

BMI Healthcare Limited

BMI The Clementine Churchill Hospital

Quality Report

Sudbury Hill
Harrow
Middlesex
HA1 3RX
Tel: 020 8872 3872
Website:

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2015
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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected 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 hospital

Requires improvement



Urgent and emergency services

Requires improvement



Medical care

Good



Surgery

Good



Critical care

Requires improvement



Outpatients and diagnostic imaging

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

BMI The Clementine Churchill hospital is an acute independent hospital that provides outpatient, day care and inpatient services. The hospital is owned and managed by BMI Healthcare Limited.

A range of services such as physiotherapy and medical imaging are available on site. The hospital offers a range of surgical procedures and as well as rapid access to assessment and investigation. The hospital also provides level three critical care facilities.

Services are available to people with private or corporate health insurance or to those paying for one off treatment. Fixed prices, agreed in advance are available. The hospital also offers services to NHS patients on behalf of the NHS through local contractual arrangements.

We carried out a comprehensive inspection of BMI The Clementine Churchill Hospital on 29 - 31 July 2015 (announced) and 11 August 2015 (unannounced). The inspection reviewed how the hospital provided outpatient services (including to children), medical care, surgical services, critical care and minor injuries service as these were the five core services provided by the hospital from the eight that that are usually inspected by the Care Quality Commission (CQC) as part of its approach to hospital inspection.

Prior to the inspection, the hospital's senior management team took the decision to stop treating and admitting children under the age of 16 other than in an outpatient setting.

At a previous CQC inspection, in January 2014, we found concerns with a number of areas including governance, safeguarding, medicines management, the physical environment, equipment, staffing levels, infection control, staff support, auditing, and records.

Our key findings in July and August 2015 were as follows:

Are services safe?

- There was an appropriate system for reporting and learning from incidents with a paper based reporting system that was logged electronically. Although staff were able to demonstrate that there was a robust investigation of incidents, this was not always fully evidenced due to the template that BMI used. Risks were mostly recorded but some had been fully mitigated but not archived.
- The hospital performed well in relation to preventing patients coming to harm with a low rate of falls and pressure ulcers in particular.
- Medicines were well managed. Regular audits were carried out although they did not include medicine reconciliation. However, there were some concerns with legibility of medicine administration records.
- There were some concerns with equipment checks, particularly in outpatients, the intensive care unit (ITU) and surgical wards where mostly portable appliance tests were not up to date.
- The environment in phlebotomy was not fit for purpose with a lack of space meaning there was a risk of safety related incidents.
- A new endoscopy unit had been opened in recent weeks that had been built with the assistance of a JAG accreditor.
- Infection prevention and control (IPC) was poor in the medicine ward and ITU. There was poor compliance of hand hygiene and wearing personal protective equipment on the medical ward and poor cleanliness in the ITU on our announced visit although this had improved on our unannounced visit. The hospital currently had a temporary lead IPC nurse and was due to appoint a permanent one. Many areas of the hospital were still carpeted.

Summary of findings

- Staff were aware of their responsibilities regarding safeguarding vulnerable adults and children and knew who to contact if they had any concerns.
- Mandatory training was up to date in most areas although we received a lack of detail as to whether some subjects had better compliance rates than others.
- Patients who deteriorated were appropriately monitored and responded to.
- There were insufficient permanent nurses employed although staffing levels mostly met the acuity and dependency of patients. There was a high reliance on agency staff in some areas although recruitment drives were taking place that had some recent success and there was a robust checking and induction of agency nurses.
- The hospital contracted four resident medical officers (RMO)s who rotated mostly two at a time on a weekly basis 24/7. to cover the wards. Additionally there is 24 hour RMO cover in ITU, and a further RMO to cover ECC while it is open. However there were concerns that one RMO covered the ITU and crash calls at the same time.
- Although there were 462 consultants who had practising privileges and either were in attendance for their patients or had cover if there was a deterioration, the emergency care centre was not meeting national guidance for seniority of doctors on shift.
- The hospital used paper records for patient care, however there was varying quality of completion of medical records with poor completion on the medical and surgical wards but satisfactory records in the emergency care centre, ITU and theatres.

Are services effective?

- National guidance was mostly followed. However some of both BMI and hospital policies and procedures required updating, particularly with regard to the removal of children's inpatient and emergency services.
- Where we could benchmark the hospital nationally for patient outcomes, the hospital either met or was better than the national average. However, we were provided with little information to benchmark the hospital either to other BMIs or independent hospitals.
- There was a robust induction and orientation process for bank and agency staff with checklists they had to complete before they started a shift. These staff also had to evidence their competencies such as giving intravenous therapy (IV). Staff were also developed including support for external courses. However there was a lack of ITU nurses that were critical care trained.
- Medical and surgical staff were required to have practising privileges to work at the hospital and these were appropriately checked and maintained by the Medical Advisory Committee as necessary. We saw evidence of consultants being removed or suspended if they did not meet the practising privileges criteria. However there were a number of consultants that had practising privileges that had not conducted a clinical activity at the hospital in the last year.
- Although there was mostly an understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards, some of the patient records for these were not complete.
- Internal multidisciplinary working was in place in most departments. Although there was a lack of formal external working, when working with other organisations was required, there were no concerns with how this operated.
- Some of the records regarding nutrition were not complete. Most patients were happy with the food they received but there had been a high amount of complaints regarding food quality in recent months. The hospital had started taking action to address this.

Are services caring

- Mostly all the patients we spoke with gave a positive experience about their care. They reported staff were caring and maintained their privacy and dignity.

Summary of findings

- Patients and their families reported being involved in their care including being informed about potential costs in most departments.
- Staff offered support to patients and families who wanted or required it including having difficult conversations.

Are services responsive?

- Flow through the hospital was well managed including discharge although targets for discharging were not always in place and there was some improvement still to make with pre-operative assessment.
- There was some specific support given for individual patient needs such as those living with dementia or those that required translation services but support for other patient groups, including children, was limited.
- The hospital met and exceeded targets responding to patient needs such as referral to treatment and waiting time in the emergency care centre.
- Complaints were mainly well-managed and learnt from across the hospital.

Are services well-led?

- Most services were well-led with visible leaders and local visions and strategies. However ITU leaders had limited visibility and forward planning.
- Governance and performance monitoring was in place across most services. All services were involved in briefing sessions, called Comm Cells which were effective in all areas other than ITU. ITU also lacked auditing and improvements were not made from audits undertaken.
- Although the senior management team were risk aware and actions were in place to address areas of risk, there were some areas that had not been actioned or identified such as the phlebotomy environment.
- The culture of the services was mostly positive and staff felt engaged in how the hospital was to improve. However some local staff survey results were not very positive and there was some discontent with some consultants due to recent management decisions on practising privileges when incidents had occurred.

Was the hospital well-led?

- The Executive Director (and registered manager) had been in post around 18 months and most of the senior management team (SMT) had been in post a year or less. However staff described that they had mostly been a positive effect on the hospital.
- The SMT had brought in 'Comm Cells' which were briefing sessions that occurred at all levels, from SMT, to ward and department levels with a heads of department meeting, which all staff were invited to. These went through a number of aspects including activity, performance, patient safety and incidents. Each acted as a filter for other Comm Cells so everyone in the hospital knew what was happening both in their own department and across the hospital.
- The SMT had recently taken a decision to reduce the amount of services they provided to children, removing inpatient services, and emergency care provision. This had been taken quickly and policies and procedures had not been updated to reflect this but evidence showed if they had carried on the inpatient provision, it would have been a safety risk.
- There was a focus on governance across the hospital and this had led to improvements with learning and actions from incidents to improve practice. Auditing had also improved with a range of audits and monitoring taking place in each of the services provided.
- There was a clear nursing strategy directed by the Director of Nursing focusing on the 6 Cs and catering for patient needs such as those living with dementia.

Summary of findings

- The SMT were mostly aware of the areas they needed to improve including infection control, catering and staffing levels. The hospital was risk aware although there were improvements needed with the appropriateness of items on the risk register and the BMI template used for root cause analysis.
- A strong hospital vision was in place with key performance metrics that were continually monitored and reviewed which had both commercial and clinical performance at the forefront, although some benchmarking was lacking. The hospital was aspirational but knew there were many improvements needed to achieve their targets.

We saw several areas of outstanding practice including:

- The hospital had a good system of raising issues and concerns across the hospital in a timely manner through its 'Comm Cells' meetings and display boards. This meant that hospital staff could access up-to-date information about the hospital's performance and any concerns or changes in practice in a timely manner. This had been embedded throughout the hospital and staff spoke positively of how much communication had improved across the entire site.
- The emergency care centre (ECC) had introduced reflections about a year ago and a means to support staff when there had been a difficult shift and there was no one to talk to about it. Staff are encouraged to write up what's happened, their feelings, what action they have taken and what difference they have made. We saw good examples which were open and honest for example when a patient has fallen, where there had been staff shortages, concerns about a patient who deteriorated post discharge, and when there had been a busy shift. It gave staff an opportunity to express how they felt. Staff reported that this promoted discussion within the team and allowed the centre manager to support and guide them.

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

Importantly, the provider must:

- Ensure the ITU environment and equipment is clean and the hospital meets infection prevention and control guidance such as ensuring staff have clean hands and wear personal protective equipment when necessary.
- Take action to ensure the phlebotomy administrative office and storage room is suitable for the purpose for which it is being used for and ensure floors in the area are clear of boxes and consumables to allow for appropriate cleaning.

In addition the provider should:

- Review all policies relating to children to denote the service now being provided at the hospital and provide staff with a clear policy and procedures in relation to children using outpatient services.
- Ensure that there is additional nursing cover available in the ECC when staff from the centre attend a cardiac arrest.
- Review the statement of purpose to reflect that post discharge reviews and all medical admissions are assessed and transfers from NHS and other providers are admitted via the ECC.
- Take action to ensure all equipment is safe to use.
- Ensure that the guidance from the College of Emergency Medicine is followed which states that a 'service should have a minimum of ST4 or equivalent working in the department when the service is open'.
- Ensure patient records are complete and up to date including care plans and nursing assessments.
- Ensure the ITU audits and benchmarks its performance so it can monitor and improve its service.
- Ensure there are sufficient staff available to cover any additional admissions from the ECC.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

The service did not always work in a way that ensured that patients were protected from the risk of avoidable harm. There were particular concerns with infection control, cleanliness, the phlebotomy premises, patient records and staffing levels.

However, there was a system for reporting and learning from incidents. Patient safety performance was positive and staff had awareness of safeguarding.

Requires improvement



Are services effective?

Services were not always effective. There was limited benchmarking, policies and procedures were sometimes out of date, and records relating to nutrition and mental capacity were not always complete. However there was a robust system for ensuring staff were competent and developing, national guidance was followed and multidisciplinary working was in place.

Requires improvement



Are services caring?

The service was caring. Patients were mostly well cared for and their privacy and dignity was maintained. They were involved in their care and emotionally supported.

Good



Are services responsive?

The service was responsive. Flow was well managed, targets for responding to patients were met or exceeded, and complaints were learnt from. However there was limited support for some patient groups.

Good



Are services well-led?

Services were mostly well-led. Visions and strategies were in place. Appropriate governance was apparent with performance monitoring. The culture of services was mostly positive. However there were concerns mainly with the leadership and governance in ITU. There was risk awareness and actions in most areas.

Good



Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement

Rating



Why have we given this rating?

We have rated the ECC as requires improvement. The ECC was increasingly being used to review patients who had called their consultants with complications or worries post discharge. Therefore more complex patients and all medical admissions were going through the centre. This was not reflected within the ECC's statement of purpose or in the level of medical staff providing cover. The number of patients being admitted to the hospital from the ECC had increased by 55% between October 2014 and June 2015 and was on an upwards trajectory.

The ECC was staffed with ST1 and ST2 grade agency doctors although they were well inducted. The College of Emergency Medicine (CEM) recommendation that a 'Service should have a minimum of ST4 or equivalent working in the department when the service is open'. The ECC was not meeting this recommendation.

Staff from the ECC form part of the hospitals cardiac arrest team which means when there is an emergency the centre is left with no medical cover and short on nursing staff.

Pain scores were not routinely recorded and due to cost implications patients often declined analgesia. The ECC only recorded patients observations using a national early warning score (NEWS) system to identify patients whose condition was at risk of deteriorating when they were going to be admitted to the hospital or when the patient's condition started to deteriorate.

55% of patients were seen and treated within an hour, with patients being offered an immediate appointment with a nurse and if required a doctor. However the ECC did not monitor their performance in relation to initially assessing patient's within 15 minutes of arrival. Patients received a follow up call following discharge to provide them an opportunity to feedback on the service they received.

In June 2015 the ECC ceased providing services to children under the age of 16 years. The hospital advised that this decision had been taken quickly. Staff told us that the resuscitation equipment was

Summary of findings

removed from the centre without any discussion. However staff were concerned that patients may still bring children to the ECC and there were no referral pathways for children in place. Patients were treated with compassion, dignity and respect. We observed staff being polite and introducing themselves by name. Treatment plans were explained in terms that were easily understood. Staff were supported to spend time and to talk to patients and we observed a patient come into the ECC to thank the staff for their care and help. Staff reported that they had an appraisal and were encouraged to attend further training related to their role. Staff had received training in Mental Capacity Act (MCA 2005) and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns. The staff felt they supported each other, were a good team and enjoyed working in the ECC. Staff were focused on providing good care to the patients who used the ECC.

Medical care

Good



Medical services were good. Patients were protected from avoidable harm, there were good governance processes including learning from incidents and risk management, medicine management was appropriate, national guidance was followed, patients were mostly well cared for and improvements were on-going. However, there were concerns in a number of areas in safety and effectiveness including poor infection control compliance, nursing staffing levels, completeness of records, a lack of benchmarking evidence and food provision. There were also some concerns with flow from the ECC and local leadership.

Surgery

Good



Overall, we found the surgical service was good. Patients were protected from avoidable harm, incidents were reported and the department was engaged in governance activities. A comprehensive audit programme was in place and safety performance data was at or above target levels. Staff were competent and opportunities for further

Summary of findings

professional development were available. Consent was obtained from patients prior to procedures and staff ensured patients understood information provided to them.

Access and flow through the service was effective and NHS patients were consistently admitted within the 18 week referral to treatment target. Patient outcomes including mortality were mainly within expected ranges and many aspects of care were based on national guidance. All patients received follow-up telephone calls on discharge to check for issues. Patient and relative feedback was positive and complimentary about staff throughout the service. Complaints were managed appropriately and staff adhered to duty of candour principles and their regulatory requirements. Staff received feedback about incidents, complaints and other issues raised within the hospital during daily Comm Cell meetings, including learning points.

The surgical environment and equipment available were mostly fit for purpose, clean and well maintained although there was some equipment that was out of date. Medicines were mainly stored and managed correctly, although some issues with controlled drugs including record keeping were observed.

Critical care

Requires improvement



Overall, we rated ITU as requires improvement. We had concerns there was an under-reporting of incidents and no evidence of action to improve this. We also found important safety data was not audited or monitored. Lack of full patient outcome monitoring, in addition to the unit not participating in national benchmarking, made it difficult to fully assess performance. There was no ITU follow up clinic available to patients.

The cleanliness of equipment and the unit itself was poor, although we found a vast improvement at the unannounced inspection. We observed staff were not always compliant with infection prevention and control processes, including being bare below the elbows and cleaning hands before giving intra-venous medicines. There was a higher than recommended usage of agency staff, although many of these nurses worked on the unit regularly. There was a lack of multi-disciplinary team (MDT) communication, ward rounds or meetings and we

Summary of findings

Outpatients and diagnostic imaging

Good



were give examples of where poor communication had been detrimental to patient care. Staff were not adhering to Deprivation of Liberty Safeguards processes however awareness of mental capacity and consent principles was good.

Access to and flow through ITU was seamless and the service was mainly responsive to the needs of individuals. Permanent nursing staff were initially supernumerary and were required to complete specific competencies including for medicines administration before working unsupervised. Staff were well supported, enjoyed their work and provided good standards of care. There was clear vision for developing the unit and introducing additional quality and safety measures.

We found that the Outpatients and Diagnostic Imaging service (OPD) at the BMI Clementine Churchill Hospital was well-led, caring and responsive to patients' needs. However some parts of the service require improvement to ensure patient and staff safety such as equipment checks. We found sufficient levels of cleanliness, infection control and hygiene across the OPD service. There was adequate staffing and completion of mandatory training. There were also effective systems in place to report incidents and manage concerns and complaints. We saw examples of patient feedback being used to improve services.

Patients in OPD received effective care and treatment that met their needs and there was evidence of positive feedback from patients. Their care and treatment was planned and delivered in line with national and local guidelines. Patients were treated with compassion, dignity and respect. All of the patients we spoke with praised the staff for the care they provided and said that they would recommend the hospital and outpatient services. Flexibility, personal choice and continuity of care were embedded in OPD services. There was a flexible and easy to arrange appointment system and patients did not experience long waiting times. Services were planned in a way that met the different needs of patients using the hospital and staff in OPD were aware of the different cultural backgrounds and needs of patients. The OPD service

Summary of findings

saw few children or people living with dementia or patients with learning difficulties; we found that staff required further guidance and training to meet the needs of these particular patient groups. The leadership, governance and culture of the OPD service promoted the delivery of high quality, person-centred care. The hospital had a clear vision and values, driven particularly by quality. Staff were focussed on providing the best service they could for all patients whether they were privately or NHS funded. Staff told us they were supported by their departmental managers and there was a culture of openness to learn and develop services. Performance information was shared within the department and there was clarity of responsibility for clinical and non-clinical performance. Staff were given opportunities to provide feedback and inform service development. They were also supported by managers to develop their knowledge and skills to improve the quality of care provided to patients. We had some safety concerns, particularly within the phlebotomy services and the electrical testing and calibration of equipment used for tests and in emergencies. The phlebotomy administrative office was cramped and there were frequent interruptions while staff were checking and booking in the samples, which could lead to delayed or incorrect blood test results. We also found the phlebotomy staff did not follow hygiene procedures consistently. Equipment such as defibrillators, electronic scales and blood glucose machines were available; however most of what we inspected did not have current portable appliance test (PAT) certificates or been regularly calibrated.

Requires improvement 

BMI The Clementine Churchill Hospital

Detailed findings

Services we looked at

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

Detailed findings

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Background to BMI The Clementine Churchill Hospital

BMI The Clementine Churchill Hospital is a 120 bed acute general hospital in Harrow, Middlesex. The hospital was acquired in 1981 by what subsequently became known as BMI Healthcare. In 2001 the hospital began an expansion programme and now offers a wide range of outpatient facilities, such as imaging, pathology, physiotherapy and minor injuries. The main hospital provides services to adults and young adults over the age of 16; both private and NHS patients, as well as a paediatric non-interventional outpatient service. The hospital has seven theatres, two of which are minor surgery operating theatres. Three of the theatres have Laminar Flow. BMI The Clementine Churchill Hospital also has an endoscopy suite; a six bed level three Intensive Care Unit and also offers a self-pay, walk-in Emergency Care Centre, which is open from 8am - 8pm, Monday to Friday and 8am - 9pm Saturday and Sunday. The Emergency Care Centre offers diagnosis and treatment for minor accidents and injuries on a walk-in, self-funded basis. The service is available to adults and young people over 16 years of age, with no appointment necessary. Where needed patients can also be admitted directly to one of the hospital's wards.

Additionally, BMI The Clementine Churchill has an on-site pathology laboratory and an imaging suite which includes an MRI scanner, CT scanner, FFDM (Full Field Digital Mammography) and ultrasound service. The hospital offers a wide range of services including orthopaedics, neurophysiology, general surgery, gynaecology, urology, oncology (except chemotherapy), ear nose and throat services, cosmetic surgery and physiotherapy. During the period April 2014 to March 2015 the hospital cared for 10,867 inpatients, of which 7,194 were admitted as inpatients for day case procedures. The five most common procedures performed were:

- Image-guided injection(s) into joint(s) (568)
- Multiple arthroscopic operation on knee (514)
- Epidural injection (366)
- Phacoemulsification of lens with implant (232)
- Hysteroscopy (224).

Our inspection team

Our inspection team was led by:

Inspection Manager: Ian Brandon, Care Quality Commission

Detailed findings

The team included a CQC inspection manager and team of inspectors supported by a number of specialists including: a consultant anaesthetist, a consultant physician, two surgical nurses, an infection control nurse, an expert by experience and an emergency care nurse.

They are granted the same authority to enter registered persons' premises as the CQC inspectors.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to peoples' needs?
- Is it well led?

Before visiting we reviewed a range of information we held about the hospital and spoke to a range of stakeholders including private medical insurance companies, and a local NHS trust. Patients were invited to contact CQC with their feedback.

We visited the hospital to inspect on 29 - 31 July 2015 to undertake an announced inspection. We returned on 11 August 2015 to carry out an unannounced inspection.

As part of the inspection visit process we spoke with members of the executive management team and individual staff of all grades. We also met with groups of staff in structured focus groups.

We spoke with both inpatients and people attending the outpatient's clinics as well as those using the emergency care centre. We looked at comments made by patients who used the services of BMI The Clementine Churchill Hospital when completing the hospital satisfaction survey and reviewed complaints that had been raised with the hospital.

We inspected all areas of the hospital over a three day period, looking at outpatients, medical care, surgical care, critical care and the emergency care centre as these were the only core services provided at the hospital.

Our inspectors and specialist advisors spent time observing care across the hospital, including in the operating theatres and the radiology department. We reviewed patient's records where necessary to help us understand the care that they had received. We also reviewed maintenance, training, monitoring and other records held by the hospital.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experience of the quality of care and treatment at BMI The Clementine Churchill Hospital.

Facts and data about BMI The Clementine Churchill Hospital

At the time of the inspection visit, there were 462 doctors and dentists working at the hospital under practicing privileges. There were no employed medical or dental staff.

There were 115.4 full time equivalent (FTE) registered nurses employed at the Hospital at the time of our inspection. Of these, 71 were working on the inpatient department, 30 were working in theatres and 14.4 in the

outpatients department. There were 42.4 FTE care assistants working in the inpatient departments, 18 in theatres and 6 FTE care assistants in the outpatient department.

During the period April 2014 to March 2015 the hospital cared for 10,867 inpatients, of which 7,194 were admitted as inpatients for day case procedures.

Detailed findings

Pathology, microbiology, registered medical officers, intensivists, decontamination, stoma nurses, catering services and histopathology were outsourced to third party suppliers.

End of life care, maternity services, children's services (other than as outpatients) and termination of pregnancy services are not provided at the hospital.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement

Notes

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & diagnostic imaging.

Are services safe?

Our findings

- There was an appropriate system for reporting and learning from incidents with a paper based reporting system that was logged electronically. Although there was a robust investigation of incidents, this was not always fully evidenced due to the template that BMI used. Risks were mostly recorded but some had been fully mitigated but not archived.
- The hospital performed well in relation to preventing patients coming to harm with a low rate of falls and pressure ulcers in particular.
- Medicines were well managed. Regular audits were carried out although they did not include medicine reconciliation. However there were some concerns with legibility of medicine administration records.
- There were some concerns with equipment checks, particularly in outpatients, the intensive care unit (ITU) and surgical wards where particularly portable appliance tests were not up to date.
- The environment in phlebotomy was not fit for purpose with a lack of space meaning there was a risk of safety related incidents.
- A new endoscopy unit had been opened in recent weeks that had been built with the advice of a JAG accreditor although it was not yet JAG accredited.
- Infection prevention and control (IPC) was particularly below standards in the medicine ward and ITU. There was poor compliance of hand hygiene and wearing personal protective equipment on the medical ward and poor cleanliness in the ITU on our announced visit, although this had improved on our unannounced visit. The hospital currently had a temporary lead IPC nurse and was due to appoint a permanent one. Many areas of the hospital were still carpeted.
- Staff were aware of their responsibilities regarding safeguarding vulnerable adults and children and knew who to contact if they had any concerns.
- Mandatory training was up to date in most areas at around 90% although we received a lack of detail as to whether some subjects had better compliance rates than others.
- Patients who deteriorated were appropriately monitored and responded to.
- There were insufficient permanent nurses employed although staffing levels mostly met the acuity and dependency of patients. There was a high reliance on agency staff in some areas although recruitment drives were taking place that had some recent success and induction processes were robust.
- The hospital contracted four registered medical officers who rotated mostly two at a time on a weekly basis 24/7. However there were concerns that one RMO covered the ITU and crash calls at the same time.
- Although there were 462 consultants who had practising privileges and either were in attendance for their patients or had cover if there was a deterioration, the emergency care centre was not meeting national guidance for seniority of doctors on shift.
- The hospital used paper records for patient care, however there was varying quality of completion of medical records with poor completion on the medical and surgical wards but satisfactory records in the emergency care centre, ITU and theatres.

