisors were required to complete desktop major incident tests that examined their approach to major incidents, as laid out in the business continuity plan.

Are surgery services effective?

Surgery

Good 

Evidence-based care and treatment

- Both pre-operatively and post operatively the service complied with the evidence based guidelines provided by the National Institute for Health and Care Excellence (NICE). An example of this was that patients' temperatures were recorded throughout the operative period, in line with NICE guidelines.
- The hospital contributed to the national joint registry (NJR). The NJR was set up by the Department of Health to monitor performance of joint replacements in orthopaedic surgery.
- The hospital provided data to the national Patient Reportable Outcomes Measures (PROMs). PROMs use patient questionnaires to assess the quality of care and outcome measures following surgery. It is usually for NHS patients having hip and knee replacements, varicose vein and groin hernia surgery.
- The service had a clinical audit programme in place. Theatres maintained a comprehensive clinical audit calendar that included the monitoring of: surgical site marking, anaesthetic equipment, theatre gloving and gowning, and implant and instrument documentation.

Pain relief

- Nurses routinely assessed pain levels of each patient in the pre-assessment. If a patient was in pain pre-operatively, then the anaesthetist would be informed and RMOs advised.
- Pain was scored using two methods. The first was a numeric rating scale (NRS) that scored pain from zero to 10. In this scale, zero meant no pain and ten was extreme pain. The second tool saw pain used faces to determine the extent of pain. A green smiley face indicated no pain whereas a red sad face indicated the worst pain possible. We found use of both methods in the records we observed.
- An audit of 10 medical records from December 2016 found that 100% of applicable patients (6) received written evidence that a pain assessment tool was used in recovery. In the same audit, 100% of applicable patient records contained written evidence that appropriate analgesia was administered, in line with the patient pain score.

- All pain related matters were discussed at the Drugs and Therapeutics Committee meetings. A Pain Management Program meeting also took place monthly. The pain consultant and pain nurse attended this. Minutes of this meeting from October 2016 showed that the plans for the next residential 'veterans with pain' course were the main discussion point.

Nutrition and hydration

- Upon admission, all patients were screened for their risk of malnutrition. A tool based on the malnutrition universal screening tool (MUST) was used to identify the risk of malnutrition. Whilst there was no on site dietitian, the hospital maintained a service-level agreement (SLA) with a local dietitian team from a neighbouring private facility. Staff told us that they could contact them easily.
- Records showed food and fluid intake on the wards was recorded to monitor patients post-operatively.
- The hospital took part in the annual PLACE survey. Between February 2016 and June 2016, the hospital achieved 97% for ward food. This is just above the England average of 92% (based on 1,291 assessments across 287 organisations). Food and Hydration includes a range of organisational questions relating to the catering service, for example, the choice of food, 24-hour availability, meal times and access to menus. An assessment of food services at ward level and the taste and temperature of food was also completed.

Patient outcomes

- The hospital participated in the National Joint Registry (NJR), Patient Related Outcome Measures (PROMs) and Breast Cancer in Pregnancy (BCIP).
- The NJR data showed that the orthopaedic department scored 80.7% in respect of attaining patient consent. This was below the national average of 86%. The NJR data also contained the revision rates for both hip and knee replacements at one, three and five years. The revision rate for hips at one year was 0.92% against a national average of 0.75%. The revision rate for knee replacements at one year was 2.36% which is above the national average of 0.48%. The service informed us that a knee replacement surgeon was an outlier on the NJR data due to the complexities of the particular surgery itself. This is an on going debate with the NJR.
- In the 12 months prior to our inspection, there were 35 procedures cancelled for a non-clinical reason. The majority of these (15) were cancelled by the consultant

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due to personal sickness or unforeseen circumstances. Of these patients, 100% were offered another appointment within 28 days of the cancelled appointment.

- Between October 2015 and September 2016, there were 17 unplanned returns to theatres. The majority of these (seven) related to the evacuation of a haematoma.
- In the same reporting period there were 24 cases of unplanned readmission within 28 days of discharge. This was lower than average. These readmissions were for various reasons, from pain and nausea to chest infections, medical assessments and patients being generally unwell. One of these readmissions was the result of sepsis post-surgery.
- The hospital submitted data to the Private Healthcare Information Network.

Competent staff

- The appraisal year at the hospital ran from March to February. All inpatient and theatre staff had received an appraisal in the year prior to our inspection. In the 2016 employee satisfaction survey, 72% of staff rated the quality of their appraisals favourably (compared to the external benchmark of 64%).
- All staff were provided with an induction over the course of two classroom days, which aimed to provide new staff with a good understanding of the hospital standards. Classroom sessions over the year provided access to competency training. Classroom sessions included: IV study, medical gas training, pressure ulcers & nutrition, venepuncture & cannulation and venous thromboembolism study day.
- Nursing revalidation is the new process by which registered nurses are required to demonstrate on a regular basis that they are up to date and fit to practice. Information from the hospital showed that all nurses were revalidated with their healthcare regulators.
- The provider had undertaken a recent audit of consultant files to ensure they contained current evidence to support competency for the practising privileges granted, including scope of practice, appraisal, DBS, references, GMC registration and confirmation of identity). We reviewed personnel files for four consultants and found they contained the necessary evidence.
- Data provided by the hospital showed that 17 consultants had appraisals that were overdue.

Multidisciplinary working (in relation to this core service only)

- The hospital informed us that it had a 'multidisciplinary approach to care'. Whilst on inspection, we observed varied professionals working together to plan the delivery of patient care. In the medical records, we observed input from physiotherapists, dietitians and speech and language therapists (SALTs) where necessary.
- Staff on the wards spoke very highly of the RMOs, pharmacists and the matron, all of whom offered daily support to the assessment and delivery of patient care.
- The hospital had multidisciplinary team (MDT) terms of reference that showed that breast MDTs were held monthly, to ensure all appropriate cases were discussed. We requested minutes from previous MDT's but the information was not provided by the service. Data provided by the hospital showed that of the 284 consultants with practising privileges, nine showed no evidence of attendance at MDT meetings.
- There were several SLAs in place throughout the hospital, covering aspects such as removal of waste to pathology services. Staff confirmed that these arrangements worked efficiently.

Seven-day services

- Pharmacy services were open every day from 8.30am to 6.30pm. Out of these hours, both the matron and the RMO were able to access emergency drugs.
- All three theatres operated six days a week, Monday to Saturday, 7am to 9pm. The recovery area closed when the last patient left.
- Within the surgical service there was RMO cover 24 hours a day, seven days a week.
- Physiotherapists provided a seven day service to inpatients, as well as supervision of the use of the hydrotherapy pool.
- Both speech and language therapist (SALTs) and dietitians were available on call.
- There was access to diagnostic imaging and tests, 24 hours a day, seven days a week. There was an on-call radiographer providing general diagnostic imaging support, as well as an on-call neuro-radiologist.

Access to information

Surgery

- The vast majority of surgical patients were pre-assessed by the nurses that ran the pre-assessment centre. These patients were assessed either on the phone, or in person. After the assessment, the notes were provided to the ward staff.
- Whilst on the ward or in the day unit, the patients records were maintained on paper.
- Upon discharge, the ward staff provided the patient with a discharge letter that outlined the summary of care, their condition on discharge, medication received on discharge and follow-up information, with contact details if need be.
- Patients also received a letter from their consultant's secretary in the post. They would then be able to share this with their GP.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Both doctors and nurses asked patients for consent prior to procedures. Patients we spoke with informed us that clinical staff always asked for their consent. All of the 11 records reviewed contained signed consent from patients. The hospital had an up-to-date consent to treatment policy in place.
- Not all staff were able to give clear explanations of their roles and responsibilities under the Mental Capacity Act 2005 (MCA) regarding mental capacity assessments and Deprivation of Liberty Safeguards (DoLS). Some staff seemed unclear regarding the threshold of referring a patient for a capacity assessment. Across the hospital, 74% of staff had completed training specifically related to the MCA, and 100% had covered this topic in their annual clinical update.
- The deputy matron was also the hospital Deprivation of Liberty Safeguards (DoLS) officer.
- None of the patients whose notes we looked at were on do not attempt cardio pulmonary resuscitation (DNACPR) pathways and this was evident in the notes.

Are surgery services caring?

Good



Compassionate care

- The single en-suite rooms ensured that patients' privacy and dignity was not compromised. Nursing staff

understood the importance of maintaining patient dignity. We observed patients being treated with respect, with doctors and nurses introducing themselves when entering patient rooms. On the wards, the senior sister performed a twice daily ward round to see how patients were.

- The hospital took part in annual PLACE survey. Between February 2016 and June 2016, the hospital achieved 74% for privacy, dignity and wellbeing. This is below the England average of 83% (based on 1,291 assessments across 287 organisations). The assessment of privacy, dignity and wellbeing included infrastructural/organisational aspects such as provision of outdoor/recreation areas, changing and waiting facilities, access to television, radio, computers and telephones. It also included the practicality of male and female services such as sleeping and bathroom/ toilet facilities, bedside curtains sufficient in size to create a private space around beds and ensuring patients were appropriately dressed to protect their dignity.
- Patients we spoke with were consistently positive about the care they received. We heard that staff were "wonderful" and "very caring". Patients informed us that staff made them feel comfortable and respected. We observed call bells being answered as soon as possible. Patients told us that they never waited long for help from staff.
- The hospital inputted data to the friends and family test (FFT) that asked patients whether they would recommend the hospital to their friends and family. Between April 2016 and September 2016, the results ranged between 95% and 100% of patients saying that they would recommend the service. The hospital's response rate ranged between 19% and 29%, which was below the England average of NHS patients.
- Out of the 76 "tell us about your care" comment cards we received, 74 were very positive about the care patients received at the hospital.

Understanding and involvement of patients and those close to them

- All patients that we spoke with informed us that their consultant had explained their procedure when asking for consent to proceed. Patients told us that they felt involved in their care plan. One patient said, "I've had loads of time to ask questions and have seen the consultant every step of the way".

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- The admissions team were responsible for briefing the patient on payment of fees, which would be agreed prior to admission for the procedure. There was written information available on how to pay for treatment.

Emotional support

- The Matron and Deputy Matron visited the wards every day and spoke with patients and their relatives to ensure they felt supported and listened to during the course of their stay.
- The service had access to Christian, Jewish and Muslim chaplaincies. Staff were aware of how to access the details for these services. The hospital had a SLA with a counselling service. Staff on the ward were aware of how to access this service if required by patients.
- We observed supportive interactions between physiotherapists, nurses and patients. Patients were supported by staff to manage their own health. Patients spoke highly of the supportive environment and most said they did not require access to counselling as staff were “already so supportive”.
- The hospital had a number of volunteers that made patient's feel comfortable and talk to them to help prevent loneliness and isolation while in hospital.
- The hospital had a pet policy to allow patients to see their pets if they are hospitalised for a long time.
- The hospital provided birthday cards and homemade birthday cake to any patients that have their birthday in the hospital.
- The hospital had a dedicated Christmas party every year for any patients and relatives that were using the hospital at that time.

Are surgery services responsive?

Good 

Service planning and delivery to meet the needs of local people

- The service had been adapted to meet the needs of its population. As the hospital offered private care, the majority of surgeries were elective. This meant that admissions to the surgical inpatient wards were planned with the patient in mind.