Are services effective?

Our findings

- National guidance was mostly followed. However some of both BMI and hospital policies and procedures required updating, particularly in regard to the removal of children's inpatient and emergency services.
- Where we could benchmark the hospital nationally for patient outcomes, the hospital either met or was better than the national average. However, we were provided with little information to benchmark the hospital either to other BMIs or independent hospitals.
- There was a robust induction and orientation process for bank and agency staff with checklists they had to complete before they started a shift. These staff also had to evidence their competencies such as giving intravenous therapy (IV). Staff were also developed including support for external courses. However there was a lack of ITU nurses that were critical care trained.
- Although there was mostly an understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards, some of the records for these were not complete.
- Internal multidisciplinary working was in place in most departments. Although there was a lack of formal external working, when working with other organisations was required, there were no concerns with how this operated.
- Some of the records regarding nutrition were not complete. Most patients were happy with the food they received but there had been a high amount of complaints regarding food quality in recent months. The hospital had started taking action to address this.

Are services caring?

Our findings

- Mostly all the patients we spoke with gave a positive experience about their care. They reported staff were caring and maintained their privacy and dignity.
- Patients and their families reported being involved in their care including being informed about potential costs in most departments.
- Staff offered support to patients and families who wanted or required it including having difficult conversations.

Are services responsive?

Our findings







- Flow through the hospital was well managed including discharge although targets for discharging were not always in place and there was some improvement still to make with pre-operative assessment.
- There was some specific support given for individual patient needs, such as those living with dementia or those that required translation services but support for other patient groups, including children, was limited.
- The hospital met and exceeded targets responding to patient needs such as referral to treatment and waiting time in the emergency care centre.
- Complaints were mainly well-managed and learnt from across the hospital.

Are services well-led?

Our findings

- Most services were well-led with visible leaders and local visions and strategies. However ITU leaders had limited visibility and forward planning.
- Governance and performance monitoring was in place across most services. All services were involved in briefing sessions, called Comm Cells which were effective in all areas other than ITU. ITU also lacked auditing and improvements were not made from audits undertaken.
- The senior management were risk aware and actions were in place for identified areas of risk. However, there were a few issues we identified that had not been actioned or noted such as the phlebotomy environment.
- The culture of the services was mostly positive and staff felt engaged in how the hospital was to improve. However some local staff survey results were not very positive and there was some discontent with some consultants due to recent management decisions when incidents had occurred.

Urgent and emergency services

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

Information about the service

The emergency care centre (ECC) BMI The Clementine Churchill hospital offers a minor injuries service to adults and young people aged sixteen years or over who require immediate access to a nurse and/or doctor although the website and statement of purpose describes in some places as treating 'accidents and emergencies'. It offers diagnosis and treatment for minor accidents and injuries on a walk in basis and acted as an assessment centre for patients who were being transferred in from NHS or other providers following referral from patient's consultants or their GP's.

The core ECC nursing staff are trained in advance practice to provide advice and treatment for patients who attend with minor injuries such as sprains, fractures, minor wounds and ear, nose and throat conditions and other minor medical complaints. Anyone who attends the centre with a major injury, illness or / and emergency is stabilised by staff and, depending on the urgency, may be immediately transferred by ambulance to a local accident and emergency (A&E) department or advised to visit their local GP or local hospital as soon as possible for further advice or investigation.

The service is open seven days per week from 8.00am to 8.00pm Monday to Friday and 8.00am to 9.00pm on a Saturday and Sunday.

BMI The Clementine Churchill provides onsite imaging and pathology testing; pharmacy and physiotherapy support to patients and can also offer private onward referral to specialist consultants at BMI for further investigation.

The ECC treated 3279 patients the period October 2014 to June 2015 of which 493 patients were admitted to the hospital. This was less than the number of patients seen in the previous 12 months. However the number of admissions via the ECC had increased by 55% due to international patients and transfers being assessed in the ECC.

We spoke with three patients including their family members and carers, seven staff members including nurses, doctors, consultants and support staff. We observed interactions between patients and staff, considered the environment and looked at eight care records. We received comments from people who contacted us to tell us about their experiences. We reviewed other documentation from stakeholders and performance information from BMI The Clementine Churchill.

Urgent and emergency services

Summary of findings

We have rated the ECC as requires improvement.

The ECC was increasingly being used to review patients who had called their consultants with complications or worries post discharge. Therefore more complex patients and all medical admissions were going through the centre. This was not reflected within the ECC's statement of purpose or in the level of medical staff providing cover. The number of patients being admitted to the hospital from the ECC had increased by 55% between October 2014 and June 2015 and was on an upwards trajectory.

The ECC was staffed with ST1 and ST2 grade agency doctors although they were well inducted. The College of Emergency Medicine (CEM) recommendation that a 'Service should have a minimum of ST4 or equivalent working in the department when the service is open'. The ECC was not meeting this recommendation.

Staff from the ECC form part of the hospital's cardiac arrest team which means when there is an emergency the centre is left with no medical cover and short on nursing staff.

Pain scores were not routinely recorded and patients often declined analgesia. The ECC recorded patients observations using a national early warning score (NEWS) system to identify patients whose condition was at risk of deteriorating when they were going to be admitted to the hospital or when the patient's condition started to deteriorate.

55% of patients were seen and treated within an hour with patients being offered an immediate appointment with a nurse and if required a doctor. However, the ECC did not monitor their performance in relation to initially assessing patients within 15 minutes of arrival. Patients received a follow up call following discharge to provide them an opportunity to feedback on the service they received.

In June 2015 the ECC ceased providing services to children under the age of 16 years. The hospital advised that this decision had been taken quickly. Staff told us that the resuscitation equipment was removed from the

centre without any discussion. However staff were concerned that patients may still bring children to the ECC and there were no referral pathways for children in place.

Patients were treated with compassion, dignity and respect. We observed staff being polite and introducing themselves by name. Treatment plans were explained in terms that were easily understood. Staff were supported to spend time and to talk to patients and we observed a patient come into the ECC to thank the staff for their care and help.

Staff reported that they had an appraisal and were encouraged to attend further training related to their role. Staff had received training in Mental Capacity Act (MCA 2005) and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns.

The staff felt they supported each other, were a good team and enjoyed working in the ECC. Staff were focused on providing good care to the patients who used the ECC.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement



The BMI Clementine Churchill ECC was not meeting the College of Emergency Medicine (CEM) recommendation that a 'Service should have a minimum of ST4 or equivalent working in the department when the service is open'. The centre was staffed with ST1 and ST2 grade doctors.

Staff from the ECC form part of the cardiac arrest team which means, when there is an emergency, the centre is left with no medical cover and short on nursing staff.

The environment was visibly clean and tidy and environmental audits were undertaken in the ECC. Infection prevention and control audits were carried out which included audits of hand washing. Personal protective equipment (PPE), such as disposable aprons and gloves were available and there were hand-washing facilities and hand cleaning gels available throughout the department.

Staff in the ECC were aware of how to report incidents. We saw that incidents were reported and that these were investigated with learning points identified. Staff were also aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns.

Incidents

- There were no 'never events' reported between February 2014 and January 2015. (Never events are serious events 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.)
- They had 901 clinical incidents reported in April 14 – March 15, with an increase in the number of clinical incidents reported in the last quarter (January – March 15). ECC Clinical team meeting minutes for the period January 2015 to June 2015 confirmed that a total of 12 incidents were reported during this period and demonstrated that trends were being monitored and learning points were identified such as a spike in

readmissions in February 2015. We saw that staff in the ECC reported incidents using a paper based system which was then inputted onto a computerised system centrally.

- The ECC had undertaken two root cause analysis (RCA) into incidents that had occurred. We saw that these had been investigated and learning points were identified.
- Staff in the ECC had undertaken training in the duty of candour. We asked staff about their understanding of the new regulation concerning duty of candour. Most were able to describe the concept and understood the organisation's responsibility for transparency and openness as necessary by the Duty of Candour requirement as well as the need to apologise and share any investigation findings.
- All patient mortality was reported in the bi-monthly Clinical Governance Reports and reviewed by the Clinical Governance Committee meetings which were held bi-monthly. The care of patients who had complications or an unexpected outcome was discussed. We saw learning points were not always recorded as part of this process particularly for expected deaths.

Cleanliness, infection control and hygiene

- The hospital had an infection prevention and control (IPC) policy that had been issued in February 2015 and an infection prevention and control work plan for 2014/2015 that was updated and reviewed on a quarterly basis. We saw that this was RAG rated to indicate which areas of work had been completed, where work was being progressed and where actions were outstanding.
- The Infection Prevention and Control Annual Report October 2014 – September 2015 indicates that training across the hospital IPC was 98% for IPC awareness, 80% for IPC High Impact Interventions/Care and 82% for hand hygiene.
- Personal protective equipment (PPE), such as disposable aprons and gloves were used as appropriate. There were hand-washing facilities and hand cleaning gels available throughout the department. We saw good examples of hand hygiene being maintained by staff.
- The ECC was visibly clean and tidy. An environmental audit in the ECC undertaken in June 2015 for cleaning and contamination showed that the centre was 100% compliant. The waiting room was furnished with chairs with soft furnishings which appeared clean; however this meant that they would be difficult to wipe down on

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a regular basis. We saw that this had been identified on the hospital risk register and had been reviewed in June 2015 and was still outstanding. The risk register did not indicate why the risks had not been addressed.

- Audits of infection prevention and control (IPC) were carried out. Monthly audits of hand washing showed that compliance in the ECC for June and July was 80%. The ECC was one of three areas in the hospital where compliance was less than 100%.
- The Patient Led Assessments of Clinical Environment (PLACE) audits conducted annually shows that in 2014 the BMI Clementine Churchill scored 99.76% for cleanliness which is higher than the national average.

Environment and equipment

- The ECC had a dedicated entrance not far from the main reception. The waiting area was staffed by the ECC's receptionist and was bright and clean with sufficient seating. There was a drinks machine available for patients.
- The ECC was divided into different areas depending on the acuity of patients. The resuscitation area had resuscitation equipment, a drug cabinet and monitoring equipment. One cubicle had been set up for plastering and suturing, with another cubical for general examination. The ECC complied with 16 out of 23 facility standards set by the Department of Health guidance, Health building Note 15-01: Accident and Emergency Departments.
- There was adequate adult resuscitation and medical equipment in the ECC. This was clean, regularly checked and ready for use. The resuscitation equipment had comprehensive checks and these were up to date with a check list for July in place. We also saw that Portable Appliance Testing (PAT) labels were attached to electrical systems showing that they had been inspected and were safe to use.
- The ECC had its children's resuscitation equipment removed in June 2015. This was after a decision from the senior management team that they felt the hospital could not provide safe children's inpatient and emergency care service. This was a decision taken within a month of being flagged as a concern. The senior management team advised this was highlighted via the hospitals website and consultants bulletins. However staff were concerned that patients may still

bring children to the ECC and there were no referral pathways for children in place. We were not aware that any children had been brought into the ECC since the decision had been made.

- We saw that the sluice was clean and organised and that a chemical spillage kit was in place.
- We found that there was a panic button that staff could use to summon help in the event of an emergency. There was also a grab bag which was checked monthly which staff could take if they needed to respond to an emergency in another part of the hospital.
- A staff member from the ECC had been nominated as health and safety person, they take the lead within the ECC and attended hospital meetings. We saw that the minutes of the meeting were available for the staff to read.

Medicines

- Locks were installed on cupboards and fridges containing medicines and intravenous fluids. We saw that the drugs cupboards were well stocked and that contents were within date. Keys were held by the appropriate nursing staff.
- Controlled drugs (CD) were regularly checked on a daily basis by staff working in the department. We audited the contents of the CD cupboard in the resuscitation area against the CD registers and found that they were correct. The CD register was completed fully, with two signatures for each drug administered. Pharmacists visited ECC daily to carry out medicines reconciliation and check for medicines to take away (TTA). This meant there were no delays in obtaining TTAs particularly at the weekend and if there were CD medications prescribed.
- Patients' allergy status was recorded in all of the eight records we reviewed.

Records

- Patients were registered on the ECC computer system, which tracked the patient journey through the department and highlighted any delays. A paper record was also generated registering the patients' arrival in the department and detailed the time when patients were first registered in the unit, when patients were triaged, seen by a clinician, diagnosed, and when a decision to admit the patient had been taken. All healthcare professionals recorded care and treatment using the same document.

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- In the ECC we looked at eight sets of medical notes. We found that these were clearly documented and easy to follow with patient allergies documented. However we found there were no risk assessments or no pain scores recorded.
- When patients were discharged from the ECC, a patient referral letter and discharge notification was completed. Copies of both are given to the patient and sent to their general practitioners (GP)
- We saw that all patient records were held securely within the ECC reception. We saw no evidence that patient records from the ECC were linked to the outpatient department or medical records.

Safeguarding

- Staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns. Staff reported that they worked closely with the local authority when reporting safeguarding concerns. ECC clinical meeting minutes showed that they worked closely with the local authority safeguarding team.
- The hospital advised us there had been no safeguarding alerts; however we saw that the staff in the ECC had reported concerns through to the local safeguarding team. The ECC Clinical team meeting minutes for the period January 2015 to June 2015 reported that three safeguarding alerts had been raised and followed up. We saw that the safeguarding concerns were also reported through the quarterly clinical governance reports.
- We saw that all the nursing staff in the ECC had received Level 3 safeguarding adults. Staff were unsure whether training in safeguarding children would be maintained as the ECC has stopped treating children in June 2015.

Mandatory training

- The staff in the ECC had an 89% completion rate for mandatory training. We requested a full training matrix for clinical staff working at the BMI Clementine Churchill Hospital but did not receive detailed information about what training was mandatory for the staff in the centre.
- Doctors' training was managed by the agency that employed them. One of the doctors we spoke with advised that they completed 10 mandatory training

modules every year and these included control of substances hazardous to health (COSHH) and the reporting of injuries, diseases and dangerous occurrences regulations (RIDDOR).

- Staff we spoke with had completed mandatory training and were encouraged to keep their manual handling training up to date.
- Receptionists had regular appraisals and mandatory training, their training was via e-learning and they were encouraged to keep their manual handling training up to date.
- ECC had one member of the nursing staff that was trained in emergency paediatric life support EPLS.

Assessing and responding to patient risk

- The hospital had a standard operating procedure for cardiopulmonary Resuscitation in place but this was out of date. We saw that this had been reviewed in March 2013 and had been due for review in March 2015. It also referred to another hospital so the locations of key equipment were not correct although current practice had not changed in a major way. Therefore the policy was not fit for purpose.
- Staff advised that a national early warning score (NEWS) system was only used to identify patients whose condition was at risk of deteriorating when they were going to be admitted to the hospital or when the patient's condition started to deteriorate. It was not used routinely as it was thought to be of little value in the ECC since they were mainly treating minor injuries.
- There was no monitoring of initial assessment in the ECC there was no evidence to show either how they met this timescale or whether they prioritised their patients according to risk.
- Patients who attended the centre with a major illness or if their condition deteriorated while they were being treated, were stabilised by staff and, depending on the urgency, may be immediately transferred by ambulance to a local accident and emergency (A&E) department or advised to visit their local GP or local hospital as soon as possible for further advice or investigation as required by the hospital policy. Staff advised that any patient presenting with a chest pain were normally transferred out via ambulance to the NHS. In June 2015, 14 patients were transferred to NHS hospitals. The hospital did not

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routinely admit patients to the intensive treatment unit (ITU) as staff advised one of the reasons was there was no formal pathway between the ECC and the ITU for the transfer of patients.

- Staff in the ECC highlighted that if patients presented late in the day and required certain diagnostics, they cannot complete the episode of care as the laboratory's are closed. This is particularly relevant for the patients with potential pulmonary embolism for example. They said there was no clear pathway in place to manage this situation so patients were either transferred to an NHS accident and emergency setting or return the next day for their results. We saw that this had not been risk assessed, but staff told us this had occurred a number of times. As part of factual accuracy we were told tests can be sent to TDL Ealing with a turnaround time of 60-90 minutes.
- We saw that follow up calls were routinely made to patients who had been discharged.
- The registered medical officer (RMO) and a nurse from the ECC form part of the cardiac arrest team for the hospital from 8.00am to 8.00pm daily. Staff advised that this leaves the ECC with no medical cover and short on nursing staff. Best clinical practice states a nurse should stand in on the ECC but this is not the current practice.

Nursing staffing

- The ECC department was currently staffed to their established staffing level. Staffing rotas confirmed that two nurses worked each shift. We saw no evidence of an acuity tool being used.
- The ECC was reliant on using agency and bank staff to cover annual leave and sickness. The opening hours of the ECC had recently changed to 8am to 8pm Monday to Friday and 8am to 9pm at the weekend to accommodate the long-term sickness of one member of staff. The ECC had previously been open from 8am to 10pm 7 days per week.
- The rota confirmed that five agency or bank staff usually worked in the ECC. We saw that a comprehensive induction and orientation had been put in place for the agency staff.
- All the nursing staff who worked in the ECC had been trained to advanced nurse practitioner (ANP) or had experience of working within a NHS accident and emergency setting and were trained in advanced life

support (ALS) and one member of staff was trained in emergency paediatric life support (EPLS). If the EPLS trained nurse was not on shift, the RMO could be contacted if someone under the age of 18 attended.

Medical staffing

- Two NHS emergency medical consultants provided support and governance to the ECC, however they didn't see patients. They provide an on call service on a week on week off basis to the doctors, review all the clinical notes and investigations and attend meetings with the senior management team representing the centre.
- All the Doctors who worked in the ECC were employed through an agency or via the hospital's bank which was in line with the unit's statement of purpose. ST1 ST2 grades were employed as RMO's to cover seven days per week, with one on shift at a time. The Head of Department told us that all doctors who work in the ECC have at least a years experience in accident and emergency and are current with ALS and EPLS training. Doctor's we spoke with told us that they had A&E experience and that that the agencies they worked for ensured that their training was kept up to date.
- The A&E consultant we spoke with advised that the current staffing of the ECC reflected the original model of how the ECC was first developed and felt that ST1 and ST2 grade doctors were "adequate and safe". Guidance from the College of Emergency Medicine states that a 'Service should have a minimum of ST4 or equivalent working in the department when the service is open' which is a more experienced grade of doctor than was currently being provided.
- Doctors confirmed that the NHS consultants come in on a daily basis, checked and signed off patient notes and they were able to be contacted via telephone if they needed advice. They also confirmed they reviewed all investigations, x-rays, bloods, and ECG's. The doctors also advised that they were able to access support from the consultants who worked regularly within the hospital if necessary.
- Patients were initially registered to be seen by a nurse from the ECC who carried out an initial clinical assessment (streaming) prior to being seen by the doctor. Patients were either discharged or admitted to the hospital or transferred out by ambulance to a NHS hospital.

Major incident awareness and training

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- The hospital had a business continuity plan for the management of all serious incidents.
- We saw that staff had major incident training. Staff spoken to were knowledgeable about the process and were aware of how they should respond. Staff were able to access the plans on the hospital's intranet.
- Chemical spillage equipment was available to deal with casualties contaminated with chemical, biological or radiological material, or hazardous materials and items (CBRN).

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement



Pain scores were not routinely recorded and patients often declined analgesia.

Staff were able to access policies and procedures through the hospital intranet, however they had not all been reviewed within the timescales indicated. The ECC had its own standard operating procedures that were available to staff.

There was a lack of patient outcome audits although the hospital was not required to submit to the national College of Emergency Medicine audits.

The number of patients being admitted to the hospital had increased by 55% between October 2014 and June 2015 due to international patients and transfers being assessed in the ECC; and was on an upwards trajectory. The ECC was increasingly being used for more complex patients and all medical admissions were going through the centre. This was not reflected within the ECC's statement of purpose or in the training that clinical staff received.

Staff reported that they had an appraisal and were encouraged to attend further training related to their role. Staff had received training in the Mental Capacity Act (MCA 2005) and Deprivation of Liberty Safeguards (DoLS).

Evidence-based care and treatment

- Policies and procedures were based on national guidelines, such as National Institute for Health and Care Excellence (NICE) guidelines and other national

guidelines, where appropriate. For example the Cardiopulmonary Resuscitation Policy makes reference to guidelines recommended by the Resuscitation Council (UK). However we noted that not all the policies had been reviewed within the timescale indicated. For example the BMI Safeguarding Children and Vulnerable Adults was due to be reviewed in March 2015 and not up to date with current guidance.

- Guidelines were available on the hospital's intranet. The ECC had its own standard operating procedures which was available to staff that worked in the unit however, we were not able to confirm if they met the College of Emergency Medicine (CEM) Unscheduled Care Facilities as this had not been audited or checked by the hospital. Staff that we spoke with knew how to access the guidelines and would also refer to the ECC's standard operating procedures including agency and bank staff.
- The ECC was not required to participate in national audits due to the small volume of patients through the centre. However we saw that the ECC undertook local audits for infection control and the monitoring of waiting times of patients through the centre

Pain relief

- The records we reviewed did not record pain scores on patient's notes. Staff reported that they were not routinely recorded because they were frequently declined by patients.
- The ECC has adequate stock of pain relief medicines such as paracetamol or diazepam which was offered to patients. Staff advised that patients routinely declined medicines such as analgesia.

Nutrition and hydration

- The ECC was able to access food and hot and cold drinks for patients from the hospital kitchen if required.
- The hospital scored 93.87% for food in the PLACE audits in 2014 which was better than national average score.

Patient outcomes

- The ECC did not conduct any patient outcome audits such as readmissions or returns to the service following assessment at the ECC. They did not meet the criteria for any of the College of Emergency medicine audits due to the low amount of patient numbers they treated.

Competent staff

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- Information provided by the hospital showed that 67% of nursing staff across the hospital had an appraisal in 2014. Staff we spoke with in the ECC told us that they had an appraisal and were able to access supervision.
- Staff advised us that they maintained their clinical skill by working shifts in NHS A&Es as agency workers as they were able to deal with more critical patients. The hospital was able to check this as this type of information was required of staff undertaking shifts at the hospital and we saw evidence of this being submitted and checked by the Medical Advisory Committee when reviewing practising privileges.
- Staff advised us that they had recently completed training in dementia and had opportunities for further training. Staff had also participated in study days, for example, in dealing with critical patients.
- There was a structured process for signing off agency medical and nursing staff. Agency staff were asked to visit the centre ahead of their first shift for a full orientation. A doctor reported they had a very good orientation and had been introduced to all the staff who worked in the ECC.
- Doctor's advised they were able to contact the on-call NHS A&E consultants and that other consultants working at the hospital were available for support and advice. The A&E consultants confirmed that they provided supervision by reviewing patient notes and giving feedback.

Multidisciplinary working

- ECC staff were able to access and felt supported by imaging and phlebotomy services within the hospital.
- Doctors advised us that they were able to access consultants from within the hospital as there was always someone available.