- The housekeeping team could put a compassionate bed in the room of a patient, if the patient requested. This meant that a patient could have a relative stay the night. There was also a daily guest menu.

Access and flow

- Between October 2015 and September 2016, there were 3,661 visits to the operating theatre. The most commonly performed surgery at the hospital was orthopaedics (1201) which included surgery on knees, hips, ankles, shoulders, spines and arthroscopy. After orthopaedics, ophthalmology (498) and gynaecology (405) surgeries were the most commonly performed.
- In the 12 months prior to our inspection, 35 procedures had been cancelled for a non-clinical reason. Of these, 100% were offered another appointment within 28 days of the cancelled procedure.
- The elective nature of surgical procedures meant that patients rarely waited long for a procedure. The service informed us that patients were usually offered an appointment within two weeks of wanting or needing treatment. For this reason, waiting times were not audited by the service.
- There was a bed management meeting every weekday morning to discuss patient admissions, bed capacity and patient discharges. We attended this meeting during the course of inspection and found it to be concise and thorough.
- Upon discharge, patients were provided with leaflets on the process of leaving hospital, as well as information on their procedure, discharge medication and if any follow-up treatment was necessary. They were also provided with a discharge letter that they could share with their GP, and the contact details for the service should they have any concerns.

Meeting people's individual needs

- The Matron was the adult safeguarding lead and was responsible for ensuring that the hospital had processes in place for monitoring patients with dementia and liaising with social services if required.
- Patients with complex needs, including learning difficulties and dementia, were not actively admitted to the hospital. Staff on the wards were made aware of any such patients via the pre-assessment process. At the time of our inspection, there were no patients with

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learning disabilities undergoing surgery. Staff did not have any training to care for such patients. Staff told us that all concerns would be escalated to the Matron in the first instance.

- There was a dementia champion that had arranged talks from dementia charities for the staff. A dementia integrated care pathway had also been created.
- The service did not admit a large number of overseas patients, so translation services were not available in house. The hospital did however have access to interpretation services. Staff were aware of how to contact interpreters and patient Embassies if need be.
- If a patient was hard of hearing, a note was placed on the patient door. This was also the case for patients with a visual impairment.
- The menus on the ward were varied and catered for several diet types including: vegetarian, gluten free, sugar free, continental and soft food diet. There was no red tray or jug system for patients that required assistance with eating but both the catering team and nurses on shift would be made aware if there were any such patients.
- Patients spoke very highly of the menu and the variety choices available. Dietary information of patients was discussed every morning between the catering team and the nurses on shift. The day case patients also had a separate menu.
- The service had access to a multi-faith chaplaincy service.
- The physiotherapy service ran a daily hydrotherapy class for women only. This catered for all women who wanted more privacy. These women were able to wear what they wanted whilst in the pool.
- The hospital took part in annual PLACE survey. Between February 2016 and June 2016, the hospital achieved 94% and 88%, for dementia and disability, respectively. This was just above the England average, of 80% and 81% respectively.

Learning from complaints and concerns

- Ward staff dealt with informal complaints in the first instance. The Matron made daily ward rounds to ensure that patients were happy with care. If a complaint became formal, the Matron would handle it.

- Hospital policy stated that written acknowledgements of complaints should be sent within two working days of receipt of complaint. After a full internal investigation, the results of this were communicated to the complainant within 20 working days.
- Between January 2016 and December 2016, the inpatient service received 16 complaints. Two of these related to complaints about accounts and another two were non-clinical complaints. There were no trends with the complaints received. They ranged from a patient being unhappy with the discharge process to patient dissatisfaction with the number room moves during their hospital stay. Five of the complaints were responded to verbally, with the rest receiving a written response. All complaints responses met the 20 day target.
- If a nurse was involved in the complaint, they would be written to directly by the Deputy Matron to ensure they were aware of any learning from the complaint. A face-to-face meeting would be held if necessary. Complaints were discussed at daily handovers and at the Patient Safety Group meeting that took place every quarter. The inpatient 'hot boards' also contained 'you Said, we Did' topics, that highlighted how improvements were made after patient comments and complaints. However, we observed on one inpatient ward, the monthly "you said, we did" comments were not aligned.

Are surgery services well-led?

Requires improvement 

Leadership / culture of service related to this core service

- There was a clear senior management structure within the hospital. The Chief Executive Officer took oversight of the hospital's leadership. This role was supported by both the Matron and the Deputy Matron, who oversaw the day-to-day running of the wards. There were several relatively new employees within the surgical department prior to our inspection. During our inspection, there was an interim theatre manager in post who oversaw the management of the theatres. At the time of our inspection the interim theatre manager had only been in post for three weeks.

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- Clinical leadership of the surgical service was the responsibility of the Theatre Manager and the Matron.
- Staff we spoke with informed us that they felt well supported by the senior management team. Staff of all levels spoke very highly of both the Matron and Deputy Matron.
- We observed information leaflets on the unit encouraging staff to speak up (whistle blow) if they saw something was being done wrong. There was an up-to-date whistleblowing policy, which outlined how to escalate any concerns. Staff supported this ideal and informed us that they were comfortable to speak up in the event of something going wrong.

Vision and strategy for this core service

- The service vision statement was “to be recognised as a highly regarded private hospital with a charitable conscience, delivering clinical excellence within a culture of kindness”. The strategy included: increasing the activity and revenues of the hospital, becoming a more efficient business and developing the hospital to provide first class facilities for patients and consultants.
- The hospital values (professionalism, quality, respect, safety, teamwork) were printed on the back of staff’s ID badges.

Governance, risk management and quality measurement for this core service

- There was a defined governance structure at the hospital. The Clinical Governance Committees (CGCs) were held on a quarterly basis. These meetings discussed incidents, complaints, risks and patient outcomes amongst other things. A Risk and Quality Governance Committee meeting also met every quarter. The CEO chaired this meeting, which was attended by other members of the senior executive team. This meeting discussed infection control rates, patient satisfaction survey results, complaints and the risk register.
- Both of these committees reported to the medical committee. The medical committee was chaired by the medical director and met every quarter.
- The CGC oversaw eight working groups including: pressure care, nutrition, blood management, documentation, clinical audit and research, patient safety, safeguarding and falls.
- There were 140 active risks on the hospital risk register at the time of our inspection. Of these, seven were ‘high’

risk. None of these high risks were clinical risks and all related to matters of finance or general health and safety. Some entries on the risk register had been active since 2015 and there were 51 risks with no date, time or responsible person included. The risk register was not a live up-to-date document and therefore the risks on it did not reflect the risks that we found whilst on inspection.

- The Heads of Department (HoD) meeting took place every month and was well attended by the HoDs, including the Theatre Manager, Matron and Deputy Matron. This meeting discussed marketing, finance and fundraising, amongst other things. Minutes from this meeting were shared with staff on the wards and in theatres.
- There was a lack of oversight of consultant’s practising privileges, with 68 consultants not having the expected full standard of documentation in their files at the time of inspection. Of those 68 consultants who were not fully compliant, 38 had an out of date DBS and 20 had files missing scope of practice. The service were aware of this and we were assured that the consultants had been written to by the CEO and were made aware of their lapses in documentation. The hospital informed us that consultants who failed to respond had their practising privileges suspended.
- We saw that there was a backlog of 671 incidents with some awaiting investigation and some awaiting completion by senior staff. In May 2016, the DNV International Accreditation Standard for Hospitals found there were over 100 incidents, some from 2014 that had been reported and were awaiting management review. The hospital reported that key performance indicators (KPIs) for completion of incidents were not in place and a number of managers left without completing the incident forms. Training sessions in the completion of forms was planned for all staff and managers in July 2016. However, these issues still remained at the time of inspection.

Public and staff engagement

- Results from the hospital wide employee satisfaction survey, carried out in November 2016, included comparisons with external benchmarks of 70 other organisations. In total, 123 (52%) of employees were surveyed. The overall engagement index (number of positive responses) was 72%, which was in line with external benchmarks (72%).

Surgery

- A further 86% of employees reported communication within the hospital was good, which exceeded the external benchmark of 66%. In addition, 73% of staff rated management positively, compared to the external benchmark of 58%. However, 34% of staff rated the hospital as providing them with good career prospects, against an external benchmark of 48%. The report included details of areas that required further development, including career prospects and equal opportunities.
 - The Matron informed us that ward sisters who were in charge of each ward carried out a Nurse in Charge daily round of all patients on their ward. Whilst we did not see any documentation to support this, we spoke with patients who confirmed this was the case.
- Innovation, improvement and sustainability**
- From April 2017, the pharmacy team intended to expand their service to theatres. Plans involved an automated top-up service that would be provided by pharmacy technicians. This would ensure that the theatres would not run out of prescribed medications and would operate more self-sufficiently.

Critical care

| | |
|------------|-----------------------------------|
| Safe | Not sufficient evidence to rate ● |
| Effective | Not sufficient evidence to rate ● |
| Caring | Not sufficient evidence to rate ● |
| Responsive | Not sufficient evidence to rate ● |
| Well-led | Requires improvement ● |

Are critical care services safe?

Not sufficient evidence to rate ●

Incidents

- The hospital reported to the Strategic Executive Information System (STEIS), which records serious incidents and never events.
 - The service reported no never events for the 12 months prior to our inspection. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurring for that incident to be categorised as a never event.
 - Incidents were reported via online forms that could be accessed by all staff and completed on any hospital computer.
 - Between January 2016 and December 2016, the critical care service reported 23 incidents. Of these, 15 were reported as no harm, five low harm, one moderate harm, two severe harm (death). We reviewed the incident log and found the most common themes were resuscitation events, pressure ulcer, medication incidents and data protection errors.
 - Serious incidents (SI) are those that require investigation. Senior leaders told us there had been no serious incidents on critical care in the past 12 months.
- However, data provided by the hospital indicated between January 2016 and December 2016, the service had one serious incident (SI). We asked for the investigation report for this incident and were provided with an incident review form. This stated a full investigation had been completed but this was not provided upon request. The document also stated lessons learned as a result of the incident. However, we saw no evidence of action plans to ensure these recommendations were met.
- Staff across critical care were able to identify how to report incidents and the types of situations that should trigger incident-reporting completion, including near miss situations.
 - Staff told us they received feedback and learning points from incidents, including those that occurred in other units within the hospital. Staff told us learning was shared via email and through the monthly team meetings. However, when we asked staff to give examples of learning and action points from incidents, a number of staff were unable to describe this.
 - Senior leaders told us that due to low rates of mortality and morbidity (M&M) they did not hold monthly M&M meetings. M&M meetings were held on a responsive basis as needed. Cases were discussed and recommendations and actions would be assigned. All medical staff confirmed this was the procedure. We requested to see M&M meeting minutes and were told there were no formal minutes. We were told deaths and morbidity was discussed as part of patient safety meetings.
 - The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of

Critical care

health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with had variable knowledge of duty of candour; however, senior staff were very clear about the requirement of this.

- We reviewed an incident review form and saw that it was not recorded whether an apology was provided to the appropriate person. Therefore, we could not confirm if the service had followed duty of candour guidance.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The service was using a clinical quality dashboard and this information was displayed on the ward.
- There were three unit acquired pressure ulcers reported within critical care between January 2016 and December 2016. During our inspection, we saw patients' risk of developing a pressure ulcer was assessed using Waterlow pressure ulcer prevention score. Tissue viability nurses were available Monday to Friday from 9am to 5pm.
- There were three falls reported between January 2016 and December 2016. We saw evidence of patient mobility assessments by physiotherapists and patient risk assessments completed when appropriate.
- Catheter care bundles were not used by staff throughout critical care and there had been no instances of catheter associated urinary tract infections (CAUTI) between April 2015 and April 2016.
- Venous Thromboembolism (VTE) risk assessment was recorded on the patients' record and completed on a daily basis. Hospital audit data showed compliance with this assessment was at 80% in December 2016. However, we were shown no action plan to improve this.
- Green 'I am clean' stickers were used to identify which equipment had been cleaned by staff and was ready to be reused, such as commodes. We saw stickers had been marked with the date the item had been cleaned and observed staff replacing stickers once they returned the clean equipment.
- We inspected various pieces of equipment such as commodes and arterial blood gas machines and found a good level of cleanliness.
- Infection prevention and control was part of the clinical update mandatory training which been completed by 100% of staff which met the hospital target of 100%. CCU staff had also received training on hand washing, 100% of staff had completed this.
- There was easy access to personal protective equipment (PPE) in all areas we inspected and staff used PPE during their activities as required.
- Staff were 'bare below the elbow' and adhered to infection control precautions throughout our inspection, such as cleaning hands when entering and exiting the unit and bed spaces, and wearing PPE when caring for patients.
- Alcohol hand gels were readily available at the entrances to the critical care unit and at each bedside. We observed staff and visitors decontaminating their hands when entering and leaving the unit.
- The clinical dashboard showed it had been 213 days since the last infection. There had been no cases of methicillin-resistant staphylococcus aureus (MRSA) or Clostridium difficile (C-Diff) infections within the past 12 months. MRSA and C.Diff are both healthcare-associated infections (HCAIs) that can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting.

Cleanliness, infection control and hygiene

- There were hospital employed housekeeping staff for cleaning the Critical Care Unit CCU. Housekeepers worked from 7.30am to 8pm each day. For out of hours a team was available on call.
- We reviewed patient areas on the CCU as well as sluices and treatment rooms. All areas were visibly clean and free from dust.
- Patients were swabbed for MRSA on admission. We were told audits of compliance were undertaken as hospital wide audits.
- Intensive Care National Audit and Research Centre (ICNARC) data showed the rate of unit acquired blood infections. The CCU was performing better than comparator units and the average for unit acquired infections in the blood.

Critical care

- Critical care did not produce its own hand hygiene audits. At the time of the inspection hand hygiene was assessed hospital wide, compliance in October 2016 was 95%. The hospital told us they recognised that hand hygiene and IPC audits would need to be department specific in the future.

Environment and equipment

- There was an electronic swipe card entry system for staff and a buzzer entry system at the entrance to the CCU which was used by visitors. This meant staff could control who accessed the CCU when the door was secured.
- There was CCTV in use in some areas on the ward including the isolation room and family visiting area.
- The CCU was a purpose built bright and spacious unit and there was appropriate levels of storage. Most of the areas had natural light and space between beds was in line with Intensive Care Society standards.
- There was a resuscitation trolley available in the CCU. We saw the contents of the trolleys were checked daily by nursing staff and were tagged and sealed.
- There was a 'difficult airway' intubation trolley, which contained equipment to help staff intubate patients with challenging anatomy. The content of the trolleys met recommendations from the Difficult Airway Society (DAS) 2013. However, the trolley was stored upstairs within theatres and recovery and not in the CCU. If both services required the use of the trolley at the same time this would leave patients at risk.
- Needle sharp bins were available at each bed space. All bins we inspected were correctly labelled and none were filled above the maximum fill line.
- Dirty utility rooms contained facilities for disposing of clinical waste and cleaning equipment.
- Staff told us they were able to access equipment required to care for patients. We checked various and numerous equipment during the inspection and found it all to be safety tested. We reviewed service records and found them to be up to date.
- We observed spare consumables and other equipment were appropriately stored.

- There were hand washing basins at each bed space, which were easy to access.
- Patients and visitors shared the same entrance. This was against recommendation in the HBN 04-02 to prevent visitors from observing patients coming in and out of the critical care unit.
- The unit had one separated single room that was used for isolating infectious patients. There was negative airflow available, but not positive air flow. However, the room did not fulfil requirements for an isolation facility as per Health Building Note 00-09, as the room did not have a lobby.

Medicines

- The CCU maintained the governance of controlled drug (CD) audits that were undertaken by the pharmacy department. We saw evidence of second signatures, total balances maintained accurately when being moved from page to page and the appropriate storage of these medicines.
- We spoke to the lead pharmacist who told us the unit used medicines reconciliation process, which meant that when patients were admitted to hospital the medicines they are prescribed on admission correspond to those they were taking before admission. There was evidence of clear records of previous medicines in the notes from the pharmacist and in patient notes.
- We reviewed six prescription charts and saw they were fully completed. Allergies were clearly documented and allergy stickers were applied to patients' records.
- All staff had access to British National Formulary (BNF) as well as policies and information relating to medicines management, including the antimicrobial formulary.
- Some medicines were stored in fridges and we saw fridge temperatures were checked on an automatic system.
- Recommendations from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units identify there should be 0.4 Whole Time Equivalent (WTE) pharmacist for the number of critical care beds provided. We found that although the service could not tell us the dedicated pharmacy time, this had no detrimental effect on patient care. The hospital

Critical care

pharmacist visited the ward on a daily basis. Staff we spoke to said they had access to the on-call pharmacist when required out of hours and did not experience delays in receiving discharge medicines.

- The unit was also not meeting the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units recommendations around pharmacy technical support. There was no technical support available on the CCU. However, this did not lead to any delays in receiving pharmacy support.
- We reviewed six prescription charts and found there was good completion. VTE prophylaxis regimes were consistently prescribed and administered.

Records

- Paper based medical notes were used to record medical interventions and involvement from the multidisciplinary team. These notes were kept securely at the nurses' station for easy access. We reviewed six sets of patients' records and found they were legible, signed and fully completed.
- Medical records showed daily documentations from nursing and medical staff about ward rounds, results, patients' progress and family discussions. All records included details of allergies, daily treatment plan and evidence of daily consultant reviews.
- Patient observations and assessments were recorded on the daily record sheet, which was kept at the end of the patients' bed. Nursing documents were clear and concise and care plans fully completed. This included information such as regular observations, fluid balance and pain scores.
- Of CCU staff, 100% of nursing staff and all three full time Intensive Care Unit (ICU) fellows had completed data protection training, against a hospital target of 100%.
- Doctors and nurses were able to view patients' monitors with vital signs at the nurses' desk and staff escalated concerns as appropriate.
- Within patient records we found evidence of the insertion of invasive lines. However, we found no documentation to show staff were reviewing this on a regular basis.

- The CCU was using a basic care plan. We were told a new revised care plan had been developed and was in the stage of being printed. However, we did not see this.

Safeguarding

- Staff we spoke with were aware of their responsibilities in relation to safeguarding vulnerable adults and could locate and describe the hospital safeguarding policy.
- Nursing staff were able to give examples of what would constitute a safeguarding concern and told us they would seek advice from senior staff members and the hospital safeguarding team if they had any concerns.
- All staff we spoke with knew who the safeguarding lead was and could identify where to find their contact details if required.
- Safeguarding training was completed by staff as part of the hospital's mandatory training. All staff were required to attend this training and 100% of staff had completed safeguarding training. However, senior leaders were unable to confirm the level of training provided. Safeguarding training was via an external organisation and senior leaders said the company could not confirm in writing that training was to level two.

Mandatory training

- Mandatory training for CCU staff included bullying and harassment, data protection, equality and diversity, hazardous substances, health and safety, internet user, lone working, manual handling, risk assessment, safeguarding, infection prevention and control, slips trips and falls, social media and stress essentials.
- The CCU staff met the hospital target of 100% for most topics for nursing staff. Manual handling and stress essentials had compliance rates of 86%, which was because one nurse had not completed these trainings.
- There were three permanent Intensive Care Unit (ITU) fellows who completed mandatory training. One doctor had not completed hazardous substances, lone working, manual handling and risk assessment. Stress essentials had only been complete by one of the three doctors. All other mandatory training had been completed.
- The service offered basic life support, intermediate life support and advanced life support training to staff. Training had been completed by 100% of staff.

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- CCU staff also completed additional clinical training required for their role as critical care nurses. We reviewed training records and saw the majority of staff had up to date training. However, one staff member's training was completed over three years ago and was out of date. This included aseptic technique, basic life support, intermediate life support, clinical record keeping, Entonox and hand washing. A second staff member had training in central venous line care and arterial line care that was completed over three years ago and was therefore out of date.

Assessing and responding to patient risk

- Medical staff told us they used the 'Richmond Agitation-Sedation Scale' (RASS) to score the level of sedation for each patient receiving sedative medicines. However, we found no evidence of this assessment within patients' records. Nursing staff told us they did not use this scale.
- Staff were not evaluating patients using the Confusion Assessment Method for ITU (CAM_ICU) flowchart to determine whether delirium was evident, in line with best practice guidance from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units. This meant patients were not being screened for delirium on a regular basis.
- There was a written escalation procedure that identified the criteria for the management of emergency admissions to CCU. All patients requiring emergency admission were referred to the critical care consultant on duty and the ITU fellow.
- There was an established Critical Care Outreach Team (CCOT) staffed by the ward manager (when on duty), an ITU fellow (on bleep) and a critical care nurse. The CCOT team deliver level zero to level three critical care to non-critical care areas. CCOT worked 24 hours seven days a week and reviewed sick and deteriorating patients within the hospital.
- The National Early Warning Score system (NEWS) was used throughout the hospital wards to enable early identification of deteriorating patients. This was in line with guidance from the Royal College of Physicians and compliant with the NICE 50 guideline. Hospital documentation identified that a referral to CCOT should be made when the NEWS reached a score of five or above or if a person had any single score of three.
- Staff told us the sepsis pathway which helped them identify sepsis earlier. The screening and management proforma allowed staff to follow a flow chart when a patient was deteriorating. This incorporated the Sepsis Six, which is a bundle of medical therapies designed to reduce the mortality of patients with sepsis.
- There was a cardiac arrest team who met twice a day at 10:30am and 9:30pm. This team involved key people from hospital including the CCOT. The ITU fellow was usually part of the resuscitation team and told us they recorded the room number of any patient whom there were concerns about within the hospital. This helped them respond faster in the event of an emergency.
- We reviewed the 'transfer of critical care patients' policy. This policy was in place to ensure timely transfer of an intubated/critically ill patient from the CCU to a critical care unit within the London North West Critical Care Network or alternative hospital. The policy described the procedure staff must take in the event of a transfer/retrieval. Data showed that there had been two transfers in the 12 months preceding our inspection.

Nursing staffing

- There were eight Whole Time Equivalent (WTE) members of qualified nursing staff who worked across critical care including one WTE vacancy (12.5%), as of February 2017. There were seven staff in post, including ward manager, a sister and senior staff nurses. We requested the sickness rate and turnover rate from the hospital, but this was not provided.
- At the time of the inspection, nurses worked either day shifts or night shifts. Staff told us that newly employed nurses would work on an internal rotation contract and therefore worked both days and nights.
- Staffing levels were based on the Faculty of Intensive Care Medical Core Standards for Intensive Care Units. This states that all ventilated patients (level three) are required to have a registered nurses to patient ratio of a minimum of 1:1 to deliver direct care, and for level two patients a ratio of 1:2. Patient allocation records demonstrated critical care complied with the required staffing levels. Patients with additional care needs would be nursed by two nurses.
- New staff completed a period of supernumerary working supported by a mentor and were allocated a

Critical care

mentor to support them during the induction period. There were specific competencies in place that had to be signed off by their mentor before the staff member was able to work independently.