Access to information

- Staff were able to access information and policies and procedures through the hospitals intranet. Staff also had access to the ECC Standard Operating Procedures and we saw that signing sheets were in place to confirm that staff had read and understood them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw that staff had received training in Mental Capacity Act (MCA 2005) and Deprivation of Liberty Safeguards (DoLS). Staff were clear about their responsibilities.
- Patients were asked to consent to procedures appropriately and had the charges explained to them.

Are urgent and emergency services caring?

Good



We observed that the staff spoke with patients in a kind and helpful manner. A relative told us that “you pay your money and get quality care here”. Staff reported that they were supported to spend time and to talk to patients and patients were contacted by the lead nurse following discharge to check on their progress. We observed a patient come into the ECC to thank the staff for their care and help.

Compassionate care

- Patients were treated with compassion, dignity and respect. We observed staff being polite and introducing themselves by name. Treatment plans were explained in terms that were easily understood.
- In bays we saw that patients were screened to give them privacy.
- Relatives told us that they brought lots of overseas patients to the ECC. They told us “here you pay your money and get good quality care”.
- The hospital received feedback from patients via the Friends and Family Test (FFT) from both NHS patients and those paying privately. For the period October 2014 to March 2015 the hospital had consistently high FFT scores for both NHS funded and other funded patients which is above the national average. This was based on a moderate response.

Understanding and involvement of patients and those close to them

- Patients could be supported by family or friends during consultations if they chose.

Emotional support

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- A doctor told us that they were supported to spend time and to talk to patients. They were very positive about the culture within the department.
- Patients were contacted following discharge to check on their progress following treatment they had received.
- We observed a patient come into the ECC to speak to the receptionist wanting to thank the staff for all their care and helping him through the system.

Are urgent and emergency services responsive to people's needs? (for example, to feedback?)

Good



The ECC offered patients an immediate appointment with a nurse and if required a doctor, with 55% of patients being seen and treated within an hour. Patients also received a follow up call following discharge to provide them an opportunity to feedback on the service they received.

Patient information was available and staff were able to access an on site interpreter and a telephone translation service when dealing with people from overseas. An average of 2 or 3 complaints were received each month mostly related to the additional charges for services.

Service planning and delivery to meet the needs of local people

- Staff told us that the ECC saw approximately 13 patients per day. Figures available from the hospital showed for the period April 2014 to March 2015 this was approximately 372 per month. Staff told us that the ECC was rarely full.
- The ECC opening hours were from 8am to 8pm Monday to Friday and 8am to 9pm on Saturdays and Sundays. The opening times of the ECC had recently reduced due to long term staff sickness. Staff reported that the weekends were their busiest periods.
- The ECC ceased providing services for children under the age of 16 years in June 2015. The hospital advised that this decision had been taken quickly after a corporate-led audit of children's services was undertaken which highlighted that the hospital wasn't

able to meet the needs of children in line with national standards. Staff told us that the resuscitation equipment was removed from the centre without any discussion.

- Patient information was available in English, but not available in any other language or format. Telephone translation services were available for patients whom English was not their first language and there were also on site interpreters on site who spoke Arabic to support international patients.
- The ECC had it's own waiting area which had adequate seating for patients and their relatives. Hot and cold drinks were available for people to help themselves. The ECC had access to public toilets available at reception with nappy changing facilities
- If patients were planned to be admitted to the medical wards, they were required to attend the ECC and be initially assessed by one of the ECC RMO before they were admitted onto the ward.
- Information relating to the service provided and charges were available on the website.
- Patients were informed of all costs when they booked into the ECC. Patients were informed of any additional charges should they require any tests, medicines or imaging.

Meeting people's individual needs

- Doctor's reported they were able to access appropriate services and refer patients on if they had complex needs such as a learning disability or living with dementia. Staff told us of a patient who had been discharged early by the NHS was brought to hospital for continuing treatment and rehabilitation. The patient remained in the ECC for several hours. A decision was made by the hospital not to admit the patient as there no one to one support available for the patient and they were redirected back to NHS. We saw the clinical incident report related to this.
- Staff told us that they could access a telephone translation service and that some staff in the hospital spoke different languages.

Access and flow

- Patients attending the ECC were directed to the reception area where administrative staff took their details and reason for attendance. Patients were informed of the cost of the consultation at this point.

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- Between October 2014 and June 2015 a total of 493 (15%) patients from the ECC were admitted to the hospital. This was an increase for the same period of 6% in 2014. Staff advised us that the ECC was increasingly being used as the default place to review patients who called their consultant with complications or worries about post discharge worries, so they were seeing for complex admissions. All new medical admissions and transfers go through ECC and patients had a full assessment prior to being admitted. In June 2015, consultants referred 21 patients to the hospital via the ECC and, for the period October 2014 to June 2015, 170 patients were referred by consultants. The ECC also saw patients post discharge for follow up.
- Doctor's advised that a lot of patients arrive and expect to see a consultant straight away; however patients could be referred to a consultant quickly if they needed one.
- The hospital provided on-site imaging, plastering of simple fractures, pathology testing, pharmacy and physiotherapy support.
- The ECC monitored its see and treat waiting times and for the period April 2014 to March 2015 2447 (56%) of patients were seen and treated in under one hour and that 56 (1.28%) of patients spent over 4 hours in the ECC. This did not include planned medical admissions. The ECC did not monitor their performance in relation to triaging patient's within 15 minutes of arrival and the figures did not show how long over four hours the minority of patients waited.
- The ECC provided services to returning patients attending for post operation reviews and following referrals from their consultants or general practitioner (GP). Patients transferring from the NHS or another provider were also assessed in the ECC prior to being admitted to the wards.
- Staff told us that there were occasional issues with referring patients to wards and sometime patients had to wait up to 6 hours for a bed to become available or there were insufficient staff on the wards. A doctor commented that the transfer to patients to the wards could improve and become more fluid.
- We saw that the number of patients admitted to the hospital had increased. For the period October 2013 to September 2014, 318 patients were admitted. For the period October 2014 to June 2015 493 patients were admitted. This was a 55% increase in 10 months.

Learning from complaints and concerns

- Complaints were dealt with by the head of department in the ECC. The head of department advised that the ECC received an average of two or three complaints per month and these related to the charges of the unit. These were due to patients having to pay for additional services such as blood tests, ECG's and imaging which were additional to the cost of the initial assessment.
- Information on how to raise a complaint was located in the waiting area. Patients were able refer complaints to the the Independent Sector Complaints Adjudication Service (ISCAS) an independent external adjudication process once the hospitals internal complaints process had been exhausted.

Are urgent and emergency services well-led?

Good



Staff were focused on providing good care to the patients who used the ECC. The staff felt they were a good team and supported each other. Staff enjoyed working in the ECC and felt it was a good department. The head of the department was visible and worked alongside the staff; staff felt supported in their roles and were happy with the management.

Governance systems and risk management had been established to monitor patient outcomes and improve care although some areas still required actioning. The Centre had regular clinical and non-clinical team meetings and staff were able to feed back their concerns or issues via reflections which prompted discussion and provided support within the team. The team also had regular feedback of key messages from the Comm Cell meeting attended by the head of department which aided communication across the hospital. However, the ECC's statement of purpose had not been reviewed to reflect the increase of patients being assessed or transferred to the hospital via the ECC.

Vision and strategy, innovation and sustainability for this core service

- The ECC's statement of purpose set out the objectives of the centre as providing treatment of minor injuries including single limb trauma which was based on an

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urgent care centre model with some patients presenting with more emergency based ailments. We saw that this had not been reviewed to reflect the change in how the ECC had been used over the last 12 months which saw all medical admissions and transfers in and out the hospital being managed through the ECC.

- Staff we spoke with were focused on providing a good care to the patients who used the ECC.

Governance, risk management and quality measurement for this core service

- The ECC fed into the hospital wide risk register. We saw that there were four items identified as a risk in the ECC; these included insufficient toilets, lone working, unwipeable seats and work-related neck and upper limb disorders (WRULD) at the ECC workstation. We saw that these had been reviewed in June 2015 and were still outstanding. A doctor we spoke with was concerned that ECC's statement of purpose had not been reviewed that there was not a full understanding of the increased risk this posed. We noted however that the risk register was not business critical as the focus was on environmental risks, not risks we identified such as lacking patient outcome auditing, or increased activity.
- Governance mechanisms within the ECC had been established to monitor and improve standards of patient care. ECC clinical meetings were held on a bi-monthly basis they showed staff were updated on policies and procedures and staff issues. Staff were also encouraged to report safeguarding concerns and incidents and we saw that these were followed up and discussed.

Leadership/culture of service for this core service







- Staff reported that the head of department was visible and provided good leadership, was supportive and that they felt able to raise concerns. One member of staff told us that were happy with the management of the ECC and that they had a consistent approach.
- The senior management team was visible and visited the centre daily. We received mixed views about the senior management team as some staff felt that they were approachable and others had a different view.

- On a daily basis the heads of departments clinical and support services and senior management team meet for a 'Comm Cell' meeting which was introduced about 9/12 months ago to improve communication across the hospital and update departments on key issues. Heads of departments also reported daily performance. The Heads of departments then feed back to their own teams; staff confirmed that the lead nurse attended and feedback the key messages.
- The ECC has introduced reflections about a year ago as a means to support staff when there had been a difficult shift and there was no one to talk to about it. Staff were encouraged to write up what happened, their feelings, what action they have taken and what difference they have made, We saw good examples which were open and honest. For example when a patient had fallen, there had been staff shortages, concerns about a patient who deteriorated post discharge, and when there had been a busy shift. Many of them had been raised as clinical incidents. Staff reported that this promoted discussion within the team and allowed the centre manager to support and guide them. The Head of department advised that reflections was commended by a visiting nurse from NHS England and had asked the manager to write up a model.
- Clinical and non-clinical staff told us that that they enjoyed working in the ECC and that it was a good department. All the staff felt they were a good team and supported each other. A doctor reported that the ECC had a positive working environment, with dedicated staff.

Public engagement

- We saw that local patient questionnaires were available and themes collated and used for patient experience planning. Patients also received follow up calls which provided patients an opportunity to feed back on their experience.

Medical care

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

Information about the service

Medical services at the hospital included inpatient services on the 23 bedded Epping Ward and the eight bedded and two treatment room endoscopy unit. Epping ward treated mostly elderly or general medicine patients with conditions such as sepsis, pneumonia and chest infections, with a high amount of these being international patients, mostly from Kuwait. There were a total of 206 general medical, 16 cardiac and 121 chest patients (not including ECC attendees with chest pain) in 2014/15. We visited both these areas, spoke with seven patients and a relative, 19 members of staff including nurses, healthcare assistants, allied health professionals (including pharmacists and therapists), as well as administrative and ancillary staff such as porters and housekeepers. We reviewed five patient records, and a range of other hospital records such as policies, procedures and audits. We also conducted observations.

Summary of findings

Medical services were good.

Patients were protected from avoidable harm, there were good governance processes including learning from incidents and risk management, medicine management was appropriate, national guidance was followed, patients were mostly well cared for and improvements were on-going.

However there were a number of areas we were concerned with in safety and effectiveness including poor infection control compliance, nursing staffing levels, completeness of records, a lack of benchmarking evidence and food provision. There were also some concerns with flow from the ECC and local leadership.

Medical care

Are medical care services safe?

Requires improvement



The safety of the medical services required improvement. There was poor infection control compliance such as wearing personal protective equipment or hand washing between patients despite high compliance audits in these areas. Patient record completeness was not up to standard with multiple areas missing information. Nursing levels did not meet the staffing establishment or the patient activity levels that came from the emergency care centre plus there was a high use of agency staff. There was no recorded review of expected deaths.

However, there was evidence of learning from incidents via various meetings and methods. There were appropriate measures to prevent patients coming to harm although medical interventions were not always in place. Equipment and environment checks were up to date although carpets were still in use on the ward. Medicine storage and management met national guidance. Medical staffing were always available either on site or contactable.

Incidents

- The service had no reported never events (Never Events are serious events 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.) or serious incidents. Hospital wide, there were 640 patient safety incidents in 2014/15 which is at a rate just above the national average. Most non-adverse incidents reported related to administration and equipment issues or medicine errors.
- Senior nurses felt Epping ward reported three to four incidents a month on average and this had dropped from previous levels. There had been no adverse incidents recorded against the endoscopy unit since it opened. The last incident was a contamination issue in the old unit which was resolved by the opening of the new unit.

- Incidents were recorded by staff on paper which were then logged by the quality and risk team (Q&R) electronically. Q&R then assigned the incident to be investigated with a set timescale and monitored it till completion including an actions and learning required.
- Incidents were logged and reported which were then discussed at various daily briefings from senior management to wards called Comm Cells and monthly team meetings. Feedback was also given once any investigation had been completed. However, some staff felt there was under reporting of non-medical incidents and we observed some copies of incident reports were not kept on Epping ward, although a carbon copy was available to be taken.
- Staff were aware of their responsibilities under the Duty of Candour regulation and information was displayed on the ward.
- Staff felt they could challenge each other if there was a concern or error in practice. However when we observed practice that should be challenged, it wasn't.
- Unexpected deaths were subject to a root cause analysis. However expected deaths were not reviewed although they were highlighted at clinical governance meetings.

Safety thermometer

- Safety thermometer results were recorded monthly. These showed no patients had come to harm since January 2015 and only two patients had not been venous thromboembolism (VTE) assessed, with no concerns regarding prescription of prophylaxis. Hospital wide audits for VTE showed 94% compliance and four incidents of either VTE or pulmonary embolisms (PE). There had been five VTEs or PEs in the last 12 months. When we reviewed patient records, we observed that VTE screening was completed but patients were not always prescribed prophylaxis or stockings as required and there were sometimes discrepancies between VTE assessments and bleeding risk. When discrepancies were pointed out, reasons for lack of prophylaxis were given but these reasons were not clear within the notes.
- The last clinical governance report showed any acquired blisters were attributable to surgery patients only. However the report showed incidents were being declared relating to pressure ulcers that were present on admission.

Medical care

- There was often not a plan in place to action concerns regarding falls, pressure ulcers or nutrition when there was a high score requiring intervention or support. Senior staff felt falls were a risk.

Cleanliness, infection control and hygiene

- The service had no reported incidents of infection including Methicillin-resistant Staphylococcus aureus (MRSA), Clostridium Difficile (C Diff) or Methicillin-sensitive Staphylococcus aureus (MSSA) in 2014/15.
- The last cleanliness audit found compliance at 70% in endoscopy and 89% in Epping ward. The last patient led assessment of the care environment found cleanliness at just below 100%. However, we observed the ward area, endoscopy and equipment as visibly clean and tidy with clean stickers within the last 24 hours. Disposable curtains were within date.
- The ward area was carpeted. A refurbishment programme including bringing in laminate flooring was due to take place within the next three years.
- The last hand hygiene audits for Epping ward and endoscopy were 100%. Personal protective equipment (PPE) and hand washing facilities were available. However there was some lack of signage for rooms where additional infection control protocols were required and we observed various types of staff walking into rooms without PPE or hand washing where it was required. Literature displayed on infection control was only in English. Urinal bowls were also on bedside tables. When we highlighted these concerns, they were fed back to staff as part of the next day's Comms Cell. Senior nurses felt hand hygiene was mostly an issue with agency nurses. When we spoke with senior staff, they told us audits were completed by the ward's own staff rather than as a peer review and sample sizes could be low.
- Epping ward fell well below the hospital target for its last sharps audit. The sharps bin in endoscopy was unclear when it was assessed as the original date said 7 November 2014 but was changed to 7 November 2015.
- Clean endoscopes from the endoscopy unit were being transferred in a trolley box under a green cover, although it was clear scopes were tracked through the decontamination process with separate clean and dirty areas to ensure no cross contamination. Otherwise staff in the unit adhered to infection control practices.

- Infection control link nurses were in place and were up to date with infection prevention and control (IPC) audits such as sharps, hand hygiene and other IPC precautions which were conducted monthly. However it was acknowledged by senior staff that there was a need for a permanent IPC lead to help improve compliance and minutes of meetings showed there were concerns regarding the capacity of the current IPC staff.
- Staff were aware of some of their requirements for adhering to IPC practice such as isolation processes but were not aware of contact precautions. They had all had IPC training although as of June, hospital wide compliance with training was 80% for Aseptic Non Touch Technique (ANTT) e-learning, 82% for ANTT practical, and 77% for hand hygiene practical.
- Endoscopy recovery area had a cleaning schedule and this was audited.
- The last waste audit for Epping ward found compliance at 85% and endoscopy at 100%.

Environment and equipment

- Resuscitation equipment was available and records showed they checked daily.
- We checked medical gases and there were mechanisms in place for these.
- Although the endoscopy unit was not (joint advisory group) JAG accredited, it was a new unit that had only been open a few weeks. In planning the unit, the hospital had requested advice from a relevant JAG person to ensure it would meet their requirements for accreditation and it was CFPP-01-06 compliant. The service was actively trying to get JAG approval at the time of our inspection.
- Equipment in the endoscopy unit had up to date checks. Audits had taken place to ensure first aid kits were in place in both endoscopy and Epping ward. Other consumable products were in date.
- Personal appliance tests were up to date. This had been identified as an issue in a previous insurers audit in January 2015.

Medicines

- Controlled medicines (CDs) were correctly stored and checked at the start and end of each endoscopy list. Other medicine checks in the endoscopy unit were up to date and in line with guidance such as when medicines were used and disposed of. Stock levels were appropriate with no more than two to three lists worth

Medical care

of medicines stored on the unit. One consultant had their own preferred medicines which they stored separately on the unit but this was also secure and checked. None of the medicines we checked were near their expiry date. If there was ever a discrepancy, staff were not allowed to leave until the discrepancy was investigated.

- Medicine administration records (MARs) were not always legible and administration records did not always match prescriptions such as with oxygen.
- Prescriptions were monitored by pharmacists and added their own notes to patient records.
- Medicines in endoscopy were prescribed and administered to individual patients with records that showed specifics on how it was to be administered, dose and amount discarded. Although some of the equipment used meant there were multiple dose bottles, nozzles were changed for each new patient.
- There was an up to date antibiotic protocol which included first and second choice medicines to use, dosage and duration of treatment.

Records

- The last patient record audit showed compliance on Epping ward of 74% with issues with consultant notes, patient labels and signing. Medical pathway records were 88% complete on their last audit with concerns with fluid balance charts. Patient records we checked were not always complete, particularly nursing assessments. Medical histories were not complete, gaps were found in medical pathway documentation, falls assessments and catheter care. Manual handling assessments were not complete despite support arrangements being needed for some patients such as difficulties with communication and visibility. Allergies were recorded as sensitivities on separate documentation. Some notes had not been updated for a week despite staff telling us their care plan had changed. Admission documentation was not always complete.
- Some patient pathway sections were not complete such as medical or therapist input. However these were separately recorded on separate notes within the same patient record due to a lack of space. This meant there was a risk staff may not know what medical and therapist input there has been if they reviewed the wrong part of the record.

Safeguarding

- The service had no reported safeguarding alerts in the last 12 months.
- Staff were aware of their responsibilities to safeguard vulnerable adults and knew the relevant safeguarding leads. They had been previously trained regarding safeguarding children but it was not clear if this would be maintained since child inpatients up to the age of 16 had been discontinued recently.
- Safeguarding was part of staff mandatory training but we were not given training records to show what compliance of each subject was, despite requesting this.
- Any external contractor had to go through a risk assessment before they started any work at the hospital and had to fulfil a sign in and out process.

Mandatory training

- Mandatory training compliance was 90% overall though this was partly due to nine new members of staff. Information we received from the hospital showed 72% compliance with training in endoscopy and 93% for Epping ward. Mandatory training included information governance, equality and diversity, health and safety and infection control. Staff told us it was easy to get time to complete their training. Staff were sometimes sent to another BMI site if the in house training was not soon enough. Staff were emailed to ensure they kept up to date with training. However we were not given training records to show what compliance of each subject was, despite requesting this.
- Induction of agency staff was robust with a checklist that required completing before they could work including an orientation of the unit, an introduction to the hospital overall plus statutory requirements such as fire procedures, health and safety and IPC. Attempts were always made to use agency nurses they had used before. All agency staff required a copy of their certificates such as intravenous competency, basic life support and manual handling.
- Registered medical officers (RMOs) were required to send evidence of their mandatory training and we saw this was recorded in their files.

Assessing and responding to patient risk

- Staff were aware of how to escalate a patient if they deteriorated but some staff told us they had not been

Medical care

part of a simulation exercise. We saw records of simulations that had taken place but none involved Epping ward or the endoscopy unit. However, staff that had attended a crash call told us they worked well.

- Patients were not always reassessed after a fall.
- The national early warning score (NEWS) was in place with an up to date policy on how and when to escalate patients. Although this was not audited at the time of our inspection, all the observation charts we checked were up to date.
- The hospital had a designated crash team although they were staff that also covered other areas of the hospital.

Nursing staffing

- A safer staffing tool was in use with an establishment of four registered nurses and four or five healthcare assistants (HCAs) during the day plus an overseas nurse, student nurse and a supernumerary sister covering up to 23 beds. At night it was supposed to be four to five nurses and three healthcare assistants. Each shift was planned the previous morning and we observed junior sisters booking staff for shifts. However we found staffing levels during the day were mostly three nurses and two HCAs and at night were mostly two nurses and two or one HCA covering 15 patients. The junior sister was not always supernumerary and sometimes took on one patient whilst getting additional staff to come in. Senior nurses felt these levels were appropriate although they were concerned about the skill mix. Staff told us staffing levels and skill mix had improved due to an increase in establishment of four nurses leading to better prevention of patient harm and senior management told us they would never have less than two nurses on shift at night.
- There were concerns that staffing levels did not reflect any additional admissions from the Emergency Care Centre (ECC) and that there was a lack of flexibility to arrange this with patients waiting over an hour to be admitted so additional staff could be brought in on the ward. Staffing levels were inconsistent and the rotas were unclear and changed constantly. However, any patient living with dementia had one to one care from a healthcare assistant.
- There was a high use of agency staff although it varied between two and six agency nurses each day and they were robustly inducted. We were told this was due to recent resignations of two nurses and senior staff acknowledged this was a risk. Vacancies across the

hospital were at 30% for nurses. However, there was a robust recruitment drive including recruiting from overseas with 28 nurses due to start shortly across the hospital. In addition, skill mix was reviewed such as number of staff that could administer intravenously. Agency nurses also covered when there was sickness, training or annual leave.

- Staffing levels were appropriate for the endoscopy unit for the list sizes with ten staff covering a list although they were using two agency staff, one of which was regular.
- Handovers we observed were appropriate and robust.

Medical staffing

- Doctors were always available and consultants visited daily although some patient told us they saw a doctor less often. Consultants confirmed that they sometimes telephoned on a Sunday rather than come in. However consultants or designated alternative cover were always available by phone which was an appropriate arrangement and staff told us this worked.
- Doctors attended quickly if they needed to assess or treat a patient. If a consultant was away, they arranged cover.
- One registered medical officer (RMO) covered the medical ward 24/7 on a rotational basis whilst also covering the surgical wards. Sometimes a second RMO was also on duty depending on how full the hospital was.
- All RMOs were required to be trained in advanced life support, and have 12 months experience in medical work. We saw evidence that those on the staff rota had these competencies and experience. They were also General Medical Council registered.
- There was no formal service level agreement between the hospital and any NHS trust although most patients that required transfers were transferred to the local NHS hospital. When we spoke with another hospital regarding transfer arrangements, they had no concerns.

Major incident awareness and training

- A business continuity and major incident plan was in place with action cards for different types of incidents including loss of water, loss of power, lack of medical gas, reduced staffing, loss of electronic systems, and flooding with responsible staff highlighted with immediate and long term responses to each scenario.

Medical care

Are medical care services effective?

Good



We were concerned about the effectiveness of medical services at the hospital. Staff were aware and followed national guidance. Patients' pain was monitored and well managed. Staff were kept up to date and developed to improve their competency. Multidisciplinary working was in place.

However the information we received showed either average or above patient outcomes, benchmarking information we received for this was limited. There were some concerns with the food provision although this was starting to improve. Records relating to nutrition and mental capacity were not always complete. Although communication processes were in place, they were not always used effectively.

Evidence-based care and treatment

- Staff were aware of national guidance and local protocols and knew where to find them. Copies of policies were available both on the intranet and in folders which all staff could access including agency staff.
- Physiotherapists reviewed neurological rehabilitation patients twice daily which met national guidance.
- Medical device and medicine alerts were reported monthly.

Pain relief

- Pain screening/scores took place and these were acted upon with pain relief where necessary. Patients told us their pain was mostly well managed.
- The hospital were due to audit pain management towards developing nurses regarding pain management. However there was no current pain team at the hospital.

Nutrition and hydration

- The last patient led assessment for the care environment (PLACE) rated the food at just below 94% which is better than the national average. Patient satisfaction with catering was 86%. We received a mixed response from patients about food and drink although it was always available. One patient told us the food was

“not too bad” and there was “always something to drink.” Another patient said the food had “improved slightly since June” but that there was no menu changes and some food either was not fresh or did not taste fresh. We observed patients always had drinks available in their rooms.

- If patients had any concerns with the food, nurses, catering staff and ultimately the catering manager tried to resolve them. All concerns were passed to the Operations Manager and had been voiced at a regional meeting with the outsourced company that had taken over the catering contract in recent months, and some improvements following this meeting had been made. An action plan had also been drawn up which included training of hostesses, increasing choice for longer stay patients, development of specialist dietary menus and food available out of hours.
- Malnutrition scoring tools (MUSTs) were not always complete with scores not being totalled. Swallow tests were not always conducted. Action plans were not always in place for high MUST scores where an intervention was required. It was not clear if speech and language therapists were referred to when required.
- There was dietician support but we noted they had not assessed a patient with a percutaneous endoscopic gastrostomy (PEG) feed. Patients were only referred to a dietician reactively and this had to first be authorised by a patient's insurer or the payee.

Patient outcomes

- The hospital measured patient outcomes via a range of measures including mortality, transfers out, infection rates, average lengths of stay, readmission rates, satisfaction rates, patient questionnaires, incidents, complaints, claims, activity, staff questionnaires, national audits, compliance with national guidance, quality scorecards, Friends and Family Tests, mandatory training rates, BMI visits and whistleblowers. These were compared both regionally and nationally across BMI but we did not receive the benchmarked scorecards for these despite requesting any audit data they had.
- National audits participated in included Medicines and Healthcare Products Regulatory Agency (MHRA), Commissioning for Quality and Innovation (CQUINS) and National Confidential Enquiry into Patient Outcome and Death (NCEPOD). However we did not receive the results for these despite requesting them.

Medical care

- Hospital wide they had around the national average unplanned readmissions compared to other independent hospitals of similar size between April 2014 and March 2015, with 32 declared readmissions at a rate of 0.4%. These were reported at clinical governance meetings but were not investigated.
- Hospital wide unplanned transfers were around the national average compared to other independent hospitals of similar size. These were highlighted at clinical governance meetings but were not always investigated. The hospital changed the admitting process so all patients were admitted through the Emergency Care Centre to reduce the amount of transfers out and the hospital felt this had led to a decrease. This was due to be re-audited in January 2016.
- All mortalities within the medical service were expected with an overall SHMI of 0.2 which was much better than the national average.

Competent staff

- Overseas nurses that were recruited had an adaptation course of three to six months which included an English language test, then a two week induction programme at the hospital and were mentored by a permanent nurse. However, physiotherapists had less of a formal induction as although they received an orientation and were informed about the hospital structure; they shadowed their line manager in the morning before taking on a patient case load in the afternoon of their first day.
- A competency based training programme was in place for nursing staff including healthcare assistants. In particular, HCAs were being supported to gain NMC registration. The professional development process was clear on what staff were required to do as part of their role and what areas of development they would like to do, plus appraisals and practice sessions. Other areas of training that were available included phlebotomy, and dementia. HCAs could gain competencies in observations, echocardiograms and admitting patients.
- Hospital wide, although appraisal rates for most staff groups were above target at nearly 80% or above, for nurses, they were below target at 67% although this was an improvement from 12 months ago. These figures were not broken down by the hospital to department level.

- There was a lack of evidence of training for endoscopy staff to show it was up to date or had been signed as completed although there were certificates in place. However, there was competency training regarding scope cleaning and representatives came from the equipment companies to aid training.
- All consultants working with the hospital had practising privileges which required consultants to have an up to date General Medical Council (GMC) registration, evidence of indemnity insurance and revalidation certificate. These were reviewed monthly to check who had expirations and these were highlighted at Medical Advisory Committee meetings. However the corporate practising privileges policy we received was out of date by over 12 months.

Multidisciplinary working

- There was evidence of multidisciplinary working (MDT) between therapists and other staff on medical wards. This included discharge planning. We observed staff working as a team for patients.
- Doctors had started to attend the ward Comm Cells meetings but not the ward team meetings.

Seven-day services

- Consultants and RMOs were available seven days a week.
- There was an out of hours rota for pharmacy, radiology and physiotherapy with one staff member available for each. Senior management team members also had a rota where one would attend out of hours each day for a week at a time.

Access to information

- Comm Cells meetings took place at 11.00am which conveyed any relevant information to ward staff. However, these were sometimes rushed and messages were not always clear.
- There were discrepancies between the boards in endoscopy and the Epping ward for bookings which meant information was not always up to date in some areas.
- An account manager was employed who has continuous contact with GPs and a newsletter to GPs was due to start in September 2015.
- Displays clearly showed which staff were on duty.

Medical care

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and training had been undertaken to support this.
- Consent was obtained before any endoscopy procedure, however consent on the Epping ward regarding who could discuss care with the patient, and to have their name on the door were not always complete. Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) status and bed rail assessments were not always complete so it was not always clear to staff if a patient was for resuscitation.

Are medical care services caring?

Good



Medical services provided were caring and involved patients. Most patients reported that they were well cared for and recommendation scores were above the national average. Although there were a few observations that were not caring or involving, most patients reported feeling informed about their treatment including any costs. We saw displays of empathy and procedures were in place to support staff emotionally.

Compassionate care

- The Friends and Family Test (FFT) results were above the national average across both NHS and private patients with a moderate response rate of around 40%. Patient satisfaction scores and overall quality of care were at 98%. However there had been seven out of ten items of feedback on NHS Choices which were unlikely to recommend the service and scores were lower at 93% for nursing care.
- Patients were well cared for. Staff were very welcoming to patients and treated them with privacy and dignity. One patient gave an example of how their privacy and dignity was maintained whilst they were showered by staff. Bedroom doors were kept closed for any patient discussions. Patients reported their stays as 'pleasant'. Most questions we posed to patients had a positive response. However we did see a small minority of examples of staff not showing care towards their patients such as dismissive behaviour.

- We observed call bells being answered quickly but intentional rounding's were not always completed.

Understanding and involvement of patients and those close to them

- Staff were able to demonstrate that they were aware of what patients wanted and needed.
- Patients had named consultants looking after them. Patients were allocated a nurse and/or HCA to look after them each shift. Patients told us they were always introduced to their nurse, though sometimes they arrived whilst they were still asleep.
- Patients told us, if they were insured, the hospital made clear what was and was not covered by their insurance and arrangements were made if they wanted care they were not insured for, done by the NHS, such as outpatient follow up appointments.
- All the patients we spoke with felt involved in their care and were kept informed about their treatment. Care plans were shared with patients. However a few patients thought some nurses were not able to understand English very well, particularly agency staff.

Emotional support

- Staff took time with patients and their families if they were upset. We saw staff display empathy and support towards patients and their relatives.
- Corporate employee support was available 24/7 which included counselling and information and advice in a range of areas.

Are medical care services responsive?

Good



Medical services were mostly responsive to patient needs. Staff were trained and aware of how to meet the needs of patients with dementia and more detailed care plans were due to be rolled out in September 2015 to further aid this. Visitors were well catered for, including being able to stay overnight. Complaint themes were highlighted in reports although we did not observe this communicated fully at a local service level. Discharge was mostly well planned although discharge dates were not always in place.

Medical care

However, there were delays with flow between the emergency care centre (ECC) and the medical ward as well as issues with the physical flow of patients through endoscopy.

Service planning and delivery to meet the needs of local people

- Patient satisfaction with the environment was 90%. Although the environment did not meet IPC standards, we had no other concerns with the environment's responsiveness to patient needs. All patient rooms were single en-suites.
- Although the hospital had visiting hours, patients and their relatives told us they were always able to visit. Visitors were also able to stay overnight on the ward if required.

Access and flow

- All patients were admitted through the Emergency Care Centre to reduce the amount of transfers out. However there were sometimes delays between decision to admit at the ECC and admission onto Epping ward.
- Bed capacity planning was conducted on a weekly basis with the expected amount of patients due to stay overnight but the planning document did not state any expected admissions. Endoscopy had the planned amount of patients due for procedures each day.
- Discharge planning with a discharge team was in place with a flow chart for these. However, deadlines for discharge were not routinely set apart for patient convenience. We were concerned this may be a factor in delays with admissions from the Emergency Care Unit. Discharges for the day were highlighted at the Comms Cells. Patient satisfaction with discharge was 86%.
- The electronic discharge letter was not user friendly as it was difficult to navigate and we observed the screen freeze often.
- To take home tablets (TTOs) were timely on discharge from the pharmacy, although some nurses told us they took over an hour to dispense.
- Patients in the endoscopy unit had to come into the unit the same way they exited, as the door to the discharge lounge was locked and not in use. Although the unit had not been designed to segregate males and females, this was achieved as much as possible with the layout.
- Patients were able to have an endoscopy the same day as their outpatient visit.

- Due to the lack of staff on the endoscopy unit, only one list of six to eight patients ran at a time.
- There were no social services staff on site but patients were referred if they required an assessment. Occupational and physiotherapist support was also provided in these circumstances to aid a package of care on discharge.
- We requested the hospital tell us about any patients that were discharged out of hours but we only received the corporate guideline for discharging surgical patients following general anaesthetic.
- Each patient received a patient guide. This included information on how charges work, meals, access to a chaperone, what clothes to bring, discharge arrangement and hospital procedures such as infection control.

Meeting people's individual needs

- The hospital had an international service that served the high Kuwait originating population of the area. Language line was also available as well as Arabic interpreters. Information leaflets were available but were not available in different languages unless specifically requested.
- Although currently no specific care plan was currently in place, patients living with dementia were due to have a specific care plan from August 2015 for their needs and their needs were identified as part of their admission. Staff were aware of how to cater for specific needs although plans were not always in place to meet them. Around half of nurses had received specific training regarding dementia. Most staff had watched 'Barbara's story' which was a video regarding care of a patient living with dementia.
- We requested information relating to how the service catered for people with learning disabilities but only received information relating to dementia care.
- The admissions policy did not allow any patients with a psychiatric disorder to be admitted.
- Patients were able to have a hairdresser attend if necessary.

Learning from complaints and concerns

- Patient told us most concerns were dealt with informally by the staff on the ward. Any formal complaints would either go to the patient services manager or director of nursing and would be logged electronically with investigations conducted by the head of department.

Medical care

- There were very few complaints about medical services and none about endoscopy. We were told complaints would be discussed at Comm Cell meetings but we did not observe this happening although we were not made aware of any complaints being received during our inspection. We requested a range of complaints response letters but none related to medical services provided at the hospital.

Are medical care services well-led?

Good



Medical services were mostly well-led. There were clear visions and strategies that staff were aware of. Clear governance processes and structures were in place with constant monitoring and review. Services were driven by performance and improvements were continuing to take place. Risks were identified and actioned but not always up to date.

However there were some concerns regarding local leadership accessibility and there had been some poor performance relating to staff questionnaires although based on a limited response rate.

Vision and strategy for this service

- Staff were aware of the hospital wide vision of 'Best Care Always' which included talks from external speakers such as the chief nurse of England but staff were unsure how the concept was to be implemented.
- Senior staff in endoscopy had a clear vision on how the service was to move forward.
- The six Cs (Compassion, Competence, Care, Communication, Courage, Commitment) were displayed throughout the unit and staff carried cards of these with them. Key objectives were set against the six Cs with targets for achievement.

Governance, risk management and quality measurement

- Medical services fed back via a range of meetings and committees via their leadership team including heads of department meetings, and nurse leadership into the hospital wide clinical governance committee.
- Ward team meetings were held every six weeks and the minutes were clear with high staff attendance,

structured agendas such as IPC, training, quality and staff concerns. Meetings also took place covering all nursing staff on a weekly basis which enabled any issues to be flagged although they also had structured agendas with actions. However it was not clear if previous actions were closed off. Information was fed down from the clinical governance committee which included updates on incidents, mortality, patient outcomes, complaints, audits and risks.

- The risk register included concerns regarding car parking when patients were being discharged, pressure ulcers, falls, nutrition, age of scopes and fire risk assessment. The hospital wide risk register still included the endoscopy unit despite the new unit opening several weeks ago, inadequate beds despite new beds being delivered. However the latest draft clinical governance report recommended the fire assessment, and endoscopy risks be archived. Most staff in Epping ward had signed to say they had read their local risk assessments but no staff in endoscopy had recorded that they had.
- A hospital wide set of objectives were set with timescales attached with implications for medical services. These included reviewing and standardising RMO support, improve end of life care including recruiting a palliative consultant, improve dementia care by having courses for staff and reviewing patient rooms surroundings, improve discharge particularly consistency and allied health professional input, training on the nursing dependency tool, review nursing shift patterns, recruitment and retention drives, improved induction programme, up to date appraisals and improved personal development, review agency use, launch green initiatives such as utility usage monitoring and green champions, improve executive approachability by audit Comms Cell key messages and a social calendar. All these were updated with progress such as booked training for dementia and nursing dependency tool, induction programme had been updated, and a green champion had been identified.
- BMI representatives at a corporate level visited the hospital in January 2015. All the actions following their visit for Epping ward had been completed such as updating the controlled drugs register, using reusable wash bowls and dusty equipment.

Leadership of service

Medical care

- Medical services had a lead nurse and ward manager who was line managed by the Director of Nursing. However staff were not always sure who to report to.
- Staff felt that the senior nurses for the ward were not visible but commented that the senior management team was visible including walk rounds and 'back to the floor' and had improved in the last year. However, many of the senior staff for medicine were new to their positions and they were conducting walk rounds.
- The endoscopy unit was led by an experienced level practitioner, not a nurse endoscopist. However the unit was managed by someone who also covered theatres.

Culture within the service

- Staff morale on Epping ward was positive. Staff felt supported by their colleagues and said their leaders were engaging and empowering. There was a concern from staff that there was only a 'BMI way' of doing things and staff had varying experiences of being valued.
- Epping ward received an 'Oscar' reward from the hospital last year for improvements made.
- Sickness rates for all staff were better than the hospital target at below than 10%.
- There was low turnover of staff although healthcare assistants that had been at the hospital over a year was below average. We requested a range of exit interviews but none related to medical services staff.

Public and staff engagement

- Comm Cells and ward meetings took place, which staff were able to feed into and key messages were highlighted. However when these were witnessed at ward level, the messages were not clear and actions were not allocated.
- There was a 'you said, we did' board showing responses to comments from staff and patients.
- A staff questionnaire was undertaken in December 2014. Only one staff member responded on Epping but six for endoscopy. Most of the scores were low for Epping but at or above the hospital average for Endoscopy. Particular concerns were team spirit, overall satisfaction and support from their manager. This was due to be re-audited in November 2015.
- We saw evidence that patients had ad-hoc visits from managers and charge nurses but we did not see any comments recorded that related to Epping ward or endoscopy.

Innovation, improvement and sustainability

- The endoscopy suite was new and had only been open a few weeks.
- There had been succession planning in the endoscopy unit for decontamination staff.
- Senior nurses felt the ward had particularly improved on its safety, teamwork and patient activity.
- Senior nurses felt performance was more highly valued over budget with requests for agency staff agreed out of senior management budgets when necessary.
- Work was being conducted with the Private Healthcare Information Network (PHIN) to compare and benchmark patient outcomes with the rest of the independent health sector.

Surgery

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

Information about the service

Surgery was the main inpatient activity within the hospital and a range of specialties were covered including orthopaedics, spinal, gynaecology, plastics, ear nose and throat, general, ophthalmic, colorectal and pain management.

There were five theatres within the main operating department and two theatres in the minor procedures unit. Each main theatre had an adjacent anaesthetic room and access to the ten bedded recovery bay. There were 70 inpatient beds across three surgical wards and a 21 bed day case ward. One surgical ward had been closed for much of the last year and remained closed at the time of our inspection due to staffing levels and activity although was open if other wards were closed for deep cleans.

There was a preoperative assessment service which comprised of two clinic rooms and a staff office. Near the main hospital entrance there was a designated reception area for patients arriving for surgery and a surgery booking office.

We visited all clinical areas including theatres, the minor procedures unit and preoperative assessment clinic over the course of three announced inspection days and one unannounced inspection day.

During our inspection we spoke with 37 members of staff including doctors, nurses, allied health professionals and ancillary staff. We spoke with the surgical leadership team and hospital management. We also spoke with 16 patients and 3 relatives. We checked 22 patient records, the ward environment and equipment.

Summary of findings

Overall, we found the surgical service was good. Patients were protected from avoidable harm, incidents were reported and the department was engaged in governance activities. A comprehensive audit programme was in place and safety performance data was at or above target levels. Staff were competent and opportunities for further professional development were available. Consent was obtained from patients prior to procedures and staff ensured patients understood information provided to them.

Access and flow through the service was effective and NHS patients were consistently admitted within the 18 week referral to treatment target. Patient outcomes including mortality were mainly within expected ranges and many aspects of care were based on national guidance. All patients received follow-up telephone calls on discharge to check for issues. Patient and relative feedback was positive and complimentary about staff throughout the service. Complaints were managed appropriately and staff adhered to duty of candour principles and their regulatory requirements. Staff received feedback about incidents, complaints and other issues raised within the hospital during daily Comm Cell meetings, including learning points.

The surgical environment and equipment available were mostly fit for purpose, clean and well maintained

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although there was some equipment that was out of date. Medicines were mainly stored and managed correctly, although some issues with controlled drugs including record keeping were observed.

Are surgery services safe?

Good



Surgical services were safe and people were protected from avoidable harm and abuse. Incidents and near-misses were reported by staff then investigated, with learning points passed on to department staff. Safety performance data was on or above target and most important assessments were completed to identify patient risks throughout admission.

Levels of nursing and medical staffing were adequate throughout the department. Most staff followed hand hygiene protocols and wore personal protective equipment when needed although there were some lapses. Mandatory training uptake was higher than the organisational target of 90%, including for level one safeguarding.

The patient environment throughout the surgical service was clean and fit for purpose, including three theatres with laminar flow ventilation. Appropriate equipment was available and most was suitably maintained, although there was no evidence of portable appliance testing on some items.

Most aspects of medicines management followed guidance although some procedures for controlled medicines were not always followed, including documentation. We observed patient records had omissions throughout the patient surgical pathway and this was supported by hospital audit data. Audits of VTE assessments were well below standards.

Incidents

- Incidents were reported via paper-based IR1 forms on the wards, theatres and recovery which were located at each nursing station, the theatre office or recovery nurses station. These were then uploaded onto the Sentinel electronic system by the Quality and Risk department. Staff within surgery generally knew how to report incidents however some staff in theatres were unsure whether incidents should be reported via the paper or online form. Staff were aware of the types of situations where incident forms should be completed including near-misses and could provide examples when they had personally submitted incident forms.

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- Completed incident forms were reviewed and investigated by senior staff, then passed to the Quality and Risk team for additional action if needed. Staff across the surgical specialty were aware of the need to complete incident forms promptly once an incident had occurred and we saw evidence showing most incidents were reported on the same day.
- Between January and June 2015 there were 42 surgery related incidents reported, including six serious incidents but no never events. Serious incidents were investigated using the corporate root cause analysis (RCA) template. We saw evidence demonstrating the RCA resulted in learning points which were disseminated to staff via the Comm Cell meetings. Theatre staff provided examples of departmental incidents and learning from these incidents, including one occasion where an incorrect medicine was given to a patient because the medicine had been drawn up for the next patient due into theatre. This resulted in a change of practice which meant only medicines for the current patient could be prepared.
- New incidents from all departments within the hospital, including theatres and the surgical wards, were discussed at the hospital-wide head of departments Comm Cell meeting, which happened at 9:00am Monday to Friday. This meeting enabled the most senior staff across all departments to identify and address potential risks and respond to incidents, which had occurred throughout the hospital. A subsequent Comm Cell meeting was held on each surgical ward and in theatres daily, so senior staff could provide feedback to department-based staff about incidents which had occurred in other areas, as well as their own.
- Night staff were told about the day's Comm Cells data prior to receiving handover at the start of their shift, ensuring they were as up to date with current incidents and learning as their daytime colleagues. However, when asked, none of the night staff on one ward knew of any incidents which had occurred that month.
- Some staff in the minor procedures unit told us they did not regularly attend Comm Cell meetings so did not know about departmental or hospital wide incidents and learning from them.
- Most surgical staff were aware of duty of candour including the need to be honest when mistakes occur and to apologise to patients. We saw evidence that the

surgical service was compliant with this regulation, for example when a surgical patient was treated with a surgical instrument which was then noted to have been decontaminated inadequately.

- There was no morbidity and mortality meeting held at the hospital due to low numbers of mortality. All patient mortality was reported in the bi-monthly clinical governance reports and discussed at clinical governance committee meetings which were held on a monthly basis.

Safety thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients receiving NHS funded care, such as new pressure ulcers, catheter and urinary tract infections (CUTI and UTIs), falls with harm to patients over 70 and venous thromboembolism (VTE) incidence. Aspects of the safety thermometer were displayed in some patient areas; however data was not easy to interpret due to the very small size and display chosen. More information was available on the Comm Cell boards which were located within staff areas.
- No hospital-acquired pressure ulcers occurred between January and June 2015 within the surgical department . We saw appropriate measures in place to assess and care for patient skin integrity.
- Staff told us there had been no CUTIs within the surgical department for “over three months” but no formal statistics were provided. Catheter care bundles were used on the wards and adherence was audited, regularly demonstrated above 90% compliance.
- Three patient falls occurred on the surgical wards between January and June 2015. A patient fall occurred overnight during our inspection and we saw evidence of appropriate documentation and actions taken in response to this, including providing the patient with supervision for the remainder of the night.
- No postoperative VTE was recorded in the period from January to June 2015. Patients were assessed for VTE risk on admission, 24 hours after admission and again seven days later. Hospital-wide audit data showed VTE assessment completion was at 50%, well below the hospital target of 95%. We saw evidence of appropriate medicinal and mechanical VTE prophylaxis during our inspection.

Mandatory training

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- All surgical staff were required to complete certain mandatory training modules for example information governance, basic life support and health and safety. Other topics such as conflict resolution, aseptic non-touch technique, infection prevention and control and blood transfusion were also covered. The training was completed by a combination of e-learning modules and classroom-based teaching. At the time of our inspection theatre and recovery staff had completed 100% of their mandatory training and ward staff had completed 91%; both of which were above the organisational target of 90% completion.
- Reminders to complete mandatory training were sent via an automated email system three months, two months and one month before the training was due to be completed. The staff member's line manager would also be copied into the one month reminder email.
- Staff were allocated one shift per year to complete their mandatory training and e-learning modules. They told us they could book this time in and it was protected for their training.
- Mandatory training for agency staff and resident medical officers (RMOs) was the responsibility of the external organisation which provided the staff member.