- Between October 2015 and September 2016, occupancy levels were low for both level two (26%) and level three (6%) beds. Staff told us there had been periods when the unit was busier than others and bank and agency staff had to be used. Best practice guidance suggests no more than 20% agency usage per shift. Nursing staff rotas we reviewed during our inspection demonstrated the service was not always compliant with this standard. Data provided by the service indicated between July 2016 and December 2016, the bank and agency fill rate ranged from a low of 22% and a high of 37%.
- Bank and agency staff underwent an induction programme to ensure they were competent to care for patients. We were shown evidence of this.

Medical staffing

- A total of five WTE consultants were in post across the critical care unit. In line with recommendations from the Faculty of Intensive Care Medical Core Standards for Intensive Care Units, 100% of consultants were Faculty of Intensive Care Medicine accredited or had suitable equivalent qualifications
- Consultant cover was in line with the Faculty of Intensive Care Medical Core Standards for Intensive Care Units recommendations that the consultant to patient ratio was between 1:8 and 1:15.
- The five consultants were working a one week in five rota to provide 24 hours seven days per week cover.
- The consultants we spoke confirmed they had other clinical commitments whilst on call. The consultants were shared with another independent hospital. Faculty of Intensive Care Medicine Core Standards guidelines state that consultant intensivists must be available at all times to offer consultant level care to patients as necessary. Consultants participating in the duty rota must not be responsible for delivering other services whilst covering the critical care unit and must be able to attend within 30 minutes. The service was not meeting this standard as should the consultants be required to attend both services at the same time, it would mean one of the hospitals would not have access to a

consultant within time and would potentially leave patients at risk. We were told by senior staff this had never caused an issue due to the low bed occupancy rates. However, there was no risk assessment so no formal plan on how the service mitigated this risk.

- Medical staff performed ward rounds twice daily, meeting the Intensive Care Society Standards.
- Consultants worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is given permission to work within an independent hospital. The medical advisory board (MAB) reviewed each application for practising privileges.
- The unit had seven ITU fellows who worked 24 hour shifts to provide 24 hours, seven days a week cover. All ITU fellows also held NHS contracts and had experience in intensive care and anaesthesia. This met the Intensive Care Society guideline for ensuring there was immediate access to a practitioner who had skills in advanced airways techniques.
- We reviewed the ITU fellow rota for January and February and saw there were 12 occasions where ITU fellows worked 48 hour shifts.
- All staff we spoke with confirmed there was good access to medical staff.

Emergency awareness and training

- All staff received fire training as part of the mandatory training programme. We saw a fire evacuation plan on the unit and staff were aware of it.
- The unit had run a practice of what to do in the event of an emergency.

Are critical care services effective?

Not sufficient evidence to rate 

Evidence-based care and treatment

- Policies and procedures were available on the hospital's intranet page. Intensive care specific policies and procedures were up to date and referenced to current best practice from a combination of national and international guidance. Staff showed us how they

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accessed these policies online and within a policy folder. However, agency nurses would not be able to access these policies online so could only access policies via the policy folder.

- We saw evidence in medical records of patients receiving physiotherapy as required by the Intensive Care Society Standards. However, this was not audited to ensure it was happening on a daily basis.
- We were told there was no formal audit calendar in place as per recommendations from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units. The hospital did not perform any local critical care audits except hand hygiene and record keeping. However, there were some hospital wide audits including nutrition.
- CCU was not participating in any quality improvement projects to ensure compliance with national guidance. However, senior leaders said this was partly due to the low numbers of patients seen in CCU.
- The Adult Critical Care Unit (ACCU) contributed to the Intensive Care National Audit and Research Centre (ICNARC) database for England, Wales and Northern Ireland. This meant care delivered and patient outcomes were benchmarked against similar units nationally.
- The hospital used a sepsis screening tool and sepsis care pathway based on the 'sepsis six', which is a national screening tool for sepsis. However, this was not audited.
- Patients were not daily assessed for their level of delirium as recommended by the Intensive Care Society Standards and NICE guidelines.
- We found no documentation to show the service was using and auditing care bundles. For example, we saw no evidence of compliance with ventilation care bundles within patients' medical records.

Pain relief

- Pain was assessed on an hourly basis as part of basic observations using a formal patient reported scoring system. Staff told us patients were asked to score their pain on a scale of one to ten. If a patient was unconscious, staff would look for signs of pain such as facial expressions and grimacing.

- Staff assessed pain using a 0-10 pain score. We saw evidence of staff assessing and recording patients' pain in medical records. We also observed a staff member asking a patient about pain during the inspection.
- There was no dedicated pain management team and pain was managed by the consultant or RMO with input from the nurses. Staff told us that one nurse had been sent on a pain management course.

Nutrition and hydration

- The service had access to an on call dietitian who was based at another hospital. This provision was not compliant with the British Dietetic Association recommended numbers for WTE dietitians for the number of critical care beds that were available (The British Dietetic Association recommends that there should be 0.05-0.1 WTE dietitian per 1 bed and that the lead dietitian for ICU should be at least a band 7). Although the services provision was not complaint with recommendations we saw from patient records that the needs of patients were still being met.
- We reviewed six patient records and found evidence of input from a dietitian in five out of six.
- We also found all six records had comprehensive fluid balance monitoring on the daily care charts. Staff used a nutrition scoring tool as part of the risk assessments but did not audit this.
- Patients were enabled to eat independently during mealtimes if possible. We observed that drinks were placed within the patients' reach
- Staff told us if a patient required enteral feeding, it was started upon agreement of the CCU medical team. Enteral feeding refers to the delivery of a nutritionally complete feed, containing protein, carbohydrate, fat, water, minerals and vitamins, directly into the stomach.
- Parenteral nutrition (PN) was started upon agreement of the CCU medical team. PN could be started out of hours or at weekends by critical care staff. Parenteral nutrition (PN) is the feeding of a person intravenously, bypassing the usual process of eating and digestion. The person receives nutritional formulae that contain nutrients such as glucose, salts, amino acids, lipids and added vitamins and dietary minerals.

Patient outcomes

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- The critical care service contributed data to the ICNARC database for England, Wales and Northern Ireland. This meant care delivered and patient outcomes were benchmarked against similar units nationally. ICNARC data quoted relates to the period from April 2016 to June 2016.
- ICNARC data showed there were no deaths on the CCU. This represented a unit mortality rate of 0% which was better than the expected mortality rate for each unit.
- The mean length of stay reported by ICNARC stay was 2.6 days which was less than other similar units (2.8 days).
- Patients discharged 'out of hours' between 1pm and 7am were associated with worse outcomes and ICNARC data demonstrated the CCU unit was performing slightly better than (0%) other similar units (0.4%).
- ICNARC data showed there were no unplanned readmissions to the CCU within 48 hours of discharge, which represented 0% of patients admitted to the unit in this period. This was better when compared to other similar units (1.1%).
- The unit had not conducted any quality improvement projects at the time of the inspection.

Competent Nursing Staff

- The appraisal rate for staff across the unit was 100%. All staff told us they had had an appraisal within the past 12 months.
- There was no clinical educator for intensive care available for staff. This was against Core Standards for Intensive Care units. However, the CCU shared a practice development nurse with the rest of the hospital.
- All new nurses working in critical care were allocated a period of supernumerary practice, during which they were expected to complete a series of competencies which had to be signed off prior to independent working.
- When staff completed the supernumerary period, they progressed to the National Competency Framework for Critical Care Nurses – Step one. This is a competency-based programme for staff to develop core skills in caring for critically ill patients under supervision from a mentor or practice development nurse. However, the service did not have its own practice development

nurse. Overseas nurses had to provide the hospital with a copy of their ICU or equivalent certificate. We were told the hospital had a train the trainer programme and critical care staff had competencies assessed and signed off by critical care trainers.

- The Core Standards for Intensive Care Units (2013) recommend that a minimum of 50% of registered nurses should be in possession of a post registration course in critical care. At the time of the inspection, the unit was achieving 100% for this standard.
- Bank and agency staff underwent an induction programme to ensure they were competent to care for patients. We were shown evidence of this.
- We found no evidence that regular teaching sessions for nurses were taking place on CCU.
- Senior leaders told us one of their main concerns about the service was staff becoming deskilled due to low occupancy levels of critical care patients. A number of nurses also raised this issue. We were told when the service was not busy, nurses would be sent to work on the medical wards within the hospital. Nurses felt this was not appropriate. Senior leaders told us they had considered a number of ways to ensure staff remained up to date with competencies. However, there was no formal plan in place for this.

Competent Medical Staffing

- All consultants were identified for suitability via the consultant selection and review committee (CSRC) with approval from the medical advisory committee (MAC). Once approved, the medical director sent a letter of invitation. Consultants were then invited to join the staff list and were either offered admitting or practising privileges. Once the consultant accepted the invite, a meeting was held with the chief executive and matron to discuss ways of developing the best possible working relationship. All consultants had their GMC registration checked on an annual basis as part of the clinical governance.
- Consultant anaesthetists were not formally invited to join the staff but had to be recommended by a consultant currently on the staff list.
- Consultants with practising privileges had their appraisals and revalidation undertaken by the NHS trust they had contracts with.

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- For ICU fellows, their appraisal and revalidation was undertaken at their primary work place of work. They also had an annual appraisal within King Edward the VII undertaken by the lead consultant.

Multidisciplinary working

- The critical care outreach team (CCOT) was responsible for reviewing patients in other areas of the hospital to determine their need for admission to critical care. There were written guidelines which advised when patients should be escalated to the CCOT, for example those with a NEWS score of five or more.
- There were daily resuscitation meetings in which CCOT were made aware of any patients who may be at risk of deterioration within the hospital. The ITU fellows made a note of these patients' bed numbers to speed up response times should they be required to attend to the patient.
- We observed no multidisciplinary team meetings (MDT) during our inspection on CCU. Staff told us there were no formal MDT meetings planned. However, discussions between the consultant, nursing staff, pharmacist and physiotherapist occurred on a daily basis as and when required for each patient. We observed discussions between different disciplines and observed a friendly, relaxed and professional atmosphere in which all staff were encouraged to participate and speak.
- All staff we spoke with said there was good MDT working between nurses, doctors and physiotherapists. Physiotherapists worked closely with ward staff to implement rehabilitation plans for each patient and we saw nursing staff and therapists working together to complete one patient's tasks and rehabilitation during the inspection.
- The CCU ITU fellows provided cover for 24 hours, seven days a week. The consultant intensivist was available 24 hours a day, seven days a week and was available to attend the unit on call.
- We looked at six sets of patient records and all of them showed evidence of physiotherapy sessions. Physiotherapy service was available seven days a week.
- There CCU did not have a dedicated occupational therapist (OT). This did not meet the ICS

recommendation of 0.22 WTE OTs per level three bed. We did not see any evidence of OT input in the notes we reviewed. We were told OT were accessed via the bank staff system.