Safeguarding

- Safeguarding training was a mandatory e-learning module and all hospital staff were required to complete this. Safeguarding adults level one training had been completed by 92% of surgical staff at the time of our inspection. Staff told us they were trained regarding child safeguarding but were unaware if this would be continued due to not treating under 16 year olds in surgical services.
- Staff were able to locate the hospital safeguarding policy and knew to raise concerns with senior members of staff including the safeguarding lead nurse if needed.
- Staff on Airlie ward told us they would never send a vulnerable day case patient home without taking action and we saw an example of documentation showing a patient who had been admitted to a surgical ward overnight when staff were concerned they would not manage overnight at home alone.

Cleanliness, infection control and hygiene

- There was an allocated housekeeper for each of the surgical areas who was responsible for maintaining the

basic daily cleaning tasks as well as more specialist 'deep' cleans when needed. A daily cleaning checklist was used in all areas and we observed several gaps in the documentation, suggesting the designated cleaning tasks may not have been completed. We discussed this with a member of housekeeping staff who told us there was "too much work for one person" and "the cleaning would have been done but the paperwork was probably forgotten". The completion of the cleaning checklist was not monitored.

- The nursing stations, clean utility rooms and corridors on the wards were seen to be clean and tidy, although corridors had carpeted floors which is not compliant with infection control guidance. We noted some equipment was stored in corridor spaces but this was cleaned regularly by ward staff, indicated by green 'I am clean' labels.
- We inspected several patient rooms and en suite bathrooms which had been cleaned and were ready to receive a patient in all four surgical wards. We found all rooms and en suite bathrooms were clean, however we saw evidence of damage to the waterproof mattress covers in some rooms and staining of the mattress underneath as a result of this. Most linen on freshly made beds was seen to be clean although we noted some bedding had stains and marks.
- One of the minor procedures theatres was seen to be clean and ready for patient use, however the other theatre was being used for storage at the time of our inspection which was not appropriate.
- Surgical equipment decontamination was completed off-site at a BMI facility. Staff told us this generally worked well, although there had been occasions where required kits were not available at the correct time. One serious incident occurred when a bone graft funnel was used on a patient and subsequently found to contain an old bone graft within the funnel. The investigation into this was on-going at the time of our inspection, but the theatre manager told us they worked closely with the decontamination unit when issues arise.
- We observed staff washing their hands and using alcohol gel correctly on the surgical wards. The most recent audit in June 2015 showed 100% compliance with hand hygiene protocols on all three open wards. This was an improvement on two wards (Airlie ward was 95% compliant in May 2015 and Downing ward was 67% compliant) and a consistent finding on Chartwell ward.

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- Most staff were observed wearing personal protective equipment (PPE) appropriately to complete certain tasks. However, we noted some anaesthetic staff did not wear gloves when inserting cannulas, which is against good practice guidance.
- During our inspection we were alerted to a number of barrier nursed patients on the surgical wards, however there were no signs to alert staff of this which meant they might enter without wearing the appropriate PPE.
- All patients were swabbed for methicillin-resistant staphylococcus aureus (MRSA) during their preoperative assessment or on admission if their preoperative assessment was completed via telephone. Staff told us patients colonised with an infection such as MRSA would be taken for surgery at the end of the theatre list to allow a thorough deep clean of the theatre prior to the next patient accessing the operating room the next day.
- Hospital-wide data showed there had been eight hospital-acquired infections in the period July 2014 to June 2015, which included five surgical site infections. Clinical governance reports demonstrated RCAs were completed when infections occurred and lessons learnt were passed onto staff via Comm Cell meetings. The surgical service was mainly compliant with 'National Institute for Health and Care Excellence' (NICE) guidance relating to the prevention of surgical site infections.
- There was one bariatric operating table available and a hover mat to assist in transferring bariatric patients. This equipment was normally located in theatre four but could be transferred to other areas if needed.
- The two minor procedure units were located adjacent to the main outpatients area. One of the theatres was used for storage at the time of our inspection and was not in use. The theatre in use contained appropriate safety equipment as well as other frequently used minor procedure equipment like diathermy. There was additional safety equipment in the minor procedures recovery area such as an anaphylaxis shock kit and a local anaesthetic toxicity kit.
- Many items of equipment in theatres, such as surgical tables and anaesthetic machines, were hired and therefore maintained via a service contract which included a regular service programme and portable appliance electrical safety testing. However we noted many other items of equipment like computers and monitors in use within the department which had not been safety tested by the hospital. We also noted many items of equipment on the surgical wards, such as televisions and fans, which did not display evidence of portable appliance testing for electrical safety.
- There was adequate storage for consumables in recovery and on the surgical wards; items were stored in labelled drawers to allow efficient access for staff. Staff told us the health care assistants were mainly responsible for stock control and initiating orders when levels were low.
- Resuscitation trolleys were available on each surgical ward and emergency equipment was available within theatres. The minor procedures unit could access the resuscitation trolley location by the outpatient consulting rooms. We observed staff checking equipment on a daily basis and this was supported by signed checklists found within each department.
- Sharps bins were located appropriately throughout theatres, recovery and the surgical wards. All bins inspected had been labelled correctly and none were overfull.
- Blood glucose machines were seen to be calibrated at the start of each day shift on the surgical wards and this was documented on designated checklists.
- Equipment faults were reported via a computer-based programme which highlighted problems to outsourced

Environment and equipment

- The operating theatres and recovery bay were located on the ground floor of the hospital close to the front entrance and had their own patient transfer lift allowing access to the wards and intensive care unit on the first floor.
- The main entrance to theatres reception and other surgical areas was accessed by a keypad locked door. An access door to one of the theatre corridors connected with the hospital canteen and was unlocked during our inspection. The corridor connected directly with the recovery area and could be accessed without difficulty as the door to recovery was not secured. We raised this concern with theatres staff who told us recovery was always staffed and the door would be locked if no staff were present, however we remained concerned patients could be at risk because of this unsecured access.
- Three of the theatres had laminar flow theatre ventilation, which was best practice for ventilation within operating theatres.

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engineers and enabled ward staff to review the status of their repair online. Nursing staff told us this system generally worked well although could sometimes take “too long”.

- All patients were accommodated in en suite private rooms, which were located off the main ward corridors. All rooms were equipped with a nurse call bell and emergency buzzers within the main bedroom area and the en suite bathroom.
- Registered Medical Officers (RMOs) and other on call staff could use empty patient rooms on Blenheim ward to rest when on duty overnight or between shifts. We were told the hospital reception maintained a record of this for health and safety purposes, however the reception staff we spoke to told us this did not happen. Housekeeping staff told us they would complete a “sweep” through Blenheim ward on a daily basis and clean any rooms which had been used, although this was not formally monitored. We saw several rooms which had been used but not cleaned after use.

Medicines

- Hospital pharmacists reviewed patient medicine prescription charts on a regular basis and we saw evidence of specific instructions being included where necessary, such as “to be given 30 minutes before food”.
- Medicines were stored within locked cupboards or medicine fridges in locked rooms in theatres and on all surgical wards. We noted the cupboards remained secured when not in use throughout our inspection.
- Intra-venous (IV) fluids were stored appropriately in drawers within clean utility rooms.
- In the minor procedures unit, some frequently used items such as lignocaine and bags of IV fluids were stored in unsecured drawers within treatment areas, making them potentially accessible to patients. Staff told us the treatment areas were always locked if no staff member was present.
- Patient drugs charts were stored in a ring binder within the clean utility rooms of the surgical wards. We checked several drug charts on each ward and found they had been completed fully, included patient allergies and all writing was legible. We noted one mistake on a patient drug chart, where the drug appeared to have been given on 29th July, despite it not being prescribed until 30th July.
- Guidelines for prescribing antibiotics (“The Clementine Churchill Hospital Anti-infective Guidelines for Medical and Surgical Patients”, March 2015) were available within the ward areas.
- The last controlled drugs (CDs) audit in April 2015 showed some of the registers were incomplete and errors were being incorrectly crossed out. CDs were correctly stored in lockable, wall-mounted units on all surgical wards. The stock of CDs were checked twice per day on each ward, by a nurse coming off duty and one starting their shift. The stock check was normally completed by the two shift leaders. We observed a stock check on Downing ward, where important information, such as the medicine name, strength, form and expiry date, were thoroughly checked against the CD stock book.
- We observed nurses notice a miscalculation in the CD stock book. They confirmed the miscalculation with one another and changed the number documented without rewriting the numbers or countersigning the record, which is against good practice guidance. This type of CD documentation error was also identified during a CD audit in April 2015 and it was documented that staff had been reminded of correct practice within Comm Cell and other staff meetings.
- During our inspection, we noted one surgical ward used two CD stock books despite this being identified as inappropriate practice during the controlled drug audit in July 2015.
- We observed CDs being administered on two of the surgical wards and correct procedures, including all relevant patient and medicine checks, were followed.
- For patients being discharged, tablets to take away (TTAs) were sent to the ward from pharmacy the day before discharge and stored in a medicines cupboard. However timeliness of these was not audited although we were told normal turnaround time was 30 minutes unless it was urgent.
- Within the clean utility rooms, the policy and relevant documentation for temperature checking the medicines fridge and room itself were available in ring binders. We noted the documentation for checking temperatures was fully completed on all wards.
- During our inspection on Downing ward, the temperature alarm for the medicines fridge was sounding and it appeared the temperature was getting

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lower than the required number. This was noticed by a health care assistant who muted the alarm but failed to check the cause of it or fill in any documentation relating to the fridge temperature.

Records

- Surgical care pathways were used to document admission details as well as patient progress in the days post procedure. There was a general surgical pathway and more specific pathways for certain procedures, such as for spinal patients. Additionally, there was a separate surgical stay booklet for day case patients.
- We saw there were many gaps in the admission details for most patients including those with specific needs, for example a mobility and living assessment was left blank for an elderly patient identified as having mobility difficulties in the admission notes. We also noted a spinal patient without a pain assessment on admission, despite a specific section for this in the pathway and a medical history of increased spinal pain.
- Staff used the 'Waterlow Pressure Ulcer Prevention Score' to assess the patients' risk of developing a pressure sore on admission and on subsequent days. This had been completed in most records we checked, although had been missed on admission in one set of notes for a patient who was deemed at high risk of pressure ulcers. Documentation showed pressure relieving equipment was provided in a timely manner when required.
- In two sets of general surgical pathways we reviewed, many of the items specified on the preoperative checklist (such as confirmation of important information such as patient identification and allergy status) had been left blank by the ward staff, the transfer escort and theatre staff sections. These omissions could indicate important checks were not being completed thoroughly before surgery, therefore placing patients at risk.
- Anaesthetic records were variable. In some cases names of medicines given to the patient were illegible and there was no indication of what time it was given. There were also gaps in documentation relating to patient past medical history as well as airway assessment and postoperative nausea and vomiting. One set of anaesthetic notes failed to document a significant postoperative risk which should have been highlighted to the recovery team.

- We reviewed several operation notes in patient records and found them to be comprehensive, legible and to contain a clear postoperative plan.
- We saw evidence the World Health Organisational (WHO) surgical checklist was completed correctly and at appropriate times. The WHO Surgical Safety Audit was completed on a regular basis and ten sets of patient records were sampled each time. Results in June and July 2015 ranged from 88% to 100% compliance with checklist completion.
- Across the surgical wards, there were many gaps in the care pathways in the days post-procedure, for example in one set of notes there were no entries or signatures to indicate whether the patient was in pain, had tolerated food or diet and could mobilise. Hospital audits between January and May 2015 showed 84-97% patient record completion, with Downing ward consistently scoring on the lower end and Airlie ward consistently scoring highly. These audits were completed by staff on the same ward and not by peers. Senior management felt there may be issues with the amount of different care pathway documents that had to be completed but these were corporate documents supplied by BMI and not locally produced.

Assessing and responding to patient risk

- Falls risk assessments were used on the inpatient surgical wards to identify and monitor those patients considered to be at risk. We saw evidence these assessments had been completed by nursing staff for identified patients. Staff told us patients at risk of falls would be allocated a health care assistant on a one to one basis to ensure their safety.
- Staff used the Waterlow Pressure Ulcer Prevention Score to assess the patients' risk of developing a pressure sore and air mattresses were available from an external company for patients with a high score. Staff reported the mattresses arrived "within hours" of being ordered and we saw evidence supporting this.
- Patients with pressure ulcers or complex surgical wounds were regularly reviewed by the tissue viability nurse to ensure appropriate management and reduce the risk of wound breakdown. Each surgical ward also had a designated tissue viability link nurse who could advice on basic management.

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- For complex or highly dependent patients, moving and handling risk assessment documents were completed daily by nursing staff and outlined how many staff and what type of equipment was needed to assist the patient safely.
- Staff told us patients were assessed for VTE risk on admission, 24 hours after admission and again after seven days. Hospital-wide VTE audits showed 50% compliance from March to June 2015, which was significantly below the target of 95%. There were particular concerns relating to reassessment at 24 hours and after seven days. We saw evidence demonstrating patients were assessed for VTE risk on admission and 24 hours after admission in patient documentation.
- Early warning scores (EWS) were calculated for patients during routine observations and high scores initiated review by a doctor or the intensive care outreach team if needed. We saw evidence of EWS calculation within patient notes and contact was made with the surgical RMO or outreach RMO as needed.
- The WHO surgical checklist was completed before patients were anaesthetised, prior to the first incision and before patients left the theatre which is compliant with international guidance. Completion of the checklist was monitored through regular audits which showed 88-100% compliance throughout June and July 2015.

Nursing staffing

- There was sufficient staffing in all areas of the surgical team to meet the needs of surgical patients admitted for procedures. On the wards, nursing staffing was determined using a nursing labour tool, taking into account patient dependence and acuity. We saw evidence of bank and agency staff usage to ensure safe levels of staffing and they were inducted robustly. The surgical wards were compliant with best practice guidance which recommended no more than 20% agency nursing staff working on a ward at any one time.
- One of the surgical wards was closed during our inspection and had been closed for a significant period before this. Senior staff told us this was largely due to insufficient permanent staffing to provide suitable care on this ward when open.
- Senior staff told us rota planning took into account staff experience and we saw an example of staff rostering in recovery which ensured there was always someone on shift who had completed advanced life support (ALS) training.

- Each area was overseen by a manager and supported by deputy managerial staff, both of which were supernumerary.
- There were 6.5 full time equivalent vacancies, from preoperative assessment through to the surgical wards. We saw evidence of recruitment activity across the department to reduce reliance on bank and agency staff.
- Ward nurses met for a handover at the start of their shift, where all patients on the ward were discussed. We observed thorough and patient-centred handovers on Chartwell and Downing wards. However, we noted a comment about a particular patient who required a two litre fluid intake restriction; this was different to the information on the handover sheet which stated the patient should be limited to three litres. None of the staff in the handover clarified what the correct figure was, potentially putting the patient at risk.

Surgical staffing

- Staff told us patients were reviewed by their designated consultant on a daily basis and we saw evidence in patients' notes to support this. Some consultants did not always review patients on their day of discharge and staff told us the consultant organised for the RMO to complete a final discharge assessment in this instance.
- RMOs were provided to the hospital by an external organisation. There were usually two RMOs deployed to cover the four surgical wards and the medical ward at any one time. RMOs worked variable shift times and there were always two RMOs on shift to cover ward tasks such as assessing patients, inserting cannulas and writing drug charts. The RMOs sometimes reviewed patients in recovery but were not involved in theatres activity.
- RMO handovers usually took place at 8am and 8pm, where the doctors on duty would handover patient information and updates to medical staff coming on shift.
- Anaesthetic cover was not part of a rota but was arranged so that each consultant was required to have an anaesthetist on site with them when they were conducting surgery and had four anaesthetists they could call on in the event of an emergency.
- Consultants were required to have designated cover who also had practising privileges at the hospital which

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had to be notified to the hospital and recorded in the patient's notes when they were on leave. Staff told us there were no issues when they had to contact the person covering.

Major incident awareness and training

- Surgical staff told us the hospital generator was tested on a monthly basis to ensure adequate power supply in the event of mains failure.
- A hospital-wide fire alarm test took place on a weekly basis and staff knew when this was planned. Staff within theatres, recovery and the wards were aware of fire evacuation procedures in line with hospital policy but told us there had been no evacuation practice although we witnessed them occurring.

Are surgery services effective?

Good



Effective care was provided by the surgical department. Many aspects of care were compliant with national guidance and most patient outcomes including mortality, were within expected ranges; however the patient reported outcome measure for hip replacements was lower than the England average. Patients told us pain was well managed and we saw evidence of regular pain assessments. Staff received local inductions and completed specific competencies. There was access to information for staff within the hospital as well as using external resources and staff were supported with opportunities for further professional development. Staff obtained informed consent from patients and had awareness of mental capacity principles, although understanding of Deprivation of Liberty Safeguards was variable.

However, the majority of consultants had not practised at the hospital for at least a year.

Evidence-based care and treatment

- Most policies within the surgical departments were corporate protocols and were up to date, adhering to current national guidance. All staff including bank and agency knew how to access policies and register lists were kept to record which members of staff had read the document.

- Monthly emails were sent to the manager of each ward containing website links to the latest NICE guidance. Key changes were printed out by ward staff and displayed on noticeboards to ensure staff were aware of any significant changes.
- The surgical service was mainly compliant with NICE guidance relating to the prevention of surgical site infections in the preoperative, intraoperative and postoperative phases of care.
- The 'American Society of Anaesthesiologists' (ASA) physical status classification was used to establish the physical status of patients prior to undergoing anaesthesia which follows best practice guidance.
- Care bundles were used on the surgical wards and included a cleaning and decontamination care bundle, chronic wound care bundle and catheter care bundle. Compliance with care bundles was audited on a monthly basis and hospital data showed results were constantly above 90% compliance.
- Best practice guidance advises the use of enhanced recovery programmes (ERP) for certain types of surgery. ERPs were in place within the care pathways used on the wards for knee and hip replacements and we saw these fully completed in most records we reviewed.
- Nursing staff on the surgical wards assessed and recorded patient visual infusion phlebitis (VIP) score in line with the 'Infusion Nursing Standards of Practice' (2011).
- If no preoperative tests were specifically requested by medical staff, preoperative assessment nurses told us they followed NICE guidance to make investigation requests. However, when we reviewed the tests requested by the assessment staff they were not in line with national guidance as additional investigations to those required by NICE were also ordered which were not appropriate.

Pain relief

- Staff told us the pain relief for surgical patients was mainly managed by anaesthetists who prescribed regular and 'as required' medicines to be used postoperatively and we saw evidence of this in patient drug charts. Most pain relief was provided orally, however some patients were prescribed IV patient controlled analgesia (PCA), which was controlled using a

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button. Patients using PCAs were cared for by nurses who had completed specific training. All patients requiring analgesia via an epidural were cared for on the intensive care unit.

- Pain was formally assessed by nursing staff using a patient reported pain scoring system every time patient observations were taken and we saw evidence of this being completed on the observation charts. Each ward had an allocated pain link nurse who provided advice and liaised with the RMO on duty when issues with pain control occurred.
- A specialist spinal nurse told us spot checks for pain management and relevant documentation completion were carried out postoperatively but these were informal checks only and there was no documentation to support this.
- Most patients reported their pain was well managed immediately postoperatively but two patients told us their analgesia was insufficient and took a long time to become controlled after their procedures.

Nutrition and hydration

- Patients were offered a choice of food and drink from a menu. Chefs within the hospital would try to provide any dish the patient wanted, if at all possible, even if it was not on the menu. We saw patients were also offered additional snacks in between formal mealtimes. Sandwiches were available for patients via the nurse in charge from 10pm to 7am.
- Support from dieticians was provided by an external organisation on a telephone referral basis. Staff told us the service was very good and the dietician would usually see the patient within 24 hours of the referral. We saw evidence supporting this within patient notes.
- Fortified drinks were kept onsite in the pharmacy department and patients were given these following advice from the dietician or if they were struggling with a normal diet postoperatively.
- We saw evidence patient fluid balance charts were recorded when requested by medical staff. In the records we checked, the charts were fully completed and nursing staff involved in the patient's care were able to describe how they monitored and recorded fluid intake.

Patient outcomes

- There was one postoperative inpatient death and one patient death within 30 days of surgery between

January and June 2015, which equated to less than 0.25% of all surgical admissions and represents a low postoperative mortality. Data regarding these deaths was submitted to 'National Confidential Enquiry into Patient Outcome and Death' (NCEPOD) for inclusion in upcoming reports.

- Between January and June 2015, 12 patients had unplanned returns to theatre which is a similar proportion as expected in comparison with other independent acute hospitals we hold this type of data for. No trend was identified for specialities these unplanned returns to theatre involved.
- There were 16 unplanned readmissions to hospital postoperatively between January and June 2016, which was within the expected range of readmission rates. Readmissions post knee procedures were slightly worse than expected and readmissions post hip procedures were much worse than expected. There was no evidence of plans in place to address this issue.
- Patient reported outcome measures (PROMs) for knee replacements was slightly lower than the England average, but this was not a statistically significant difference. There were insufficient records submitted to analyse EQ-VAS or EQ-5D indexes, both of which are additional measures of patient health outcomes.
- Hospital data showed 163 day case patient admissions were converted to inpatient stays from January to June 2015. Reasons for conversions included late returns to the day case ward and procedures being more complex than anticipated. No plans were identified to address these issues.
- Between January and June 2015 there were 14 unplanned admissions to intensive care postoperatively which was within the expected rate.
- There were 15 patients whose length of stay in hospital extended beyond the initial period booked for their procedure between January and June 2015, however the trend of extended stays was improving over the six month period.
- Hospital staff told us the organisation was working with the 'Private Healthcare Information Network' to improve reporting of patient outcomes across the independent healthcare sector. They hoped this would make patient outcome data more easily comparable with NHS providers.

Competent staff

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Nursing Staff:

- There were specific competency documents for surgical staff in all areas of the department, including theatres, recovery and the wards. Staff were able to show us their completed competency documents and describe how they had been supported to achieve their competencies. Staff in theatres showed us completed self-assessment forms relating to specific items of equipment in order to identify training needs. They told us any training needs they identified were met quickly and they were supported by the managerial staff in addressing these.
- Health care assistants had a role-specific competency booklet which was completed as part of their development. Staff showed us their completed booklets and described how they had been supported with their learning by qualified staff. Health care assistants also completed the 'Care Certificate Standards Self-assessment Tool' to identify their learning needs.
- Nursing and Midwifery Council (NMC) registration was verified at the end of March 2015 for all qualified inpatient nursing staff.
- Overseas nurse practitioners (ONPs) were nursing staff who had qualified from overseas and were working towards achieving NMC registration to allow them to practice as a qualified member of staff in the UK. ONPs worked unsupervised as health care assistants but could work as nurses when supervised, in a similar way to student nurses. When ONPs received their NMC registration, they began work as qualified nurses and worked through competencies along with their peers.
- Ward staff were supported by the hospital practice development nurse and a specific practice development nurse was in post for theatres staff.
- Staff were encouraged with their professional development and received regular teaching and 'on the job' training, for example from the spinal nurse specialist. A number of nursing staff described opportunities for additional external learning which had been supported by the hospital, such as masters degrees and anaesthetic courses. Nurses on the surgical ward also had the opportunity to rotate between different wards to gain further experience and knowledge.
- Supernumerary nursing students worked on the surgical wards during clinical placements and were supervised by nursing mentors. Their mentors were responsible for

working alongside the student nurses and scheduling teaching sessions for them. Students told us they were well supported by the qualified nursing staff and were not asked to perform duties beyond their competence.

- All new staff including student nurses, qualified staff and agency staff were inducted into their area of work. We were shown completed induction checklists which outlined department orientation and familiarisation with specific policies. Staff who had recently been inducted told us it was a thorough process, however one nurse told us the induction did not include information about contacting the crash team.

Surgical Staff:

- Surgical consultants and anaesthetists who operated at the hospital were required to maintain current practicing privileges in line with the BMI practicing privileges policy to be eligible to work on site. At the time of our inspection, there were 462 consultants with practicing privileges at the hospital, however 57% of these consultants had not carried out any episodes of care between April 2014 and March 2015 despite practising privileges being reviewed on an annual basis. We were told consultants work outside of the hospital was taken into consideration as part of their practising privileges review but received no further assurance despite requesting this and the policy did not consider episodes of care at the hospital as part of their reviewing process.
- The RMOs were recruited via an external organisation, which was responsible for ensuring all deployed staff had the necessary experience and registrations to work at the hospital. All RMOs were required to have a minimum of 12 months experience in medical and surgical care and work at a minimum of CT1 level. They were also required to have ALS and European Paediatric Life Support (EPLS) qualifications.
- All new RMOs received two days induction at the hospital, which included orientation to the wards and ways of working, as well as shadowing an RMO colleague on shift.

Multidisciplinary working

- The preoperative assessment nurses liaised with anaesthetists and surgeons to coordinate preoperative investigations; including confirming what assessments were needed and following up the communication once results were obtained. Staff told us this was often

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challenging due to the availability of the doctors involved. They also liaised closely with the specialist spinal nurse for relevant patients and the specialist often reviewed patients alongside the preoperative assessment team.

- Ward nurses communicated with the surgical RMO via a communication book for non-urgent ward tasks, such as changing a medicine from IV to oral on a patient drug chart. Staff told us this system was effective and they could bleep the RMO if something was missed.
- A designated physiotherapist collected a list of patients from all surgical wards on a daily basis and allocated patients to therapists. The allocated therapist then liaised with the nursing staff to receive a handover about their patients. We observed a handover take place at the nursing station on one surgical ward, which could compromise patient confidentiality if sensitive information was overheard by other patients or relatives on the ward, and noted brief details only were exchanged; for example “she’s hypertensive”.
- There was no evidence of multidisciplinary liaison between therapy and nursing staff for patients with complex moving and handling or mobility needs, although nursing staff told us they could ask for help from the physiotherapists if needed.
- There were no formal multidisciplinary meetings held for surgical patients, although staff told us this would be considered for particularly complex patients and discharge planning, although consultant led, involved the therapists and nursing staff.
- Access to a specialist colorectal nurse and a stoma nurse was in place via a service level agreement with a local NHS hospital. The nurses reviewed suitable patients on the wards and provided on-going support post-discharge.

Seven-day services

- Patients received a daily review from their consultant during their admission. If the consultant was not able to review their patients due to leave or other commitments, they were expected to arrange an equivalent consultant review by a colleague who must also have practicing privileges at the hospital and this had to be told to the hospital and noted in the medical notes. This was also the case out of hours. Staff told us this was not a problem and consultants regularly helped each other out.

- RMOs were available on site 24 hour per day, seven days per week. They were expected to review patients whenever needed and complete day to day tasks on the wards.
- An on-call theatre team were available for emergency returns to surgery out of hours. The team comprised of two theatre scrub practitioners, a health care assistant, anaesthetist and recovery staff.
- Diagnostic imaging was available 24 hours per day, seven days per week by an on call radiologist who was available via a bleep system within 30 minutes out of hours. There were five protected imaging slots reserved for inpatients during the daytimes, to ensure swift access when required. Images could be sent to the on call radiologist out of hours for interpretation if needed.
- There was a full physiotherapy service available for surgical patients from 8am to 8pm seven days per week, which included respiratory care and musculoskeletal treatments. An out of hours service was available from 8pm to 8am on a bleep referral basis
- Occupational therapy support was provided via an external organisation on a telephone referral basis. This support was provided Monday to Friday.

Access to information

- All documentation relating to surgical activity at the hospital was paper-based, including medical notes, nursing notes, anaesthetic and prescription charts which were combined to form a patient documentation pack. The patient related paperwork was transferred between departments during the patient journey and staff said this was effective. Staff told us missing or delayed notes were rarely an issue.
- Staff could access paper-based or digital versions of hospital policies and procedures throughout the surgical service.
- There were a number of external resources staff could access to obtain information, such as dietetic and occupational therapy support.

Consent and Mental Capacity Act

- All the patient records we reviewed showed patients had been consented for their surgical procedure. Consent forms fully described the procedure completed as well as risks associated with it and full signatures from the consenting clinician and patient. We saw

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additional consent had been obtained for blood transfusion and modifications to the original procedure if required during the operation. Cooling off periods for cosmetic patients were given and adhered to.

- Patient information was submitted to the national joint registry when knee and hip replacements were completed; data showed between 90 and 100% of patients provided written consent for this information to be shared between February and July 2015.
- Most surgical staff carried reminder cards outlining the five basic principles of the Mental Capacity Act, 2005 (MCA). Staff told us patients must be presumed as having capacity unless it was established they do not. Formal assessments were completed by the RMO on duty if there were concerns about a patient's ability to provide consent.
- Some staff were aware of Deprivation of Liberty Safeguards (DoLS) principles and knew DoLS applications had to be made to the local authority to enforce any type of limitation on a patient's freedom. Staff told us the hospital did not admit patients with a significant mental health problem and so they felt DoLS was not an issue at the hospital. However one RMO was not aware what DoLS entailed and had not received training on this aspect of patient care.

Are surgery services caring?

Good



Patients spoke positively about interactions with surgery staff throughout their hospital stay and described staff as attentive and encouraging. Relatives felt confident with the care provided and told us staff were patient and kind. Staff maintained patient privacy and dignity while assisting and examining patients. Patients and their relatives were provided with information, given opportunities to ask questions and involved in decisions about care. The hospital-wide Friends and Family Test showed positive responses for both NHS and private patients. Emotional support was provided by staff, however there was no other support service available within the hospital.

Compassionate care

- Hospital Friends and Family Test (FFT) results from October 2014 to March 2015 were consistently at 100%

for NHS patients, established from a moderate response rate. In the same period, private patients FFT results ranged from 97-100%, although had a low response rate.

- Patients were complimentary about the care they received from all surgical staff, from the bookings team to the ward nurses. They told us staff spent time with them, putting them at ease but also getting to know them as individuals, including asking what they prefer to be called. We observed staff throughout the surgical service chatting with patients in a friendly and respectful manner.
- Relatives told us staff were kind and patient; they were confident the patients were being well looked after.
- Several patients described difficulties they experienced postoperatively but explained how staff assisted with mobility and personal care tasks, ensuring privacy and dignity was maintained throughout. We observed staff examining a patient postoperatively and only exposing the necessary parts of the patient's body to allow thorough examination.
- Patients told us staff were attentive and one patient described their hospital experience as "like being on holiday".
- Staff on Downing ward told us they had helped a patient with mobility difficulties to access the outdoor area when the patient's relatives were unable to visit one day, as the patient wanted to sit in the sunshine.
- We observed staff encouraging patients to dress in their own clothes and sit out of bed for mealtimes. Patients told us they appreciated the encouragement to "get back to normal".
- Patients told us they never had to wait when they needed a nurse and we observed call bells being answered quickly. Nurses were efficient when patients requested pain relief and returned to check on the patient's pain later on.
- One member of housekeeping staff told us she regularly gets drinks for patients when she has finished cleaning their room, and sometimes even sings to them.
- We saw thank you cards and letters from patients throughout the department and one patient even returned during a ward handover to personally thank the staff six weeks after their admission.
- Staff told us they rarely care for people approaching end of life due to the high volume of elective work

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completed on the hospital. They told us patients who become unwell and are being cared for palliatively would be moved to the medical ward and cared for on a one to one basis by a dedicated nurse.

Understanding and involvement of patients and those close to them

- Patients told us they were provided with a lot of information before their procedure, including leaflets and attendance at a joint replacement teaching session which outlined what to expect from their procedure and the recovery period. They valued the opportunity to gain a better understanding of their care and the time to 'digest' the information before their procedure.
- Patients described how they were given a full overview of the risks and benefits of their procedure before being asked to sign the consent form.
- We observed staff offering patients opportunities to clarify information and ask questions during the preoperative assessment and consent process, as well as after their procedure. Staff patiently explained the same details in different ways to ensure the patient fully understood the information.
- Relatives were able to accompany patients to their preoperative sessions and speak to clinical staff about any concerns or questions they had. They told us they felt involved in the process and knew what to expect during the patient's admission and recovery period.
- Relatives told us they were involved in the patients' recovery if they wanted to be; one relative described how the physiotherapist ensured the relative knew how to assist the patient with leg exercises.

Emotional support

- Patients spoke positively about the emotional support provided by staff. One patient described getting upset about a disabled relative and how the nursing staff took time to provide support and make suggestions to ease the upset.
- Staff told us they provided emotional support to patients when they were upset or anxious. We observed a patient who was particularly nervous during their preoperative assessment; the nursing staff provided reassurance and explanations to help comfort the patient.
- There was no chaplaincy service or other spiritual support available within the hospital and staff were unsure where patients or relatives could seek additional

support away from the ward. There was a designated spiritual room located on Blenheim ward, which could be used for prayer, meditation or quiet reflection by patients and relatives.

Are surgery services responsive?

Good



The surgical service was responsive and people's needs were met through the way the service was organised and delivered. Access to surgical services was timely and patients could book procedures at a time to suit them. NHS patients were consistently admitted within the 18 week referral to treatment target. Flow through the surgical service was mostly smooth, although there was potential for delays caused by the preoperative assessment process. All surgical patients received follow up telephone calls to check there were no issues after discharge. The service dealt with patient complaints appropriately and was responsive to meeting some individual patient needs.

Service planning and delivery to meet the needs of local people

- Patients accessed the surgical service for elective procedures such as arthroscopies and epidural injections, as well as cosmetic procedures. Due to the elective nature of the work undertaken, staff told us service planning was straight forward because the workflow was predictable.
- Surgeons were provided with allocated theatre times for the next year to allow prior planning of patients and theatre activity. This was a recent change instigated by theatres management and medical staff told us this was an improvement on the rolling four week rota which was previously in place. The ability to plan ahead also facilitated the process for patients who could book procedures in ahead of time and plan around family and work commitments.
- One surgeon described some difficulties in coordinating surgical lists with colleagues so that two surgeons could be in theatre for one patient, if they were a particularly complex case. They explained this could cause delays in surgery dates for some patients.
- Anaesthetists were booked for certain days and were allocated to a theatre for that day.

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- Staff told us accessing diagnostic imaging services within the hospital could be difficult as the department was often busy with pre-booked appointments for outpatients. When observing a ward handover, we heard two examples of patients who required imaging that day. One patient required an ultrasound but nursing staff stated the department was “very busy” and might not manage to fit the patient in. The other patient needed a CT scan but nurses had been told the department was fully booked that day, however might be able to fit the patient in, and so the patient should be “starved” (fasted) just in case the scan took place. It appeared communication between ward and diagnostic imaging staff was not effective; the imaging department told us there were five protected slots reserved for inpatients each day and flexibility of access for inpatients was not a concern. We saw evidence supporting the information provided by the imaging team.
- All surgical patients discharged from the hospital, including those who had day case procedures, received a follow-up telephone call 48 hours later to ensure they were well. Any issues would be addressed during the phone call, if possible, or patients would be booked in for an outpatient review with the consultant or nurse. These calls were completed by an allocated member of staff on each ward.
- Facilities for surgical patients were appropriate for the services that were planned and delivered by the hospital.
- On Downing ward, there were six rooms identified as being suitable for bariatric patients. Bariatrics is the branch of medicine that deals with the causes, prevention and treatment of obesity. These rooms had extra wide doorways but other than that there were no other obvious adaptations that had been made to accommodate bariatric patients. Staff told us they ordered specialist equipment when bariatric patients are expected on the ward. The en suite bathrooms to the bariatric rooms were relatively small and the facilities within the bathrooms were not adapted for bariatric patients.
- Day case patients who were not assessed as being fit for discharge after their procedure were transferred to a surgical ward for overnight care if required. Staff told us this was usually recorded as an incident when the situation arose and we saw evidence of this.
- Surgical staff demonstrated an awareness of the religious needs of patients, for example one patient requested for their headscarf to remain in place as long as possible when going into theatre and staff replied it wouldn’t be a problem. This was also documented in the patient’s notes so the theatre staff would see this.
- Theatre facilities for bariatric patients were available and there were allocated ward rooms for this patient cohort. Specialist bariatric equipment such as beds and chairs could be ordered from external companies if required.
- Support for patients with a learning disability was not evident and staff were unclear how they would address the needs of these patients despite not being refused treatment under their admission protocol.
- Staff told us patients with significant mental health issues would not be admitted to the hospital due to the complex nature of mental health management.
- An Arabic translator was available onsite during the daytime and patients could access this service via the nursing staff. The translator was able to support the entire surgical process from booking through to discharge post-procedure. Translators for other languages could be booked externally if required and staff told us they would try to find staff within the hospital to translate at short notice.
- Written information was available in English and there was some Arabic literature available for patients. Staff were unsure if it was possible to access written information in other languages.
- Patients could access an outdoor garden space from the corridor between Blenheim and Chartwell wards. Within the outdoor space there were plants and trees, with benches and other seating available.

Access and flow

- Surgical bookings were made at a convenient time for the patient and surgeon involved. Patients told us there was good flexibility with booking in for procedures and they had not waited long to be admitted. Between April 2014 and March 2015 between 96% and 100% of NHS patients were admitted within the 18 week referral to

Meeting people’s individual needs

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treatment target, which is above the national target of 90%. Approximately 27% of surgical cases were NHS funded; the remaining 73% were funded by other means.

- Patients were referred to the preoperative assessment team once they had been booked in for surgery. After being triaged, telephone or face to face preoperative assessment was completed by a nurse and included a health questionnaire. Almost all preoperative assessments (More than 99% between May and July 2015) were completed on a face to face basis, despite BMI policy stating patients undergoing a procedure under local anaesthetic should have a telephone preoperative assessment. A recent change to the service meant that all endoscopy patients would receive a telephone rather than face-to-face preoperative assessment in the future.
- After the preoperative assessment, the anaesthetist scheduled to be involved in the care of high risk patients was telephoned by the assessment nurse to discuss the patient's suitability for anaesthesia. Staff told us this was a disjointed system and they sometimes struggled to contact the anaesthetist, which led to delays in additional investigations, such as echocardiograms. We saw evidence in patient notes supporting this. Private patients requiring certain preoperative investigations could be referred directly by their consultant surgeon but NHS patients had to be referred by their GP. We were told this had caused procedures to be cancelled while waiting for results from investigations to be made available, although this occurred infrequently. Senior management told us they were looking at having anaesthetists directly involved in the pre-operative assessment in the future to overcome this problem.
- Between January and June 2015 there were 56 surgical procedures cancelled for clinical reasons and 16 procedures cancelled for non-clinical reasons. This data was not compared with other similar services to monitor performance in this area.
- There were seven theatres available, five of which were open from 7:30am to 8pm Monday to Friday and from 7:30am to 5pm on Saturdays. Two theatres used as the minor procedures unit were located near the main outpatient department and were open from 8am to 8pm Monday to Friday. The theatres hosted a range of procedures and theatres were identified as locations for certain activities; for example, theatre one was used for

general surgery, cosmetic surgery, urology, ophthalmology, ENT and Gynaecology procedures, whereas theatre three was used for orthopaedics and spinal surgery.

- Access to an operating theatre and team was available out of hours in case a patient needed to return to theatre unexpectedly. Surgeons and anaesthetists were required to either be on site or come in if they were needed out of hours.
- Theatre utilisation was monitored on a monthly basis and hospital data showed an average of 30% usage between February and June 2015, including the single minor procedures unit which was in use. There were plans in place to increase theatre utilisation by cutting down time slots for lists when consultants did not use all the time allocated, and also encouraging consultants to use the theatres more if they were currently infrequent users.
- Staff on the day case ward and in theatres described difficulties they had experienced with lists starting late and therefore creating a backlog of patients. This sometimes meant there was not enough time for the last patient's procedure to be completed, leading to cancellations. We saw evidence of these instances being recorded as incidents but no resultant actions identified.
- There was a ten bedded recovery bay where patients remained postoperatively for an average of one hour before being transferred back to the ward. If patients remained drowsy or had high levels of pain, they remained within the recovery area for longer periods of time. Staff told us there were no access difficulties for patients moving into recovery from theatres as the area was never at 100% capacity.
- Patients had a designated room on one of the surgical wards which was reserved for them from admission. This meant there were no delays in discharging patients from the recovery area back to the ward.

Learning from complaints and concerns

- Complaints from surgical patients were mainly managed at ward level and the ward manager would work to resolve any immediate issues. If complaints were made, the lead nurse for surgery also spoke to the patient involved to address problems straight away if possible

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- Once a complaint was investigated, learning points from department complaints were provided to staff during Comm Cell meeting and also displayed on the ward Comm Cell boards. We saw examples of learning points on the surgical wards and staff were able to describe changes which had been made in response to complaints.
- We saw examples of complaint responses sent to patients which included apologies and explanations. Some responses also offered goodwill gestures to patients.

Are surgery services well-led?

Good



There was leadership of surgical services and they promoted the delivery of high quality care. The service was engaged in governance activity within the hospital and a comprehensive audit programme was in place. Risk management was in place including actions to address concerns. Plans were in place for service improvement and some innovation was evident. Management engaged staff in generating ideas and decision making, demonstrating the value they placed on staff within surgery. Staff received recognition for performing beyond expectations and spoke positively about the senior management team.

Staff were generally aware of the vision to develop the service, however many were unsure how this would be achieved. There was generally a positive culture, although feedback from consultants was variable especially with regards to recent suspensions affecting their peers.

Vision and strategy for this service

- Senior staff told us the surgical service at the hospital was well established and successful. The vision for the service was to drive forward quality of care provided and increase activity levels, potentially with expansion of the current surgical repertoire.
- Surgical staff understood the aim to improve quality and surgical activity but were unsure how this would be achieved. Staff suggested the re-opening of the closed surgical ward would be a step forward, especially if this was sustained.
- Staff at all levels were aware of the need to maintain an appropriate image for the hospital. Plans for ward refurbishment were underway and patient rooms were being redecorated to achieve this. Staff told us they needed to create the right “feel” in the building so the patient experience was as positive as possible.

Governance, risk management and quality measurement

- The surgical department was engaged with governance activity within the hospital and representatives for the service attended a number of governance meetings and committees, such as the infection prevention and control committee and the monthly nurse leadership team (NLT) meeting.
- The clinical governance committee met monthly to discuss a range of governance issues across the hospital and the surgical department was represented by the medical advisory committee (MAC) anaesthetic representative, MAC surgical representative, the theatre manager and the lead nurse for surgery.
- The MAC was in place to advise the Executive Director and ensure patients received the best possible treatment; maintaining high standards and improving quality. A MAC anaesthetic representative was in place, however there was no MAC general surgical representative nominated at the time of our inspection.
- Feedback from hospital-wide meetings was disseminated to theatres and ward staff via Comm Cell meetings, Comm Cell boards and update e-mails. Staff told us they were easily able to access information about key issues and were able to describe recent learning points and areas for improvement.
- Senior staff told us the main risk register for the surgical wards and theatres was held and maintained by the Risk and Quality Manager within the hospital. This risk register largely supported our inspection findings such as the carpets on the wards, and equipment availability and actions were in place addressing these issues both short and long term. Most senior staff were unsure how to access the register and unable to identify risks that may be recorded. An additional departmental risk register was maintained by the manager in each area and outlined environmental risks. However there was no acknowledgement that having a majority of consultants that have not practised at the hospital in the last 12 months was a risk.
- A formal audit planner was in place in theatres and on the surgical wards, outlining which audits needed to be completed in which clinical area and when. We saw

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evidence this programme was adhered to and audit findings were presented at NLT and governance meetings. Recommendations for improvement were identified and actions to do this were put in place.

- Ward staff told us they received regular updates about audit results, including those from other areas. One staff member told us they liked the competition between different areas to “be the best”.
- In theatres, a monthly half day session was allocated for team meetings which included feedback from governance activities, including new audit results and actions for improvement. Theatres was closed for this to occur so all team members could attend.

Leadership of service

- A monthly meeting attended by senior staff from all departments in the hospital and chaired by the Executive Director was held to facilitate hospital-wide planning for the following month. This allowed staff to raise any potential issues in terms of activity levels and staffing. We were shown minutes which demonstrated a problem-solving approach from the senior management team (SMT) during these meetings.
- The SMT attended and contributed to the daily head of departments Comm Cell meeting, which ensured they knew about significant occurrences in the hospital and any issues which had occurred. Within the Friday hospital-wide Comm Cell meeting, there was opportunity for senior staff to highlight staff who had performed exceptionally well during the week. We observed a Comm Cell meeting where this happened and senior staff were enthusiastic about the nominations made.
- Ward staff spoke positively about the SMT and told us they were seen in various departments of the hospital during daily walk rounds, including during night shifts. Staff appreciated the visibility of the senior management and told us they were always approachable and friendly, with an ‘open door’ policy. Theatres staff told us they saw the SMT in corridors or in the canteen but had not noticed them within the theatres department.
- Specific examples were provided by staff where members of the SMT had personally addressed workplace issues, such as with a consultant who had been speaking to recovery staff inappropriately, and

supported them with career progression, for example accessing a particular masters degree course. One member of the SMT was described by a member of staff as “everything I want to be as a manager”.

- Staff in all areas of the surgical service described line managers as approachable and supportive.

Culture within the service

- Staff were positive about working at the hospital and enjoyed their jobs. Staff told us people worked well together throughout the surgical team and communicated well. They valued the expertise of colleagues and peers, seeking out advice and guidance when required. We observe staff treated each other with respect and working together to complete patient care tasks.
- We reviewed staff sickness records for 2014/2015 which showed between 0-6% sickness absence each month, which was largely below expected levels.
- Feedback from consultants about the culture within the hospital was variable. We were told about two recent occasions where medical staff had been suspended from practicing at the hospital. Consultants described their concerns about the lack of consistency surrounding the suspensions and one surgeon explained how they have modified their practice by working alongside another surgical colleague to “protect” themselves from suspension. Some medical staff expressed concerns they would be castigated for making errors. However senior management told us any actions post an incident, including any disciplinary action, were taken with advice from the MAC and other stakeholders including the Medical Director at BMI and CCGs. In addition, some of the suspensions were in line with terms and conditions in consultant practising privileges regarding timeliness of statements post an incident.

Public and staff engagement

- Staff forums were held on a regular basis, providing staff with the opportunity to make suggestions for improvements and receive information about upcoming developments within the hospital. Staff spoke positively about these forums and felt their views were valued by the organisation. Minutes from departmental meetings also demonstrated staff were engaged in decision making processes within the service.







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- Some staff were aware of their team's performance in comparison with other areas of the service and told us this was because of Comm Cell meetings.
- Airlie and Chartwell wards ran an 'employee of the month' award scheme, which allowed nurses to nominate colleagues who had performed beyond expectations. The ward manager reviewed the nominations at the end of the month and the award was given to whoever had the most nominations. The person's name and reasons for nomination were displayed on the noticeboard at the nursing station.
- Each year an awards ceremony for hospital staff was held and theatres staff were recognised for their achievements at the most recent awards.