- The Faculty of Intensive Care Medicine states that patients should have access to SALT staff with critical care experience. We were told SALT was only provided on a referral basis.

Access to information (critical care only)

- Staff obtained information via the hospital's intranet and shared drive. This included policies and procedures. Staff found it easy to use and gave us a demonstration. Agency staff were not able to access policies on the hospital's computer, however, a number of policies had been printed off and added to a folder for staff to access.
- When patients were admitted to ACCU, a verbal handover was provided to the medical and nursing staff as well as written information in the patient records.
- Staff had access to patients' care plans, risk assessments and medical notes in the patients' records folder. It also contained other information such as test results, reports and letters.
- Patients could access investigations such as blood tests, X-rays and CT scans 24 hours per day, seven days per week. Staff reported there was no difficulties for accessing this type of support services and told us urgent investigations for critical care patients were prioritised. Staff accessed results of diagnostic investigations via digital services. If required, hard copies could be printed off and added to the patients' medical records.
- The ITU fellow wrote discharge letters before discharging patients to the ward. We saw discharge letters in medical records we reviewed and they contained all relevant information. A second letter was written by the consultants' secretary.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff we spoke with understood the need to obtain consent from patients before performing care tasks,

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investigations or giving medications. Where staff could not obtain consent, for example unconscious patients, staff explained they provided care in the patients' best interests.

- We reviewed six patient records and found completed consent forms in each of them.
- Staff told us Mental Capacity Assessments were completed for people who they believed may lack the capacity to consent. In patient records, we saw staff had ticked that capacity assessments had been completed. However, we found no capacity assessment documentation in any of the six records we reviewed.
- Staff's knowledge of Deprivation of Liberty Safeguards (DoLS) was good. Staff could explain the principles behind DoLS and were clear how this was applicable in a critical care setting. For example, staff knew to use hand mitts, a DoLS assessment needed to be completed.

Are critical care services caring?

Not sufficient evidence to rate 

Compassionate care

- There were very few patients on the critical care unit (CCU) during the inspection. However, we were able to observe some interactions between staff and patients and saw staff speaking to patients in a calm and reassuring manner.
- We observed staff chatting with patients and asking them questions about their interests. We spoke with one patient who said staff made them feel comfortable.
- We observed staff maintaining patients' privacy and dignity at all times by keeping them covered and drawing the blinds. Staff took extra care to ensure blinds were fully closed during ward rounds and when discussing care with patients.
- All staff treated patients in a compassionate and courteous manner.
- We observed physiotherapists encouraging patients with their rehabilitation in a supportive and positive way.

- We observed thank you cards expressing gratitude and compliments from previous patients about the care they received. Comments included: 'Thank you for the extraordinary care', 'Staff are dedicated and kind', 'Hard working'.
- The information board on the CCU displayed some data from a patient satisfaction survey. The CCU asked patients and relatives if they would recommend the service to their friends and family, 99% said they would. In addition, 100% of respondents rated the service as excellent.

Understanding and involvement of patients and those close to them

- Discussions with patients and relatives were evident in the medical records we looked at, including discharge planning, obtaining consent and planned treatments.
- We observed staff interacting with patients and involving them in decisions about their care, for example one patient was discussing food intake with a nurse.
- Staff ensured patients were fully informed before completing any interventions. For example, we observed a physiotherapist explaining some exercises to a patient.
- When patients were thought to have brain stem death or if there was a plan to withdraw life-sustaining treatment, the possibility of organ donation was discussed with the patients' next of kin. There was a policy in place to advise staff on how this should be approached.

Emotional support

- The hospital's matron visited all patients individually on a regular basis to ask how they were and see if they had any concerns.
- Staff told us they provided emotional support to patients routinely throughout their shifts. We observed staff offering words of encouragement to patients and reassurance when the patient was struggling with tasks.
- There was no chaplaincy service within the hospital. However, patients and relatives could request this.

Are critical care services responsive?

Critical care

Not sufficient evidence to rate

Service planning and delivery to meet the needs of local people

- Critical Care Unit (CCU) served a combination of specialities, including post-operative patients and medical patients. Patients could be admitted after elective or emergency operations or after becoming medically unwell on hospital wards.
- There had been no elective surgeries cancelled due to a lack of critical care beds in the 12 months prior to our inspection
- The CCU could flex patient distribution to respond to patient need. For example, CCU was intended to care for up to four patients. There were four beds which staff said could be used as both level two and level three beds.
- ICNARC data from April 2016 and June 2016 showed that CCU primarily admitted planned admissions following elective/scheduled surgery (58.3%). Admissions from wards or intermediate care area represented 33.3% of admissions. Patients transferred from an emergency department not in the hospital and unplanned admission following elective surgery both represented 4.2%.
- Unplanned admissions to the ACCU were referred to the consultant on duty and ICU fellow who were responsible for deciding whether patients should be admitted for care.

Access and flow

- The critical care unit had an admission policy and admission to critical care was usually agreed by the consultant on shift. For planned admissions, the admitting consultant had to book the admission to critical care unit (CCU) via the hospital's admission office. The policy stated that at no time must a patient be admitted to CCU without the consultant's permission, except in an emergency. In the event of an emergency, the hospital's resident medical officer (RMO) would instigate the admission with the Intensive Care Unit (ITU) fellow.

- Service leads told us the CCU did not treat patients with acute cardiology and acute stroke, however these conditions were not documented as exclusions within the CCU admission policy. We asked if the service had any service level agreements (SLAs) with other hospitals. We were told there was no SLA for stroke patients and a SLA for cardiac patients was under review. The hospital told us there were responsive procedures in place to manage these patients, however this was not a documented procedure.
- The unit cared for 127 patients between January 2016 and January 2017. There was one death reported in CCU during this period.
- There were 730 level two critical care bed days available in the hospital between October 2015 and September 2016. Of these, 193 level two beds were used, giving an occupancy rate of 26%. There were 730 level three bed days available in the same period and 41 level three bed days were used. This gave an occupancy rate of 6%.
- These occupancy rates were in line with the Royal College of Anaesthetists recommendation of 70% critical care occupancy. The recommended occupancy rates allow units to be able to take in more patients should there be an emergency. If a unit is at higher occupancy, it may be unable to respond to emergency admissions and may be required to step down patients too early.
- Recommendations from the Faculty of Intensive Care medicine Core Standards for Intensive Care Units identify that patients should not be transferred to other units for non-clinical reasons. ICNARC data from April 2016 to June 2016 showed there were no patient transfers out of the unit for non-clinical reasons on CCU, which was in line with other similar units.
- ICNARC data for April to June 2016 showed there had been 0.2% bed days of care post eight hour delayed discharges, which was higher than similar units (0.1%)
- There had been 0% bed days of care post 24-hour delayed discharges in the same period. This was the same as other similar units (0%).
- In the 12 months preceding our inspection 12% of discharges were delayed discharges.

Meeting people's individual needs

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- The hospital offered 'respite and aftercare packages' to patients as an interim step between hospital discharge and returning to home. Patients could access services such as massage, reflexology and occupational therapy at an additional cost.
- Visiting times on the CCU were between 10am and 9pm each day and we saw signs informing patients to contact the nurse in charge should they require visiting outside of these hours. Staff across the ACCU told us there was flexibility with visiting times if needed.
- There was a quiet room available for relatives. The room could also be used for difficult or confidential conversations with relatives.
- A drinks vending machine was available in the relatives room for relatives to make hot and cold drinks.
- Staff told us they could book translators for face-to-face consultations and told us services were available in a range of different languages. Staff told us that a number of staff could also speak second languages and this also aided with translation.
- The hospital offered a variety of food menus including light diet and gluten free. There was also a range of food choices for patients, including vegetarian and diabetic. Additional specific dietary requirements could be requested.
- The hospital did not have accommodation on site for relatives. Staff told us that sometimes beds in the day care unit could be used for relatives. However, this was only if the unit was not being used.
- Relatives and patients could request access to a multi-faith chaplaincy service and information on how to access this was displayed on the unit. However, we were provided with no information on how often this service was used by critical care patients and relatives.
- At the time of the inspection, there were no patients on the ward with learning disabilities. Staff told us they had received no training on mental health or learning disabilities. The hospital had no link nurses for these types of patients.

- Staff had not received training on dementia and did not understand the needs of patients living with dementia. However, senior leaders told us the dementia pathway was currently under development and staff would receive training in the near future.
- There were two leaflets available on critical care, including an information leaflet about the service and a leaflet for respite and aftercare packages. However, these were only available in English.

Learning from complaints and concerns

- Information on how to make a complaint was available in the services information book "Your Stay Book" which was available at each patient's bed space.
- Patients were advised to make any complaints to the senior nurse in charge who escalated to the matron. Staff told us that the service would aim to resolve the complaint informally immediately.
- However, if patients or relatives were still unhappy, a formal complaint could be raised. The complaint would then be logged and follow the hospital's formal complaints process. The CCU had received no formal complaints within the past 12 months.
- We asked the ward manager how many complaints there had been within the service over the past 12 months. The ward manager was unable to provide us with this information and told us the hospital's deputy matron dealt with complaints.

Are critical care services well-led?

Requires improvement 

Leadership and Culture of Service

- Clinical leadership of the critical care unit (CCU) was the responsibility of the CCU ward manager who reported to the hospital matron. One sister supported the ward manager in her duties.
- The clinical lead for the CCU worked closely with the ward manager and led the consultants and junior doctors. The clinical lead was a critical care consultant.
- During our inspection, we noticed senior staff were visible on the wards and knew ward staff across the

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service. Staff across critical care spoke positively about the senior leaders, praising their supportive attitudes and open approach to management. Staff told us that they were readily available and approachable.

- There was an open door culture encouraged on critical care and staff told us they would feel comfortable raising any issues with the CCU matron and ward manager.
- Staff commented there was a culture of 'no blame' should things go wrong. We reviewed ward meeting minutes and saw an incident had been discussed and staff were told not to worry.
- We observed information leaflets on the unit encouraging staff to speak up (whistleblowing) if they saw something was being done wrong.
- Staff at all levels were proud to work for the service and told us they had good working relationships with each other and morale was good. We observed staff work together to complete tasks and ensure suitable patient care took place.
- Staff understood the importance of being open and honest when things went wrong. However, not all staff knew what duty of candour was and there had been no training on duty of candour.

Vision and Strategy for this core service

- The leadership team of the CCU told us their plans were to increase the number of patients on CCU. The introduction of Intensive Care Unit (ITU) fellows was the first step in this process. However, there was no formal strategy in place to show the steps the CCU would take to increase patient numbers. In addition, we had concerns regarding consultant cover and ICU fellow cover should the number of patients increase.
- The hospital's vision was 'to be recognised as a highly regarded private hospital, with a charitable conscience, delivering clinical excellence within a culture of kindness'.
- Staff knew how their work contributed to the wider vision of the hospital and were aware of the hospital's values. Staff told us values were discussed during the induction and were embedded in their practice.