Innovation, improvement and sustainability

- An anaesthetic practitioner recently developed a "please sign here" alert system for the controlled drugs book within theatres, in response to the documentation not being completed fully on previous occasions. This had been approved by the Chief Pharmacist and senior staff told us this change was likely to be rolled out across all BMI hospitals.
- Staff described provisional plans to introduce a more joined up preoperative assessment service by including an anaesthetist assessment prior to admission. It was hoped this would reduce delays caused by struggles to contact specific anaesthetists regarding preoperative investigations for patients.
- Staff told us plans to introduce a flexible twilight shift for nurses on the day-case ward were in place to address the issue of late patient discharges which caused staff to finish work late.
- Hospital staff told us the organisation was working with the 'Private Healthcare Information Network' to improve reporting of patient outcomes across the independent healthcare sector. They hoped this would make patient outcome data more easily comparable with NHS providers and drive improvement in quality.
- Staff told us of plans to expand the range of surgical procedures carried out at the hospital and it was anticipated this would cause an increase in patients through the surgical department.
- Blenheim ward had been opened on several occasions and closed again due to lack of activity and staffing availability. Senior staff were aware of the need to increase surgical activity and the staff base to make opening this ward sustainable. There were no plans to re-open the ward at the time of our inspection and staff told us it was useful to have the unoccupied space while other parts of the hospital were being refurbished.
- Theatres staff described how the supply of joint prostheses was being standardised in an attempt to reduce costs for this type of procedure. Staff told us there were no other cost improvement plans within surgery at the time of our inspection.

Critical care

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

Information about the service

The intensive care unit (ITU) was a six bed facility, with four beds in the main unit and two side rooms on an adjacent corridor. Staff told us the unit accepted a maximum of three level three patients and three level two patients at any one time. 208 patients were admitted to ITU between February and July 2015.

Patients were admitted post-operatively, via the emergency care centre or after becoming unwell on the hospital wards. Most admissions to the unit were planned. An outreach service was available to assess deteriorating patients and those recently discharged from ITU.

We visited the unit, including the ITU side rooms, over the course of three announced inspection days and one unannounced inspection day.

During our inspection, we spoke with 13 members of staff including doctors, nurses, allied health professionals and ancillary staff. We spoke with the ITU leadership team and the hospital senior management team. We also spoke with one patient and one relative. It was not appropriate for us to speak with other patients or relatives on the unit. We checked three patient records, the ITU environment and equipment. We also checked other hospital records such as audits and policies and procedures.

Summary of findings

Overall, we rated ITU as requires improvement. We had concerns there was an under-reporting of incidents and no evidence of action to improve this. We also found important safety data was not audited or monitored. Lack of full patient outcome monitoring, in addition to the unit not participating in national benchmarking, made it difficult to fully assess performance. There was no ITU follow up clinic available to patients.

The cleanliness of equipment and the unit itself was poor, although we found a vast improvement at the unannounced inspection. We observed staff were not always compliant with infection prevention and control processes, including being bare below the elbows and cleaning hands before giving intra-venous medicines. There was a higher than recommended usage of agency staff, although many of these nurses worked on the unit regularly.

There was a lack of multi-disciplinary team (MDT) communication, ward rounds or meetings and we were given examples of where poor communication had been detrimental to patient care. Staff were not adhering to Deprivation of Liberty Safeguards processes however awareness of mental capacity and consent principles was good.

Access to and flow through ITU was seamless and the service was mainly responsive to the needs of individuals. Permanent nursing staff were initially supernumerary and were required to complete specific

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competencies including for medicines administration before working unsupervised. Staff were well supported, enjoyed their work and provided good standards of care. There was a clear vision for developing the unit and introducing additional quality and safety measures.

Are critical care services safe?

Requires improvement



Safety on the ITU required improvement as there was an increased risk of avoidable harm to patients and there were limited assurances about safety. There was limited use of systems to record and report safety concerns due to an under-reporting culture on the unit, this included errors involving medicines. Systems, processes and standard operating procedures were not always reliable as some safety auditing, such as venous thromboembolism (VTE) assessment and prophylaxis use, were not completed and other safety procedures, for example flushing taps to prevent legionella or pseudomonas bacteria build up, were not done consistently.

The ITU environment and some equipment were not clean, although, after we raised this concern, was largely addressed by the time we returned on our unannounced inspection. The location of waste bins and hand washing sinks meant staff had to walk through the department with used items and unclean hands to access them. Some staff did not adhere to infection control procedures, like cleaning their hands and being bare below the elbows; however there had been no unit-acquired infections and safety performance, for the indicators monitored, was positive.

There was a much higher than recommended use of agency nursing staff, however most of these staff were 'regulars', and all staff completed medicines competencies before being allowed to administer oral or intra-venous (IV) medicines as well as receiving a robust induction. Staff were up to date on mandatory training and were aware of safeguarding principles. Records, including prescriptions, were completed fully and we noted medicines storage was mainly suitable.

Incidents

- Incidents were recorded using paper-based IR1 forms, which were conveniently located at the nurses' station on ITU. Once completed this form was reviewed by the unit manager and then passed to the Risk and Quality Manager for further assessment.
- New incidents from across the hospital, including ITU, were discussed at the hospital-wide head of

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department's comm cell meeting which happened at 9.00am from Monday to Friday. This provided the most senior staff on duty each day the opportunity to immediately identify and address potential risks or respond to incidents which had caused patient harm.

- There was no formal comm cell meeting held on ITU as nurses were unable to leave their patients unsupervised, however information from the hospital wide comm cell and any department information was passed onto ITU staff during handovers at both shift changes.
- On ITU there were 13 reported incidents from February to July 2015, but no never events or serious incidents. There was no obvious trend to the incidents which had taken place. We saw evidence of root cause analysis (RCA) using the BMI corporate RCA template when incidents occurred, however these did not adequately demonstrate the investigation process.
- Staff were able to describe how they would report incidents which led to patient harm but most staff told us near-misses were unlikely to be reported. They told us they were too busy to complete the incident report and one staff member told us "no one bothers to report things that haven't caused harm". We were concerned there was a risk to patient safety as learning and improvements from near misses was not occurring.
- Unit staff were aware of their responsibilities under the duty of candour regulation but were unable to provide an example when this had been instigated. Within the RCAs we reviewed, duty of candour was not referenced in actions required, although honesty with patients was evident. Senior staff gave a specific example of a recent complaint and highlighted the apology which had been made to the patient.
- There was no morbidity and mortality meeting held at the hospital due to low numbers of mortality. All patient mortality was reported in the bi-monthly clinical governance reports and discussed at clinical governance committee meetings which were held on a monthly basis.

Safety thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients receiving NHS funded care, such as new pressure ulcers, catheter and urinary tract

infections (CUTI and UTIs), falls with harm to patients over 70 and VTE incidence. There was no safety performance or staffing level data displayed for patients and relatives to see on ITU or in the waiting area.

- Staff used the Waterlow Pressure Ulcer Prevention Score to assess the patients' risk of developing a pressure sore. There was an ITU staff nurse identified as the tissue viability and wound care lead nurse for the unit. There had been no unit-acquired pressure ulcers on ITU from January to August 2015.
- There had been no patient falls on ITU from January to August 2015. Falls risk assessments were completed on a regular basis for patients considered to be at risk. We saw completed risk assessments in the medical notes for suitable patients.
- Staff told us there had been no occurrences of unit-acquired methicillin-resistant staphylococcus aureus (MRSA) from February to August 2015; however there was no documentation available to support this information at the time of our inspection.
- Staff told us no patients had developed *Colostrum Difficile* (C. Difficile) on ITU from February to August 2015; however there was no documentation to support this information at the time of our inspection. Staff told us faecal samples were sent for analysis as soon as a patient developed symptoms of C. Difficile although this was not formally monitored.
- We did not see evidence of catheter care bundle use on the unit, which was not compliant with best practice guidance according to the Faculty of Intensive Care Medicine.
- There was also no audit data available to evaluate the rate of patient VTE risk assessments, as this information was not collected on ITU. This meant we could not assess the performance of the unit in this area. During our inspection, all patients were seen to have been assessed for VTE risk and had appropriate VTE prophylaxis if indicated.

Cleanliness, infection control and hygiene

- There was a housekeeper who worked across the surgical wards and ITU throughout the day and housekeeping cover overnight was available on a bleep system. The housekeeper was responsible for completing basic daily cleaning on the unit, and thorough 'deep' cleans when necessary. There was no

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schedule of work available on ITU to direct the housekeeper in their cleaning tasks despite a schedule of cleaning guide for high risk areas being available within the hospital.

- Staff told us the housekeeping supervisor did not routinely complete spot checks although they would liaise with the unit manager to discuss cleaning requirements. There were no other systems in place to monitor the cleanliness of the unit.
- Bed spaces which were not in use at the time of our inspection had been prepared for subsequent patients and equipment was labelled with green 'I am clean' stickers. We noted the bed space areas and some equipment was not clean, such as a layer of grime observed on an uncovered laryngoscope.
- Bed spaces were separated with disposable curtains which had been labelled with the date they were put up. Staff told us the curtains were changed on a quarterly basis or sooner if they became soiled, which was in line with best practice guidance.
- Some consumables, such as sterile water which could be used for flushing percutaneous endoscopic gastrostomy (PEG) tubes, were seen to be open at the empty bed spaces with no indication as to how long they had been open for. Certain consumables should be discarded after a specific time once opened. It would be difficult for staff to establish whether these consumables were usable as the date they were opened was not labelled.
- A ceiling air vent was seen to have some cobwebs and a thick layer of dust covering all the surfaces. When this issue was raised with a senior member of staff, we were told it would be cleaned when certain structural changes were made to the unit in September (two months after our inspection).
- The clean utility room was found to be generally clean however some equipment within the room, such as a compressor pump, was seen to have a thick layer of grime on top of it.
- The floor of the dirty utility room was not clean and a layer of grime was visible particularly at the edges of the room.
- Within the dirty utility room we inspected a commode with a green 'I am clean' sticker but found evidence of soiling on the frame and underside of the seat. We alerted a member of staff to this but found the commode had not been cleaned when we returned to the unit 24 hours later. This was raised with staff once again and was still not addressed by the time we left the unit almost two hours later.
- A hospital report completed by the Interim Infection Prevention and Control Lead Nurse dated 10 January 2015 demonstrated an audit of cleaning on ITU had been completed and scored 56% compliance, which was substantially below the scores of other wards in the hospital. Although actions for improvement were identified, it was unclear what would be done specifically to target the low cleaning standard on ITU.
- When we returned on our unannounced inspection, we found most of our concerns relating to the cleanliness of ITU had been acknowledged and addressed. Within the main ITU area, the bed spaces were seen to be clean and tidy, equipment was clean and covered where needed (such as the emergency laryngoscope) and the air vent had been thoroughly clean so no dust or cobwebs were evident. In the clean utility room, equipment had been cleaned and removed to more appropriate storage. The commode in the dirty utility room was seen to be clean; however there was still some grime on the edges of the flooring.
- Most staff were seen to be bare below the elbows, however some nursing staff were observed to be wearing long sleeves when attending to patients which was against infection control guidance.
- We saw staff using personal protective equipment (PPE), such as gloves and aprons, when performing care tasks with patients and when entering a barrier nursed patient's room during the ward round.
- The most recent hand hygiene audit dated July 2015; showed ITU staff were 100% compliant with cleaning their hands and this was consistent previously. During our inspection, most staff were observed using alcohol gel to clean their hands but we did not see any member of staff in the main ITU area washing their hands with soap and water. We observed some occasions when staff failed to clean their hands at all before performing a patient-related task, for example a nurse gave a patient an intravenous (IV) medicine without cleaning her hands prior to preparing or administering the medicine.
- There were three hand washing sinks available within the department; one in the clean utility room, one in the dirty utility and one in the main unit area within bed

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space four. This meant hand washing facilities were not readily available for staff at three patient bed spaces and staff had to walk through the unit with dirty hands to access a sink.

- The hand washing sink in the dirty utility room did not drain after use. This was reported to a member of staff who told us it had been reported to the maintenance team. We returned to the unit 24 hours later and found it had not been addressed. As this sink was unusable, staff had to leave the dirty utility to wash their hands in the clean utility room opposite, which was against infection control guidelines. When we returned on our unannounced visit, we observed the drainage problem had been fixed and the sink was back in use.
- The ITU side rooms were used to accommodate barrier nursed patients or overseas patients who required isolation until it was ensured they were clear of infective risk. At the time of our inspection both side rooms accommodated an overseas patient who required barrier nursing. There were no signs on the doors to the side rooms indicating PPE was required and we observed staff enter without PPE on two occasions.
- The side rooms were sometimes used for patients suspected of having multi-resistant infections; however there was no negative pressure facility in the ITU side rooms which allowed air to flow into the isolation room but not escape from the room.
- Patients were swabbed for MRSA on admission to ITU and on a weekly basis after that. Staff told us there had been no instances of hospital-acquired infections, such as MRSA and C. Difficile, developing on ITU; however there was no documentation to support this information.
- A form within the daily checks folder specified the sink in the clean utility room needed running for three minutes continuously each day to reduce the risk of legionella build up. The accompanying documentation showed this had only occurred on eight days in the last month. During our unannounced inspection we noted the tap task had been completed more frequently (eight days out of 11), but there were still some gaps evident.
- There was a storage box labelled 'Ebola' which staff told us was to be used if they suspected a patient may be infected with the Ebola virus. There was no policy or guidance within the box. It contained some basic PPE, such as gloves, aprons and face masks for staff. We were told none of the ITU staff had been fit tested for the masks; this could place them at risk if caring for an

infected patient. When we returned on our unannounced inspection, copies of the hospital Ebola policy had been laminated and placed within the box and additional, more suitable, PPE had been added. There was also a reminder for staff to get 'mask fit' tested.

- Infection prevention and control monitoring was recently delegated to a specific group of ITU nurses led by a charge nurse. Other than the audit completed by the Interim Infection Prevention and Control Lead Nurse cited above and regular hand hygiene audits, staff were unaware of any other measures of infection prevention and control adherence on ITU. The group of nurses responsible for infection prevention and control monitoring were expected to complete the necessary audits starting from September 2015.

Environment and equipment

- There were four bed spaces located within the main ITU department, with an additional two side rooms located down an adjacent corridor. The bed spaces were not compliant with HBN0402 ITU Facility Standards as they measured 20m², rather than the required 25.5m².
- A resuscitation trolley was located within the main part of ITU and was found to contain all essential medicines and equipment, which were in date. Stock checks should occur once each day but we saw some gaps on the recording document, suggesting these checks were not always taking place. Equipment additional to that listed on the stock list, such as extra oxygen masks and patient intubation airways, was also found on the resuscitation trolley, making the drawers' contents overflow and untidy. This could make it difficult to locate important equipment during an emergency situation.
- Difficult airway and emergency tracheostomy equipment was available on a separate trolley located next to the main resuscitation trolley which was in a variety of sizes.
- There was no evidence that some electrical equipment on the unit, such as the weighing scales or television, had undergone portable appliance testing for electrical safety which was a risk to patients and staff..
- A patient transfer bag (containing emergency equipment, fluids and medicines) was located in the corner of the clean utility room. Upon inspection, several consumables within the bag, such as a laryngeal

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mask airway, tracheal tube and sodium bicarbonate, were found to be more than three months past their expiry date. Staff told us this transfer bag was rarely used and showed us an additional transfer bag which was normally used and kept in a locked store room. Within this second bag, three syringes of adrenaline, one 500ml bag of gelofusine and a packet of salamol nebulas were seen to be more than three months out of date. This was raised with senior staff on the unit and addressed immediately. Staff told us there was no formal procedure in place to check the contents of the transfer bags.

- There was sufficient storage for general consumables within the clean utility room and drawers were labelled to assist staff in finding equipment quickly. We checked a random selection of consumables stored in this area and found they were all in date.
- The arterial blood gas (ABG) analyser was located on a work top in the dirty utility room. The machine was seen to be clean throughout our inspection. During our unannounced inspection, we found the machine required replacement of a specific part and could not be used until this had been addressed. Staff told us the person who had the spare parts was off that day and it was unclear where to access additional parts at that time. Staff had access to the ABG analyser in the recovery area of theatres, however this increased the time taken to get sample results and required a member of staff to leave the unit.
- Clinical waste bins were available within each bed space as well as the dirty utility room, the clean utility room and next to the sink in the main unit area in bed space four. General waste bins were also available through the unit. We observed some general waste bins had been fitted with yellow bin bags labelled as clinical waste. This could lead to confusion about where each type of waste should be disposed of. We observed used mop cloths had been disposed of in a general waste bin, which was against infection prevention and control guidance.
- Needle sharps bins were available at each patient bed space, in the dirty utility room by the ABG analyser and in the clean utility room where medicines were prepared. All sharps bins were seen to be labelled and signed appropriately. During our unannounced inspection we noted two sharps bins in the main unit area with items discarded above the maximum fill line, which was not in line with best practice guidance.

- The ITU resident medical officer (RMO) was required to be contactable via the hospital bleep system at all times when on shift. Staff told us the number for the RMO had changed on more than one occasion recently. This was because a new bleep needed to be issued due to breakages and it was not possible to transfer the old RMO number onto the new bleep. An email was sent to all staff to highlight the change but there were no signs on the wards indicating the new number and there was still a risk the old number would be used to contact the RMO in the event of a patient deteriorating or in an emergency.
- Senior staff told us it took a long time to get approval for new equipment as funding needed to be approved at a regional level, although other staff confirmed that equipment maintenance and repair was contracted out to another company. Staff told us this sometimes meant delays in accessing replacements when an item of equipment was no longer functional and they felt equipment was not prioritised appropriately according to need or risk.
- New daily ward safety checklists were planned to begin in August 2015 and were to be completed by the charge nurse on each shift. We were shown an example of the unit and bed space safety checklists which were comprehensive. When we returned on our unannounced inspection, we noted the safety checklists were in use and had been completed for every bed space, including those without patients. There were no gaps in documentation since their introduction.
- We observed one electricity socket near to the clean utility room had started to come away from the wall and could become unsafe to use and this was not highlighted at any of the Comm Cell meetings we observed.
- The responsibility for maintenance of equipment and materials was recently delegated to a specific group of ITU nurses. Senior staff told us the team were expected to undertake relevant audits and equipment checks from September 2015, which would be led by the charge nurse responsible for the team.

Medicines

- The door to the clean utility room where medicines were stored was seen to be propped open despite having a sign in place advising staff the door should be kept closed at all times. Staff told us it was left open because the room got too hot for medicines storage if it

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was left closed. We saw evidence the temperature in the clean utility room was checked on most days, and the door was recorded as being left open on the days when the temperature was above the target range. It was anticipated this problem would be rectified when the new ITU was built, but not addressed before this time.

- Medicines were stored in locked cupboards or a locked medicines fridge if required. All storage units were seen to be secured when not in use during our inspection.
- Emergency medicines, such as adrenaline and Propofol, in the patient transfer bag were not locked away or securely stored. This meant they could be accessed by anyone on the unit, potentially including visitors as the door to the storage room was left unsecured. When we returned on our unannounced inspection, the patient transfer bag had been moved to more appropriate secure storage.
- The medicines storage fridge was seen to be within the desired temperature range and paper records showed this was usually checked on a daily basis, although one gap occurred in July, three gaps in June and two in May. The documentation showed evidence of actions taken when the fridge was not within the desired temperature range.
- An audit of controlled drug management was completed on a quarterly basis. The most recent audit, in April 2015, identified specific learning points such as ensuring page headings were fully completed and documenting patient hospital numbers as well as names. There was no statistical information recorded on the audit results.
- Controlled drugs were correctly stored in a lockable wall unit and the controlled drugs book was suitably filled in. However, there was no copy of the authorised signatory list available and senior staff were unaware when a list had last been submitted to the pharmacy department.
- A pharmacist visited the unit on a daily basis, including at weekends, but some pharmacy staff told us they did not necessarily have specific ITU training. The pharmacist was required to cover other areas of the hospital at the same time as ITU. Cover from the pharmacy department was available from 8:30am to 8pm, and advice via the telephone was available overnight if required. The pharmacist was responsible for checking patient drug charts for medicines interactions and allergies.
- Two sets of guidelines for prescribing antibiotics (“The Clementine Churchill Hospital Anti-infective Guidelines

for Medical and Surgical Patients”, March 2015 and “Antibiotics Guidelines” which were not dated) were available within the clean utility area of the ITU.

However, these guidelines provided conflicting advice for some conditions, such as for treating endocarditis, this could lead to confusion when prescribing.

- We checked three medicine administration records (MARs), all of which were seen to be legible and fully completed in line with national guidance. There had been no missed medicine doses documented.
- Oxygen had been prescribed for patients where necessary and this was reviewed by the ITU consultant during ward rounds on a daily basis. Oxygen cylinders were seen to be in date and stored correctly in racks at the bed spaces.
- Microbiology support was provided by an external organisation, particularly because ITU admitted many overseas patients with multi-resistant infections.
- We observed nurses administering IV medicines and following correct procedure on most occasions, including the medicine being checked by two nurses. We observed one nurse administer an IV medicine without checking the patient’s name band first, which was poor practice and could lead to the wrong patient receiving the medicine. We observed nurses administering controlled medicines and following correct procedures for this.
- Senior staff told us there had been no drug errors reported from May to July 2015, but did not feel confident to state that no errors had occurred. There were two reported drug errors identified when reviewing incident data from February to July 2015, which was low for this type of unit.
- ITU representatives attended the medicines governance committee meetings held on site, where drug errors and other governance relating to medicines were discussed.

Records

- All documentation on ITU was paper-based, including daily care records, nursing notes and medical notes.
- Daily care plans and observations charts were found on the nurse’s desk at each patient bed space. Medical notes were stored separately on the unit.
- We observed nursing staff copying out blood test results from a printed sheet onto their daily care record. If transcribing errors occurred it could impact upon

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decisions made about patient care and place patients at risk. However, we were told the printed sheet was also filed in the patients' records and it was this – rather than the transcribed results – which consultants reviewed.

- We reviewed three patient records, all of which had been completed thoroughly and included holistic information about the patient as well as clinical details. Most note entries were legible and were seen to be signed and dated. Staff told us documentation audits were not routinely completed on ITU.
- Confidential patient information was placed in the patient's hospital notes for future reference or disposed of in a secure confidential waste bin at the nurses' station when no longer needed. However we found a patient prosthesis record booklet containing confidential information within a document holder on the window sill storing patient menus. This booklet was dated 31 May 2014, suggesting it had been misplaced over a year ago.
- Ventilator-associated pneumonia care bundles were seen to be documented on a daily basis, which was in line with best practice.

Safeguarding

- All staff were aware of who the lead nurse for safeguarding was and were able to locate the organisation's safeguarding policy. Staff told us they would not hesitate to contact the safeguarding nurse if they had any concerns that a patient was at risk, and were able to provide suitable examples of what might cause them concern.
- Once a patient at risk had been identified, staff told us a referral would be made to the local safeguarding team so the patient was followed up when they had been discharged from hospital.
- Information provided by the hospital showed 100% of staff had completed adult safeguarding level 1 training, which was better than the hospital target of 90%.

Mandatory training

- All ITU staff were required to participate in specific mandatory training. Some topics, for example health and safety, information governance and fire safety, were completed via e-learning and others, such as basic life support and conflict resolution were classroom based. Other topics covered included aseptic non-touch technique, infection prevention and control and blood

transfusion. At the time of our inspection, ITU staff had completed an average of 92% of the mandatory training which was above the organisational target of 90% completion.

- To be eligible to work as an ITU RMO, medical staff were required to have a minimum of 12 months experience in medical, surgical and intensive care. All RMOs were required to have Advanced Life Support (ALS) and European Paediatric Life Support (EPLS) qualifications.
- Reminders to complete mandatory training were sent via an automated email system three months, two months and one month before the training was due to be completed. The staff member's line manager would also be copied into the one month reminder email.
- Staff were given time within working hours to complete their mandatory training. Staff told us it was not ever a problem to fit mandatory training into their schedules.
- Mandatory training for agency staff, RMOs and ITU consultants were the responsibility of the external organisation which provided the staff member but evidence of this was required before they could work at the hospital.