Governance, risk management and quality measurement (medical care level only)

- Service leads told us the CCU did not treat patients with acute cardiology and acute stroke, however, these conditions were not documented as exclusions within the CCU admission policy.
- There was a sepsis protocol in place at the time of the inspection. However, the hospital had no sepsis lead and the CCU were not conducting audits to assess sepsis compliance.
- We had no assurances that CCU were following evidenced based guidelines and practice as there were no audits assessing compliance. There was a general lack of audits and quality improvement projects and no formal audit calendar was in place.
- Service leads told us there had been no serious incidents over the past 12 months. This conflicted with information provided by the hospital, which indicated there had been one serious incident. Therefore, we had concerns that senior leaders on the ward did not have appropriate oversight of incidents. We asked the service to provide us with the incident investigation report and were provided with an incident review form. The incident reported was a resuscitation event. We found no evidence of action plans as a result of the report's recommendations. Staff were unable to describe learning from incidents. There were CCU staff meetings on a monthly basis. We reviewed two sets of meeting minutes and found no evidence that incidents, complaints and action points and learning were discussed. We were therefore not assured there were appropriate systems in place at a leadership level to ensure incidents were investigated and learning shared to all staff.
- The risk register did not demonstrate that identified risks were fully mitigated. For example, the risk listed as 'patient develops infection from invasive lines' was identified as being mitigated by ensuring lines were inserted as per hospital procedure. However, we found no evidence that this was being monitored or audited to ensure compliance.
- We asked senior leaders what they felt was the main risk to the CCU. They told us that occupancy levels on CCU and staff becoming deskilled was their main concern.

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Staff also identified this as a concern. However, this was not included in the service's risk register and we found no formal plan in place to ensure staff skills were kept up to date.

- The CCU were not meeting recommendations for consultant cover as consultants were shared with another hospital. Senior leaders told us they wanted to increase the number of patients seen at CCU. We had concerns there were no formal plans in place to ensure appropriate consultant cover. We were told there was a second rota agreed verbally, but this could not be evidenced. This was also not on the service's risk register.
- There was a defined governance structure within the hospital. There were quarterly clinical governance meetings, which looked at patient satisfaction, incidents and risk. Senior leaders of CCU told us they fed into this meeting and were part of the structure.
- The CCU had monthly senior clinical team meetings, which involved the ward manager and the clinical lead. We reviewed five sets of meeting minutes and saw the CCU activity, finances, staffing and recruitment, marketing, ICNARC and resuscitation were regular agenda items.

Public and staff engagement

- Staff received information via emails, newsletters and regular meetings. Staff were regularly asked to give feedback about concerns and changes were made. For example, the controlled drugs fridge was updated due to issues raised by staff.
- Patient satisfaction surveys were given out to every patient on discharge. Patients could also complete the





survey online and via a ward based tablet. Comments were reviewed as part of a hospital wide patient satisfaction working group who met on a quarterly basis. Staff told us common themes were utilised to improve and develop the service.

- There was a hospital wide employee satisfaction survey carried out in November 2016. The report included comparisons with external benchmarks of 70 other organisations. The overall engagement index (number of positive responses) was 72% which was in line with external benchmarks (72%). The report included details of areas that required further development including career prospects and equal opportunities.

Innovation, improvement and sustainability

- We had concerns around the sustainability of staff skills on critical care. Senior leaders identified staff becoming deskilled due to low occupancy levels of critical care patients as a concern within the service. A number of nurses also raised this issue. Senior leaders told us they had considered a number of ways to ensure staff remained up to date with competencies. However, there was no formal plan in place for this. There were also no regular teaching sessions for staff nurses.
- Critical care were collaborating with the Royal College of Art on developing a patient centre intervention, aimed at enhancing patients intensive care experience. An application is being developed that aims to identify a patients sensory preferences ranging from sounds to smells and relaxing photos. The app will then generate a mood board of patients sensory stimuli . which will be used as part of a schedule. The aims is to help reduce boredom, provide structure to the day, help orientation and humanise a patients ITU experience.

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Requires improvement 

Incidents

- There were no never events reported in the period October 2015 to September 2016 specific to outpatients and diagnostics. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- No serious incidents were reported for the outpatient and diagnostic services in the same period. A serious incident requires investigation and can be identified as an incident where one or more patients, staff members, visitors or member of the public experience serious or permanent harm, alleged abuse or a service provision is threatened.
- There were nine clinical incidents reported for the outpatient and diagnostic services in the period October 2015 to September 2016. One of these incidents resulted in moderate harm related to medication given in a lower dose because a member of staff used an incorrect syringe. Other incidents caused low or no harm. Documentation and medication errors each represented a third of all incidents. The rate of clinical incidents in outpatient departments was similar to the rate of other independent acute hospitals we hold this type of data for in the same reporting period.
- There had been no ionising radiation (medical exposure) regulations (IRMER) related incidents in 2016.
- Incidents were reported using an electronic reporting system. Staff were able to tell us how to report incidents and felt encouraged to do so. We saw an example of a thorough investigation started after a reported incident during inspection.
- Incidents were discussed at monthly departmental meetings for outpatients and diagnostic imaging. Learning from incidents were cascaded through departmental team meetings, we saw evidence of this in meeting minutes. Outpatient staff we spoke with could provide examples of incidents and learning, however a significant portion of staff in the hospital felt learning from incidents could be improved as explained in the surgery section of the report.
- The duty of candour is a regulatory duty that related to openness and transparency and required providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- All staff we spoke with were aware of the duty of candour and were able to give us examples of when it was applied, for example after a patient had to return to have tests repeated as initial specimens were not correctly labelled. We were further shown evidence of written apologies of when duty of candour was applied.

Cleanliness, infection control and hygiene

- All clinical and waiting areas we visited were visibly clean and tidy.

Outpatients and diagnostic imaging

- We observed completed cleaning checklists for the current week in all outpatients areas and radiology.
- Policies for the prevention and control of infections were in place and staff knew how to access them. The hospital employed a lead infection control and prevention nurse as mentioned in the surgical core service and medical core service sections of the report.
- We observed staff adhering to “bare below the elbow” guidelines and being compliant with recommended hand hygiene practices.
- There were sufficient hand wash basins and hand sanitisers available in outpatients and radiology. Posters with illustrated hand wash instructions were placed above each basin.
- We saw bright ‘I am clean’ stickers on equipment with information about when it was last cleaned.
- We saw that sharps bins were signed and dated and not overfilled.
- Hand hygiene audit data showed 100% compliance for the imaging and outpatients departments in 2016.
- Disposable curtains in consultation and treatment rooms were dated when they were put up and when they were due to be changed.
- Local rules were seen on each modality of the radiology department with the names of the radiation protection supervisors and radiation protection advisor. These rules summarise the key working instructions intended to restrict exposure in radiation areas.
- ‘PAUSED’ posters were on display at each modality to remind staff to ‘pause and check’ patients’ identification. This followed IRMER guidance for patient identification checks.
- All clinical staff in the radiology department had valid radiation monitoring badges.
- There were emergency call bells in all clinical rooms and toilets and at reception.
- Safety testing stickers were seen on equipment across the outpatients and diagnostic imaging departments. With one exception, all equipment we reviewed had stickers that indicated that safety testing was within required timeframe.
- We noticed an ultrasound machine in outpatients, which belonged to one of the consultants and did not show recent safety testing. Consultants were informed during induction about their duty to inform the hospital about any personal item of equipment used in clinics. However, in this case staff were not aware of it. The ultrasound machine was removed for safety check.
- The equipment inventory list for diagnostic imaging was incomplete as it did not include date of manufacture.

Environment and equipment

- The environment of the outpatients and diagnostic imaging departments was adequate and well maintained. Patient waiting areas were clean and bright with sufficient seating for patients and relatives. All clinical areas seen in the outpatients and diagnostic imaging departments were visibly clean and tidy.
- Consultant rooms were spacious and adequately furnished. Each room was partly carpeted and had a separate clinical area with examination bed and clinical hand wash facility.
- Maintenance contracts were in place to ensure specialist equipment was serviced regularly and repaired. We were shown evidence of this. A monthly quality assurance programme was undertaken by radiographers, evidence of this was seen from May 2016. We further saw evidence of daily quality assurance for diagnostic equipment. This was in accordance to IRMER requirements.

Medicines

- All medicines in the outpatients department were stored securely in locked cupboards in a room with a swipe card lock, enabling only authorised personnel to enter.
- We found one of the drugs in the drug cupboard to be out of date. However, the hospital immediately reported this as an incident and initiated an investigation. We were shown documentation of quarterly drug cupboard checks undertaken by the hospital pharmacist.
- The fridge and drug room temperatures were monitored electronically. Pharmacy and matron’s office would be alerted in case temperatures were out of range.

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- The hospital did not have a pharmacy for the outpatients department. Consultants used their prescription pads to write prescriptions, which patients could use in any external pharmacy.
- Prescription pads were stored securely in a locked cupboard and individually handed over to the consultants and collected afterwards.
- Contrast media and other drugs used in the diagnostic imaging department were stored securely in a locked cupboard.
- For our detailed findings on medicines please see the Safe section in the Surgery report.

Records

- The hospital did not maintain complete records for all outpatients. All patients were registered in a hospital wide electronic hospital management system with information about attendances, treating consultants and alerts for specialist requirements such as wheelchair access. The data did not regularly include medical documentation. The outpatients department used different types of systems for record keeping, depending on the consultant. Most consultants brought patients' notes to their clinics and left with them afterwards. This meant that the hospital did not have records of the care and treatment the patients had received. Some consultants used their own electronic patient record system, storing records on a separate, secure server, which hospital staff did not have access to. To retrieve information from medical records, hospital staff would have to contact the relevant consultant. However, there had been no incidents in the reporting period for failure to obtain patient information. The diagnostic imaging department used paper referral forms and an electronic patient management system. Patients' referral forms were scanned and attached to patient files and readily available to view.
- The referral forms in the diagnostic imaging department stated that patients must be 16 years and above, although the hospital did not treat patients under the age of 18 years. Staff told us that the age restriction was implemented very recently and referral forms still

needed to be replaced. Staff reassured us that all staff were aware of the change and that it had been communicated in writing to all consultants holding practising privileges at the hospital.

- Throughout the areas we visited we found no patient identifiable documentation or information openly displayed.

Safeguarding

- Safeguarding policies and procedures were in place. These were available for staff to refer to on the hospital's intranet. Staff were aware of their roles and responsibilities to safeguard people and knew how to raise matters of concern appropriately.
- Hospital data showed 100% compliance with safeguarding training of vulnerable adults and young people up to level two and 100% compliance with safeguarding training level three for outpatients staff and the imaging manager. However, safeguarding training was provided by an external organisation and senior leaders said the company could not confirm in writing that training was to level two or three.
- There were chaperone signs throughout the outpatients and radiology department advising how to access a chaperone should they wish to do so.
- Staff in the outpatients department undertaking chaperoning were staff nurses and health care assistants. All were aware of the chaperone policy and had received in house training. The health care assistants were booked to attend additional external chaperone training in June 2017.

Mandatory training

- Staff received mandatory training on a rolling annual programme which was provided through a mix of classroom based sessions and e-learning. Topics included: basic life support, medical gases, incidents, clinical update, data protection, risk assessment, bullying and harassment, equality and diversity and stress essentials. Mandatory training completion rates for staff were 100%, except for clinical update (86%), against a hospital target of 100%. One member of staff was overdue for intermediate life support training. To maintain and improve compliance rates, the hospital implemented a compliance programme linked to the

Outpatients and diagnostic imaging

e-learning system which allowed managers to have better overview of training compliance. They further reviewed training days, offering training on different days at different times.

Assessing and responding to patient risk

- Emergency resuscitation equipment was in place in the outpatients and diagnostic imaging departments. Resuscitation trolleys were checked daily in line with national resuscitation council guidelines. The outpatients department was further equipped with wall mounted and portable oxygen and automatic external defibrillators on the first, second and third floor.
- Staff were able to describe the procedure of what to do if a patient was suspected of suffering from a cardiac arrest or anaphylaxis. All staff knew the hospital internal crash team number.
- Basic life support training was part of mandatory training for outpatient and diagnostic imaging staff. Data showed 100% compliance. Training rates for intermediate life support were 86%.
- Clear signage and safety warning lights were in place in the radiology department to warn people about potential radiation exposure.
- Diagnostic imaging department used the six point identification check as required by IRMER. In addition we saw staff check patients against their scanning area and ask patients what procedure they were booked for.
- The radiology department used a patient safety questionnaire for MRI in order to ascertain if the patient had any metal objects inside their body, the radiographers would then assess whether it was safe for the patient to have the scan. The department also had questionnaire for patients prior to administration of contrast media to ascertain if the patient suffered from any relevant allergies or conditions which put them at risk of anaphylaxis.
- Staff told us they checked female patients' pregnancy status in the radiology department before any x-ray exposure. If a patient was not sure and refused a pregnancy test, imaging tests were not performed.

Nursing and radiology staffing

- Hospital data showed that the outpatients department had a planned establishment of five whole time equivalent (WTE) nurses and one WTE health care assistant as of October 2016.
- There were no staff vacancies in the outpatient department. However, during the inspection we learned that staffing numbers had been recently increased for the outpatients department due to increased activity and opening hours and two additional health care assistants had been recruited to support staff nurses.
- The rate of use of bank nurses in the outpatients department was 6% between October 2015 and September 2016. This was lower than the average of other independent hospitals we hold this type of data for.
- The senior staff nurse told us they did not use agency staff in the outpatients department but relied on permanent or bank staff. Data provided by the hospital confirmed this.
- There were two radiation protection supervisors working in the diagnostic imaging department. We were shown evidence that their training was in date.
- Eight senior radiographers and one imaging assistant provided services in the imaging department, together with a superintendent radiographer and the imaging manager. Two imaging secretaries and an office manager further supported the department.
- A radiographer was on-call seven days to provide general x-ray and CT services.

Medical staffing

- Consultants worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. Consultants were invited to join the staff at the hospital following identification of suitability via the Consultant Selection & Review Committee (CSRC) with approval required at the Medical Committee, before the Medical Director sent a formal letter of invitation. Most consultants with practising privileges had their appraisals and revalidation undertaken by their respective NHS trusts.

Outpatients and diagnostic imaging

- There were 233 consultants with practising privileges attending the hospital, however, not all of them regularly saw patients in outpatients clinics. A total of 35 radiologists worked in the imaging department and breast centre.
- The breast centre was set up with eight breast surgeon consultants and seven radiologists who worked in the breast unit exclusively and undertook ultrasound guided biopsies.
- A general radiologist and a neuro-radiologist were on-call seven days to report images, perform ultrasound examinations or minor interventions.
- The breast centre undertook a number of audits including pathology audit (to ensure results are sent and received), recall audit, infection control cleaning audit. However, we were not provided with results from these audits.
- Outpatients policies were accessible on computers in a shared document folder. We sampled 'colposcopy' and 'pathology collection' policies, both were in date with information when to be reviewed.
- The MRI and CT scans and cardiac CT network were externally accredited.

Emergency awareness and training

- The service had a contingency business plans in place in case of an emergency. Staff had awareness of what actions they would take in the event of a major incident, including a fire. Across the hospital, 100% of staff had completed fire safety awareness training as part of their annual clinical update.
- All staff received fire training as part of the mandatory training programme. We saw fire evacuation plans in the departments and staff were aware of them.
- Department specific evacuation procedures and department specific business continuity plans were available. Staff knew where to access this.

Are outpatients and diagnostic imaging services effective?

Evidence-based care and treatment

- Radiation protection meetings were held yearly and would be held six monthly from 2017. We were shown minutes of previous meetings, which included action points assigned to individuals with deadlines. The purpose of these meetings was to monitor radiation safety throughout the hospital.
- Radiology dose reference levels were audited in the department and compared to national levels. We saw a list of expected doses in the CT room.

Pain relief

- Consultants assessed patients in their clinics and administered or prescribed pain medication accordingly.
- A dedicated pain clinic was located on the fourth floor of outpatients department with consultants and physiotherapists treating patients.
- The hospital's resident medical officers could be used to assess patients and prescribe pain relief in cases requiring urgent attention.

Patient outcomes

- All diagnostic images were reported within 48 hours unless the referrer requested earlier. This was compliant with national guidelines for radiological reporting. This included all images being quality checked by radiographers before the patient left the department.

Competent staff

- Nursing staff and health care assistants we spoke with confirmed they were encouraged to undertake continual professional development and were given opportunity to develop their skills and knowledge through training relevant to their roles. For example phlebotomy training or specialist course for endometriosis or urology.
- New staff underwent a three week induction programme. We were shown a comprehensive induction folder for one staff member.
- The hospital employed specialist nurses for breast care, fertility, endometriosis, urology, orthopaedics and pain who worked in the outpatients department in specialised clinics.

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- Radiographers held complete modality specific competencies. The imaging manager kept hard copies of this in his office as well as an electronic spread sheet with RAG (red, amber, yellow) rating and dates of competencies.
- All radiographers' HCPC (health care professional council) status were kept by the imaging manager, including expiration dates.
- We saw evidence of staff appraisals 2016. According to hospital data, appraisal rates were 100% for outpatients and diagnostic imaging department staff.
- There was no signatory list or evidence that staff had read local rules or IRMER procedures.
- The hospital ensured consultants' revalidation by checking their GMC (general medical council) registration status annually. This was obtained online and the date recorded on the consultant's file. Any doctor losing registration may not practise and must inform the hospital, as stated in the practising privileges document. See Surgery core service for additional information.

Multidisciplinary working

- There were good working relationships between consultants, nurses and allied health professionals. Members of the physiotherapy team worked closely with consultants in the pain clinic, treating patients jointly, for example.
- Consultants of different specialities worked together to achieve optimal results for patients, for example breast surgeons with plastic surgeons in the breast unit.
- The breast centre held monthly multidisciplinary team (MDT) meetings to discuss complex cases. We saw meeting minutes of comprehensive discussions.

Access to information

- All staff had access to policies, procedures and guidelines on the hospital's intranet.
- The diagnostic imaging department used a nationally recognised electronic system to report and store patient images. It was used across the hospital and allowed quick access to images.

- A list of referrers for the imaging department was held electronically, accessible to staff. This is in accordance to IRMER recommendations.
- Tests and scan results taken within the hospital were available to view on one of the hospital's electronic patient management systems. Any inpatient records could be requested from medical records.
- However, the outpatients department did not keep medical records of patients attending clinics, outpatient records were kept by the consultants. The hospital's electronic patient management system did not regularly include medical documentation. Therefore, hospital staff did not have access to information in outpatients' medical records.

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. Mental capacity act training was part of mandatory training and compliance rate for outpatients and diagnostic imaging staff was 86% in January 2017.
- The hospital had a consent policy in place and staff were aware of it and knew how to access it. Consent was obtained prior to the delivery of care and treatment. Radiographers obtained written consent from all patients before procedures. We were shown evidence of this.

Are outpatients and diagnostic imaging services caring?

Good 

Compassionate care

- We observed staff addressing patients in a polite and friendly manner and actively offering their assistance.
- The patients and relatives we spoke with gave very positive accounts of their experiences with staff and the hospital. Two patients mentioned they were 'very pleased with the hospital and consultations'.
- This was also reflected in the friends and family test for the outpatients and diagnostics services, which asked patients how likely they would recommend the hospital

Outpatients and diagnostic imaging

to friends and family. In the first half of 2016, 96% were extremely likely or likely to recommend the outpatients service to friends and family. In the second half of 2016, the rate was 100%. Data showed that 51 and 39 patients, respectively, participated in the test.

- Patient satisfaction results for the outpatients and diagnostics services of quarter 2016 showed a participation rate of 21%, which was lower than compared to other similar hospitals (25%). Overall, 94% of patients rated consultants as 'excellent', 75% patients rated outpatient nurses as 'excellent' and 77% rated x-ray/imaging as 'excellent'. However, including the results for a 'very good' answer, the rates were 100%, 93% and 95% respectively.
- Patients' privacy was respected and we observed closed doors or drawn curtains when having consultations or treatment. Staff respectfully knocked on doors before entering consulting rooms. This enabled an atmosphere for patients to feel safe and allow confidential conversations.
- We observed a member of the reception team of the main building accompany a patient to the outpatients department to make sure they arrived there without delay.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us they were given sufficient time during consultations and did not feel rushed. They felt involved in their care and treatment and felt well informed.
- One patient we spoke with said she was fully aware who she was going to see and what was happening.
- Patients we spoke with felt well informed about fees. One patients said there were 'no surprises' regarding cost of treatment.
- We observed nursing staff taking a blood sample from a patient. The nurse explained in a friendly and professional way how the sample would be retrieved and reassured the patient.
- The outpatients department collected patient feedback using a patient satisfaction questionnaire. We saw these questionnaires throughout the departments for patients to pick up.

Emotional support

- Nursing staff provided emotional support to patients in the outpatients department. Staff explained how they gave patients time in a quiet environment when needed.
- Staff told us how they would support each other as a team, including consultants, in stressful situations.
- There was no in house counselling service for outpatients available.
- The breast care unit recommended a local breast cancer support centre and provided leaflets to patients to help cope with emotional effects of breast cancer.

Are outpatients and diagnostic imaging services responsive?

Good



Service planning and delivery to meet the needs of local people

- The waiting areas were furnished to a high standard and provided sufficient comfortable seating. There was a range of free hot and cold beverages available as well as newspapers and magazines to read.
- There were eleven consulting rooms in the outpatients building and three additional rooms in the main hospital building. All were spacious and appropriately furnished with a separate clinical area and hand wash facility.
- The outpatients department offered a late clinic to 9 pm once weekly, staff told us that this was well received by patients. The diagnostic imaging department offered services on Saturdays. This allowed easier access for patients who worked during the week.
- The hospital kept an emergency bed available for urgent admissions from the outpatients department.
- A urology consultant explained how he had been able to offer a one-stop service for his patients due to same day access to diagnostic services.

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- The breast unit offered a one-stop service for patients, which included consultation, ultrasound, mammography and biopsy if required. Radiologists dedicated to the breast unit reported images immediately.
- There was adequate signposting in all areas and good lift access.

Access and flow

- Patients were able to book appointments over the phone through individual consultants' secretaries. The secretaries provided a list of booked patients to the outpatients reception team 24 hours before clinics took place.
- Patients we spoke with said they were informed of how to book appointments at the clinic and how to access other services such as blood tests or diagnostic imaging. One of the patients we spoke with mentioned that 'booking was easy'.
- Nursing and reception staff told us that patient waiting times to be seen after arriving in the clinic were usually short and aimed to be less than 15 minutes. This was not audited, however, staff told us most patients were seen straight away or within few minutes. During inspection we did not observe patients sitting in waiting areas of the outpatients department. Patients we spoke with confirmed short waiting times.
- Patients had access to same day diagnostics after consultation. Radiology staff told us they had sufficient slots to accommodate outpatients and results were available in less than 48 hours.
- Patients could access the breast unit through self referral, outlined in the hospital's self referral mammography policy. Patients had to be above the age of 40 and be registered with a GP and not fulfil contraindications as per policy. All patients filled in a mammography patient questionnaire and were given a verbal result before leaving the unit.
- The hospital offered hearing loops for patients with hearing impairment.
- The waiting areas in outpatients and diagnostic imaging provided hot and cold beverages for free. Biscuits or sandwiches could be obtained for patients if required.
- Staff told us they would come in earlier or stay late if a patient requested this to accommodate their work or travel schedule for example.
- Adjoining the mammography room was a counselling room with comfortable seating and fresh flowers to enable patients to have a quiet and private moment before returning to the main waiting area. Staff explained that patients welcomed this, as undergoing these investigations was often accompanied by fear, anxiety and emotional stress.
- The breast unit manager gave patients her private mobile phone number in case they had questions or concerns after leaving the unit. She did this to ensure patients would have a person to contact after the breast unit closed for example. However, this service was not provided when she went on leave.
- The breast care nurse offered various reading and information material to patients, including a book she had written with support of the hospital about experiences of patients diagnosed with breast cancer.
- The information leaflet about diagnostic imaging in the breast centre followed a patient friendly format with questions e.g. What is it? Will it hurt? Where will it take place? How soon will I get the results? and so on.
- There was wheelchair access to outpatients and diagnostic imaging departments and disabled toilets were available.
- The hospital provided bariatric wheel chair and armchairs for bariatric patients. The diagnostic imaging department catered for bariatric patients between 130 to 220 kilogram maximum, depending on the modality.
- The changing rooms in the diagnostic imaging department had wheelchair access and provided disposable gowns and slippers for patients' convenience.
- In the waiting area of the imaging department, a notice to inform staff in case of pregnancy was displayed in 11 languages.

Meeting people's individual needs

- Reception staff told us that their patient registration and booking system included additional information about patients, which enabled them to anticipate and plan accordingly, for example need for interpreters or wheel chair access.

Outpatients and diagnostic imaging

- There were no special arrangements to support patients with learning disabilities or patients living with dementia. Staff told us that provisions would be made on an individual basis as they rarely saw these groups of patients and that they would usually be accompanied by a carer.

Learning from complaints and concerns

- Initial complaints were dealt with by staff in the outpatients and diagnostic imaging departments in an attempt to resolve issues locally and informally. If this was unsuccessful, staff would escalate to the matron.
- There had been four formal complaints in the outpatients and diagnostics department in the period of January to December 2016. All had been formally responded to within the time scale set by the hospital. Complaints were about consultant, nursing and imaging staff care.
- Details of complaints were discussed in monthly departmental team meetings. We were shown evidence of this.

Are outpatients and diagnostic imaging services well-led?

Requires improvement 

Leadership and culture of service

- The senior staff nurse was in charge of the outpatients department and reported to the clinical operations manager.
- The imaging manager was responsible for the diagnostic imaging department and reported to the chief executive officer.
- Managers had a sound knowledge of performance in their areas of responsibility and they were aware of risks and challenges to the services.
- It was evident from our conversations with staff that they felt valued and supported by colleagues and managers. A staff nurse had received support and encouragement to undergo specialised training for endometriosis. She attended a monthly MDT meeting at a local NHS hospital and received funding for related conferences.

- It was made clear from talking to staff that there was a good working relationship between staff of all different levels. There was a good sense of teamwork and people helped each other out.

Vision and strategy for this this core service

- Staff we spoke with could tell us the hospital's vision, which was to be recognised as a highly regarded private hospital with a charitable conscience, delivering clinical excellence within a culture of kindness. All staff without exception confirmed the kind atmosphere of the hospital and their departments.
- The hospital values (professionalism, quality, respect, safety, teamwork) were printed at the backside of staff's ID badges and staff incorporated them in their daily performance.
- Senior management told us about plans to expand outpatients services by recruiting new consultants, extended clinic hours and relocation to a bigger facility. We saw documentation of this in the departmental business service plan.
- The imaging manager told us about plans to expand the diagnostic imaging service by adding further modalities, for example bone density scan and cardiac MRI. There were also plans to build another diagnostic imaging facility in addition to the one in use. This was documented in the imaging business service plan.

Governance, risk management and quality measurement

- Refer to the surgery section of the report for incident management, governance and practising privilege management.
- There were no processes in place to store complete medical records for patients attending the outpatients department. Records were kept by individual consultants and the hospital did not maintain records of the care and treatment provided.
- There were risk registers in place for the imaging department and the outpatients department. The outpatient's risk register did not reflect all risks identified by staff, for example, staffing issues or the loss of electricity in the outpatients building, which as a stand alone facility did not have a back-up generator. However, the imaging department's risk register was

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well-maintained and contained details about the risks, controls in place and additional measures to reduce risks. All risks were red-amber-green rated and dated for reassessment. Senior staff were aware of these risks.

- There were monthly heads of department meetings which were attended by the imaging manager and clinical operations manager. We saw meeting minutes, which showed discussion of standard topics, including financial, marketing, governance and departmental updates. Action points were identified with deadlines and responsible person.
- There were monthly departmental team meetings for outpatients, chaired by the director of operations. We saw meeting minutes with a structured agenda and action points. Staff discussed current issues and disseminated information.

Public and staff engagement

- Patient views were actively sought within the outpatients department with local patient satisfaction questionnaires. We saw respective forms throughout the department.
- The chief executive officer held quarterly staff forums where staff was encouraged to share opinions or concerns.

- Results from the hospital wide employee satisfaction survey, carried out in November 2016, included comparisons with external benchmarks of 70 other organisations. The overall engagement index (number of positive responses) was 72% which was inline with external benchmarks (72%). 73% rated management positively compared to the external benchmark of 58%. The report included details of areas that required further development including career prospects and equal opportunities.
- A newly appointed clinical assistant explained how she was positively impressed when she met the matron on the stairs and was addressed by her name.
- Staff received free meals in the hospital canteen.
- There was a five year employment recognition award where staff members would receive a metal badge and a voucher in a ceremony.

Innovation, improvement and sustainability

- The breast centre provided a service which was responsive to patient needs, with design examples including an adjoining the mammography room was a separate room with comfortable seating and fresh flowers to enable patients to have a quiet and private moment before returning to the main waiting area.

Outstanding practice and areas for improvement

Outstanding practice

- The breast unit was designed and organised around patients' individual needs, taking emotional effects into consideration and valuing patients' time. It was well managed and staff were enthusiastic and compassionate.
- The hospital ran two week-long residential multidisciplinary pain management courses for armed service personnel veterans with severe pain. The course was inclusive of input from pain specialist consultants, nurses and

psychologists. Patients received regular consultations for at least a year following the residential course, with 17 patients in treatment in autumn 2016. The courses tried to deal with issues surrounding pain management, which was one of the biggest barriers for veterans when trying to find meaningful employment, the hospital found. The hospital was planning a third course as demand was high, with 150 applications for the second course.

Areas for improvement

Action the provider **MUST** take to improve

- The hospital must maintain an accurate, complete and contemporaneous record of the care and treatment provided and of decisions taken in relation to the care and treatment provided for each patient, including outpatients.
- The hospital must operate effective systems or processes to assess, monitor and improve the quality and safety of the services provided. This includes ensuring that incidents are investigated and completed appropriately, and process of risk governance, where the hospital risk register reflects specific risks identified within each department.
- The hospital must ensure there are sufficient quantities of equipment to ensure the safety of patients and to meet their needs. This includes providing the critical care unit with a difficult airways trolley that is not shared with other areas/services.

Action the provider **SHOULD** take to improve

- The hospital should proactively assess, monitor and mitigate the risks relating to the health, safety and welfare of patients; including VTE and falls.
- The hospital should keep a complete equipment list for diagnostic imaging department.
- The hospital should ensure consultants report the use of personal equipment in clinics.

- The hospital should ensure the outpatients department risk register reflects all current risks.
- The hospital should ensure accurate referral forms are being used in the diagnostic imaging department.
- The hospital should provide formal training to staff in caring for those living with dementia and with learning disabilities, as well as additional training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- The hospital should consider carrying out regular Morbidity & Mortality meetings.
- The service should ensure serious incident investigation reports include appropriate action plans for recommendations made. These should be shared with all staff to encourage learning and service development.
- The hospital should ensure all staff receive training on duty of candour and understand their role with regards to the regulation. Duty of candour must be incorporated into the serious incident investigation process.
- The hospital should ensure there is appropriate consultant cover to meet national guidance.

Outstanding practice and areas for improvement

- The hospital should improve documentation in a number of areas, including capacity assessments and invasive line reviews.
- The hospital should ensure nurses competencies are kept up to date when there is a lack of critically ill patients within the service.
- The hospital should ensure ward leaders have appropriate oversight of complaints investigations, so learning can be shared with staff.
- The hospital should ensure the service establishes a process to identify and reduce risk to patients that appropriately reflects the risks to the critical care service and is regularly reviewed.
- The hospital should ensure that all discussions with patients and their families are fully recorded in the patient notes, especially in relation to ceilings of care.
- The hospital should provide further formal training to staff in caring for patients at the end of life, as identified in their training needs analysis for the next financial year.
- The hospital should ensure that advice regarding VTE prophylaxis as recommended by NICE is followed.

Requirement notices

Action we have told the provider to take

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

| Regulated activity | Regulation |
|--|---|
| Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury | <p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>At the time of our inspection we found the following;</p> <ul style="list-style-type: none">• The hospital did not maintain complete records for all outpatients. The data did not regularly include medical documentation. The outpatients department used different types of systems for record keeping, depending on the consultant. Most consultants brought patients' notes to their clinics and left with them afterwards. This meant that the hospital did not have records of the care and treatment the patients had received.• There was a backlog of 671 incidents with some awaiting investigation and some awaiting completion by senior staff. In May 2016, the DNV International Accreditation Standard for Hospitals found there were over 100 incidents, some from 2014 that had been reported and were awaiting management review. The hospital reported that key performance indicators (KPIs) for completion of incidents were not in place and a number of managers left without completing the incident forms. <p>This was a breach of regulation 17 which states;</p> <ul style="list-style-type: none">• Systems or processes must be established and operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).• Systems or processes must be established and operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of the service users and others who may be at risk which arise from the carrying on the regulated activity.• Systems or processes must be established and operated effectively to maintain an accurate, complete |

Requirement notices

and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

- Systems or processes must be established and operated effectively to maintain securely such other records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity, and the management of the regulated activity.

Regulation 17 (1)(2)(a)(b)(c)(d)

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

At the time of our inspection we found the following;

- The 'difficult airway' intubation trolley, which contained equipment to help staff intubate patients with challenging anatomy, was stored upstairs within theatres and recovery and not in the CCU. The CCU and theatres were separated by a lift and the trolley was covered with a dust cover when not in use. If both services required the use of the trolley at the same time this would leave patients at risk.

This was a breach of regulation 12 which states;

- Care and treatment must be provided in a safe way for service users. This includes:
- assessing the risks to the health and safety of service users of receiving the care or treatment;
- doing all that is reasonably practicable to mitigate any such risks;
- ensuring that the equipment used by the service provider for providing care and treatment to a service user is safe for such use and is used in a safe way;
- where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs.

Regulation 12 (1)(2)(a)(b)(e)(f)