Assessing and responding to patient risk

- When a deteriorating patient was identified on the wards via an elevated early warning score (EWS) calculation, a referral was made to the ITU outreach service. The outreach service was provided by the senior ITU nurse who was supernumerary and RMO and was available 24 hours per day. The RMO would assess the patient alongside the patient's lead consultant and determine an appropriate course of care.
- Once a patient was transferred to ITU, EWS was no longer calculated but other tools for assessment were used. For example, the team used the 'Glasgow Coma Scale' (GCS) to assess the patients' conscious level and the 'Richmond Agitation-Sedation Scale' (RASS) to measure agitation of an unconscious patient (RASS is used in ventilated patients in order to avoid over and under-sedation).
- Intensive Care Society guidelines state all patients should be reviewed by an ITU doctor within 24 hours of discharge from ITU, however we were told patients were reviewed by the ITU doctor after discharge from the unit if requested by the ITU consultant only. The number of patients reviewed was not monitored.
- We reviewed evidence which showed five patients were seen by the outreach service between January and

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August 2015. Documentation was completed for four patients; the fifth contained details of the patient's name and procedure only. All patients seen were post-operative and were either being reviewed after discharge from ITU or had been referred due to a raised EWS. Documentation showed all patients were discharged from the outreach service within 24 hours of being referred.

Nursing staffing

- The day-to-day running of ITU was the responsibility of the charge nurse on duty, who was supernumerary, and the overall management was overseen by the unit manager.
- Staff completed day shifts from 7:30am to 8.00pm and night shifts from 7.30pm to 7:30am.
- Nursing staff received a general overview of patients in the unit, before completing a comprehensive 'patient specific' bedside handover at the start of their shift.
- An acuity tool was used to determine staffing levels. The Faculty of Intensive Care Medicine Core Standards for Intensive Care Units states that those patients requiring advanced respiratory support alone or basic respiratory support along with support of at least two other organ systems).(Level three [L3]) are required to have a registered nurse to patient ratio of a minimum of 1:1 to deliver direct care, and for those patients requiring higher levels of care and more detailed observation or intervention, including post-operative care (Level two (L2) a ratio of 1:2. The unit complied with the required staffing levels and there was no evidence of staff looking after more than one L3 patient on the allocation record from March to July 2015.
- Due to the location of the ITU side rooms, there was a 'runner' member of staff allocated to assist the staff nurses working in these rooms. If no runner was available, the health care assistant (HCA) would support these staff.
- Support of one HCA was available on the unit from Monday to Friday 8:30am to 5pm. Responsibilities included stock checking/ordering and supporting nursing staff with tasks on the unit.
- At the time of our inspection there were eight vacancies for staff nurses, two vacancies for senior staff nurses, one charge nurse vacancy and one training nurse vacancy. The unit manager explained recruitment of permanent staff was difficult and they recruited from overseas when needed. This meant the unit relied heavily on the use of agency staff to maintain the required nurse to patient ratio.
- Best practice guidance suggests there should be no more than 20% agency nursing staff working on a unit at any one time. Information provided by the hospital showed there was regularly a higher proportion of agency staff working than was recommended. A high level of agency nursing staff was seen from February 2015 to July 2015. Between 1st and 29th July 2015, there were seven shifts where the number of agency nurses was less than 20% of the total staffing in comparison with 43 shifts where the agency staffing was greater than 20%. There were eight shifts where all staff working on the unit were agency staff. Additionally, there were some occasions when an agency nurse was in charge of the unit.
- Senior staff told us they were aware that the high usage of agency nurses was a risk but explained they had a group of 'regular' agency staff who knew the unit well and were competent which was evidenced in their rotas. The high use of agency staff was documented on the hospital wide risk assessment tracker and was assessed as being 'optimally controlled', although no specific controls in place were identified on this document.
- There was a formal induction process in place for agency staff and we saw evidence this had been completed. One agency nurse told us the induction had been "better than in other places" they had worked.
- We saw evidence of competencies being checked for oral and IV medicines administration for new nurses and agency staff. Agency nurses were not able to give oral medicines until they had been assessed as competent by a senior nurse within the department. Competency to give IV medicines was proven by showing the charge nurse or unit manager a copy of IV medicine training from the agency nurse's regular place of work (for example, an NHS hospital). If the agency nurse worked on ITU regularly, they could receive in-house IV medicine training to be allowed to administer this type of medicine.
- New nurses were initially supernumerary during a formal induction and orientation period. They were allocated a mentor and worked alongside other staff to "learn the ropes".

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- In addition to managing the day-to-day running of the unit, the charge nurse may also be required to complete outreach assessments for deteriorating patients or those recently discharged from ITU.

Medical staffing

- The provision of medical staffing for both consultants and RMOs was better than the ratios recommended by The Faculty of Intensive Care Medicine Core Standards for Intensive Care Units.
- Consultant cover was provided to ITU by an external organisation and comprised of three core consultants, with an additional fourth consultant who could be included on the rota when required and had practising privileges at the hospital with the same checks as other consultants.
- The ITU consultants worked on a rota basis, which was devised by the consultants themselves and varied from providing one day of ITU cover to ten days in a row. We reviewed the rota from July 2015 which showed most consultant cover was for four or five days in row, which is in line with best practice guidance for continuity of care.
- The consultant on duty personally reviewed all ITU patients during a daily ward round and was available to provide telephone advice to the RMO 24 hours per day. Documentation showed all new patients admitted to ITU were reviewed by the consultant within two hours, which was well within the 'Faculty of Intensive Care Medicine Core Standards for Intensive Care Units' target of 12 hours. The consultant also came into the unit to review patients more often if clinically indicated, with a response time of 30 minutes as specified in the service level agreement with the external organisation.
- Approximately 75% of the shifts in ITU were covered by bank RMOs, the remainder were covered through an external organisation. There was one RMO responsible for ITU at all times and shifts ranged from 12 to 48 hours, with provision for the RMO to sleep onsite as required. RMOs were required to be contactable on an allocated bleep when on shift, including when sleeping. Only RMOs approved by the ITU consultants were permitted to work a shift in excess of 24 hours which was an appropriate arrangement.
- The RMO was required to review patients discharged from ITU if required as well as deteriorating patients in other wards of the hospital as part of the ITU outreach provision. Staff told us the on duty RMO would most

commonly review patients who attended the hospital's Emergency Care Centre, rather than patients on the medical or surgical wards. The RMO was also expected to attend emergency crash calls when on shift. When this occurred, ITU had no doctor directly on the unit which is against best practice guidance.

- Medical handover meetings between the RMOs took place at 8am and 8pm on the unit, where the doctors on duty would handover patient details and updates to medical staff coming on shift.

Major incident awareness and training

- A hospital-wide generator test was completed on a monthly basis to ensure adequate electricity would be supplied in the event of a power failure.
- A hospital-wide fire alarm test was completed on a weekly basis and ITU staff were aware when this would happen.
- Staff on ITU were aware of the hospital policy relating to evacuating patients in the event of a fire, although none of the staff we spoke with had been involved in an evacuation simulation. Senior staff told us this had been identified as a potential problem and a simulation was planned for the near future.

Are critical care services effective?

Requires improvement



The effectiveness of ITU required improvement. Some patient outcomes, such as average length of stay, were not formally monitored and the unit did not contribute to a national benchmarking database, making it difficult to assess performance directly with other similar units. ITU also did not engage in critical care network activities.

There was limited multidisciplinary working. Allied health professionals had little involvement in consultant-led ward rounds, and formal multidisciplinary team meetings did not occur. Communication between microbiologist support and ITU consultants was not adequate. Also, staff told us of difficulties accessing imaging services within the hospital.

Staff were aware of DoLS principles; however mittens were used on the unit without considering making a DoLS application. Staff obtained consent from patients where possible and could describe principles of the Mental

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Capacity Act, 2005. Staff completed competency frameworks and were supported with development opportunities, however less than 50% of nurses had completed a post registration intensive care course.

Evidence-based care and treatment

- General corporate policies and procedures, such as infection prevention and control and fire safety, were available in paper-format in the ITU office. Some policies were seen to be out of date at the time of our inspection and it was unclear whose responsibility it was to maintain the information contained within the folders. Up to date policies were also available on the corporate intranet, which was accessible to all staff on ITU including agency and bank.
- Intensive care specific policies and procedures, such as hemofiltration guidelines and arterial line procedure information, were also found in the ITU office and were seen to be in date, as well as being referenced to specific national and international guidance.
- Best practice guidance for the insertion of IV lines and on-going care was followed and documented in patient notes, although this was not audited on the unit.
- Guidelines for prescribing antibiotics ("The Clementine Churchill Hospital Anti-infective Guidelines for Medical and Surgical Patients", March 2015) were available within the clean utility area of the ITU; however these were not referenced to any clinical guidelines.
- Ventilator-associated Pneumonia (VAP) and VTE care bundles were used on the unit, which was in line with best practice guidance, and were seen to be appropriately documented on a daily basis for patients on ventilators.
- We observed patients assessed as being at risk of VTE were provided with prophylaxis, such as anti-embolism stockings or anticoagulant medicines, in accordance with 'National Institute for Health and Care Excellence' (NICE) guidance.
- A consultant-led bedside ward round took place once a day at 10am which was contrary to the 'Faculty of Intensive Care Medicine Core Standards for Intensive Care Units' which states twice daily ward rounds should be undertaken. We noted the service level agreement with the external agency providing the ITU consultants supported two ward rounds per day, however there were no concerns from senior staff within the hospital (including the Medical Advisory Committee) regarding medical provision on the unit.

Pain relief

- A pain scoring tool was used on an hourly basis with all patients as part of the regular observations. The tool involved rating the patient's pain on a scale from zero (no pain) to three (maximum pain). Staff told us patients were asked if they required pain relief when awake, or unconscious patients were given pain relief if they scored 2 or above during the assessment of their pain, based upon their physical appearance at rest and during care procedures.
- A senior staff nurse was allocated as the pain management lead nurse on ITU and liaised closely with the RMO on duty.
- Senior staff told us of plans to update the pain management strategy on ITU, including reviewing the pain management policy and obtaining specialist assistance. One of the regular RMOs was a pain management consultant and was going to be heavily involved in developing the strategy.

Nutrition and hydration

- The nutrition and hydration needs of each patient were discussed on a daily basis during the bedside ward round and nursing staff completed the 'Malnutrition Screening Tool' (MUST) assessment. Fluid balance was also calculated. The MUST assessment and fluid balance had been completed in each patient daily record we checked.
- Dietetic support was provided by an external organisation, which organised a senior ITU trained dietician to visit the unit a few times' per week. Additional telephone support was also available. We saw evidence of regular dietetic reviews occurring, particularly for long term patients where formal nutritional plans were in place.
- Patients who were able to take food orally were offered a choice of food and drink throughout the day from a menu. Chefs within the hospital would try to provide any dish the patient liked, if at all possible, even if it was not on the menu. We saw patients were also offered additional snacks in between formal mealtimes.
- We observed patient's drinks were left within their reach and we noted nursing staff reminding patients to drink regularly.

Patient outcomes

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- ITU did not contribute data to the 'Intensive Care National Audit and Research Centre' (©ICNARC) database for England, Wales and Northern Ireland. This meant the care delivered and patient outcomes were not benchmarked against similar units nationally. Staff told us the unit will soon begin contributing data to ICNARC, when the new ITU training nurse vacancy was filled.
- The ITU was not part of the regional critical care network, which was made up of other critical care units in North West London and commissioning groups. Critical care networks facilitate shared learning across the region as well as providing peer support for clinical and managerial strategies. This meant the unit was not benchmarked against other regional ITUs.
- There had been three patient deaths, which were all expected, on ITU from February to August 2015, which equates to a mortality rate of 1.4% although we were unable to compare this to similar units.
- There were no non-clinical transfers from ITU between February and August 2015.
- There were seven unplanned re-admissions to ITU between February and August 2015. Additional details, such as whether the re-admission occurred less than 48 hours after discharge from the unit, regarding these re-admissions were not monitored.
- Average length of stay on ITU was not monitored.

Competent staff

Nursing Staff:

- Nurses within ITU were divided into four teams, comprising of four staff nurses, a senior staff nurse and overseen by a charge nurse (when fully staffed). Appraisals within each team were completed by the charge nurse and staff were rostered to work together when possible to make staff development and management easier.
- ITU nurse development was overseen by the Practice Development Nurse (PDN) within the hospital. Additionally, one senior nurse vacancy on ITU was converted to a supernumerary training nurse position to address specific training needs on the unit; however this role was vacant at the time of our inspection.
- Six out of 15 permanent nurses on ITU had completed a post registration intensive care course, which was less than the 50% standard recommended by The Faculty of Intensive Care Medicine. Senior staff told us it was not

possible to allocate shifts taking into account who had additional intensive care qualifications due to low permanent staff numbers and heavy reliance on agency staff. We were told "most" regular agency staff used had completed a post registration ITU qualification but this was not formally recorded.

- Senior staff described development opportunities open for staff to try and increase staff retention on the unit. An example of this was the chance to attend an ITU course immediately rather than having to wait for a year, which was the policy in a number of other organisations.
- Agency nurses were personally approved by the ward manager, who would review the experience of potential staff before they were able to work on the unit. The ward manager told us they would not accept an agency nurse back on the unit if there were any concerns at all about their performance.
- There were five ITU nurses who had completed mentorship training and a further four booked onto courses beginning later in 2015. Mentors were allocated to new starters to assist in their training and guide their development.
- New nurses were supernumerary until essential ITU competencies were signed off. Staff told us this could take anything from three to six weeks to complete. The induction competency pack was divided into three booklets and based upon the National Competency Framework for Adult Critical Care Nurses (2012). Competency documents were also in place for specific aspects of patient care, such as tracheostomies and IV cannulation, and had to be completed before nurses were able to independently complete this type of care task for patients.
- Nurses completed a competency assessment overseen by a senior nurse to be able to administer oral medications. A second competency assessment was required to administer IV medicines. We saw documentation supporting these assessments had been completed for new starters and agency staff.
- Senior staff told us there were no formal records identifying when staff had been trained on certain types of equipment. This would make it difficult to determine who needed additional top-up training. They told us it was hoped responsibility for this would be picked up by the ITU training nurse when one had been recruited.

Medical Staff:

Critical care

- As laid out in the service level agreement, it was the responsibility of the external organisation which provided the ITU consultants to ensure all deployed staff had the necessary experience and training. All consultants who worked on the unit had additional intensive care qualifications. In addition to this, all ITU consultants were required to maintain current practicing privileges in line with the BMI practicing privileges policy to be eligible to work on site. We saw evidence that the necessary paperwork was requested and kept by the hospital and reviewed by the MAC.
- The organisation which provided RMOs was responsible for ensuring all deployed staff had the necessary registrations and competencies prior to commencing work at the hospital.
- New RMOs starting at the hospital received two days induction onto ITU, which included orientation to the department and hospital, as well as shadowing the RMO on shift.

Multidisciplinary working

- Care and treatment of patients in ITU was the responsibility of the consultant intensivist on duty. Day to day patient tasks were completed by the RMO. Patients were also reviewed by their lead consultant when admitted to ITU, for example their surgeon, who would liaise with the ITU team to formulate a care plan. Staff told us there were good relationships between the ITU consultants and other consultants working within the hospital.
- Patients were discharged from the unit upon agreement from the ITU consultant and admitting consultant. Patients were followed up by the outreach team if requested by the ITU team. The ITU consultants dictated discharge summaries for all patients leaving the unit and these were available in the patient's medical notes 24 hours later.
- A daily ward round was led by the ITU consultant and attended by the RMO, charge nurse, bedside nurse and overseas liaison nurse, if required. There was no attendance from physiotherapy, dietetics or pharmacy.
- Staff told us there were no routine multidisciplinary meetings but there was regular informal communication between disciplines to discuss patient care. Staff described a previous situation where tension between nursing and physiotherapy staff had been caused due to lack of communication around treatment times. Both groups of staff had been reminded of their

professional responsibilities to patients, as well as to each other, and everyone had made a big effort to improve communication and professional relationships since then.

- Physiotherapists were responsible for setting patient goals. Staff told us it was difficult to make this a multidisciplinary process due to the high use of agency nursing staff as well as the frequent changes to the RMO and ITU consultant on duty although we found the rotas delivered continuity of care.
- Externally provided microbiologists reviewed results from patient investigations, such as swabs and sputum samples, and regularly made changes to a patient's antibiotic regime without discussion with the ITU team. This was highlighted as a concern by the ITU consultants who felt the lack of communication and multidisciplinary working with microbiologists placed patients at risk.
- The ITU was not part of the regional critical care network, which was made up of other critical care units in North West London and commissioning groups. Critical care networks facilitate shared learning across the region as well as providing peer support for clinical and managerial strategies. Consultants working on the unit were involved in the network via their regular roles for NHS organisations and could bring some elements back to the unit; however it was not their responsibility to instigate significant changes. Membership to a critical care network is not compulsory but is seen as good practice.

Seven-day services

- The unit had an on duty consultant 24 hours per day. They completed a daily ward round and reviewed patients in addition to this if clinically indicated.
- The day to day ITU tasks were completed by the resident RMO. The duty RMO was also responsible for providing the ITU outreach service to the wards.
- Some ITU staff described difficulties in getting radiology support on the unit, particularly out of hours. Staff told us there was no on call radiologist rota and so investigations out of hours would not be reported on until the next day. There were also some difficulties in accessing imaging facilities during the daytime. We were given an example where a patient required an urgent MRI scan but had to wait until the end of the day due to the elective MRI appointments taking place. However, it

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appeared ITU staff were unaware of imaging availability as this was contrary to information provided by the imaging department. The imaging department told us the on call radiologist was available within 30 minutes out of hours. Additionally, images could be sent to the radiologist for interpretation out of hours if needed. There were also five protected imaging slots reserved for inpatients during the day, to ensure swift access when required. We saw evidence supporting the information provided by the imaging team so we were concerned about communication rather than service delivery between imaging and ITU.

- Microbiology support was provided by an external organisation and telephone advice was available 24 hours per day.
- Physiotherapists reviewed patients on the ward on a daily basis and, in some cases, on more than one occasion. Full physiotherapy cover was available at weekends and an emergency overnight on call service was provided out of hours.

Access to information

- Information about patients transferred to ITU from the wards or theatre was verbally handed over to the ITU consultant by the lead consultant in the patient's care, for example the surgeon or medical consultant.
- Patient notes were paper-based and transferred with the patient when admitted to ITU. We were told there were very few occasions when patients did not have their BMI medical notes available and these instances occurred due to the patient being admitted via the emergency care centre.
- There were a number of external resources available to staff for obtaining information and guidance, for example the microbiologist, dietician and psychiatric support.

Consent, Mental Capacity Act and DoLS

- All staff on ITU could describe obtaining consent from patients prior to interventions when possible. They explained it sometimes was not possible to gain consent, such as from an unconscious patient, and told us they would therefore act in the patient's best interests. One nurse told us she had taken a blood

sample from a patient, who was unable to consent due to being unresponsive, because it was in the patient's best interests to analyse the patient's blood results to ensure the correct treatment was given.

- Staff on ITU carried reminder cards outlining the five basic principles of the Mental Capacity Act, 2005 (MCA). They were able to explain that patients must be presumed as having capacity unless it can be established they did not. Staff told us there had been a recent increase in awareness training with regards to the MCA and DoLS.
- Medical staff told us basic assessment of capacity was completed during each ward round and would be escalated to a formal assessment if there were concerns about a patient. None of the patients on the unit at the time of our inspection had required a formal capacity assessment and so no evidence of this was available.
- Staff told us the ITU did not accept patients with a history of significant mental health issues, although some patients can lose capacity when on ITU due to medications or ill health. They told us concerns about a patient's capacity would be escalated to the charge nurse and RMO for further assessment.
- Staff knew DoLS applications had to be made to the patient's local authority in order to enforce limitation on a patient's freedom when they are under supervision or control, but told us no applications had been made in recent months. Staff told us a "common sense" approach was used with regards to patients wearing 'mittens' to stop them pulling IV lines or their ventilator tube, and that DoLS applications were not made for this. This does not follow DoLS requirements.
- There was no process in place for submitting DoLS applications for overseas patients who would not have a designated local authority. Staff were unable to tell us what actions they would take if they were in this situation.
- No formal psychiatric support was available within the hospital but advice could be obtained from a psychiatric consultant who provided support from an external organisation.

Critical care

Are critical care services caring?

Good



Staff were caring towards patients on ITU. Patients and their relatives were complimentary about the friendly and supportive staff, who were always aware of maintaining patient comfort. Staff maintained patient privacy and dignity when performing intimate care tasks and were respectful to patients. Staff involved patients and their relatives in decisions about their care, giving explanations and allowing opportunities to ask questions. Emotional support was provided by staff to patients and relatives alike, however there was no support provision in place in addition to this.

Compassionate care

- Patients were happy with the care they received on ITU. They told us staff were kind and friendly, and took time to interact with them in a considerate manner. Patients told us they were always treated with compassion and one patient described the nursing staff as “marvellous”.
- Patients described how staff maintained their privacy and dignity including when receiving intimate care by ensuring the bed space curtains were fully closed.
- Patients told us they always felt the staff treated them respectfully and were quick to respond if they were uncomfortable or in pain. One patient told us staff were “always checking” if they were comfortable and would help if repositioning was needed.
- We observed thank you cards and a letter which had been sent to the unit by previous patients, thanking staff for the care they received.
- Relatives told us their loved ones were well looked after on ITU and they were complimentary about the care provided by staff.
- We saw patient dignity being thoughtfully preserved during a consultant examination on the ward round, as the consultant examined one limb at a time and kept the rest of the patient suitably covered up.
- We observed staff interacting with patients in a sensitive and supportive way, including speaking gently to the patients when sleepy so as not to startle them. We saw staff had a good rapport with patients and spoke to them about their families, interests and current affairs.

Understanding and involvement of patients and those close to them

- Patients told us they understood what had brought them to ITU because staff had provided full explanations and answered their questions. They also knew what the plan was in relation to their on-going care on the unit.
- Patients described how they had been supported to make choices about their own care and day-to-day decisions, such as selecting meals from the options available.
- Relatives told us certain investigations and meetings with the ITU team had been arranged according to when the relative was available to attend which made them feel involved and informed.
- We observed ward rounds on ITU and saw the staff introduce themselves and their role to each patient. Patients were encouraged to participate in ward round discussions and decisions about their care, for example planning when rehabilitation would fit in best with their day.
- We saw staff providing full explanations of procedures to patients, including the purpose of the intervention, and allowing them opportunities to ask questions before proceeding.

Emotional support

- Staff told us they provided emotional support to anyone who needed it, including patients, relatives and other staff members. One nurse told us it was “part of being a nurse”.
- Patients told us staff had been patient and kind with them, providing explanations when they needed information about their care or had become upset on the ward.
- One relative described how staff were understanding when a patient was having a “bad day” and provided emotional support when her mood was low.
- There was no chaplaincy or other spiritual support service available within the hospital, although there was a designated spiritual room allocated on one of the surgical wards.

Critical care

Are critical care services responsive?

Good



The service provided by ITU was responsive. Flow through the unit worked well; patients accessed ITU without difficulty and were discharged back to the wards without delay. As most admissions were planned, there was minimal pressure for ITU beds and so patients were not transferred off the unit out of hours. Very few elective procedures were cancelled due to a lack of ITU beds.

The unit was responsive to the needs of individuals; offering several different specialist menu options, a translation service and flexible visiting times if needed. There was evidence of response to complaints, but it was unclear how on-going performance would be monitored.

There was no formal guidance in place suggesting when patients should be booked for an ITU bed post procedure and a high number of planned ITU admissions were cancelled. There was no information available on ITU advising how to complain or about the performance of the unit. There were no formal processes in place for supporting patients living with dementia or those with a learning disability and they could be admitted under the hospital's admission criteria. Additionally, there was no ITU follow up clinic in place once patients had been discharged.

Service planning and delivery to meet the needs of local people

- Patients accessed ITU post-operatively, after becoming unwell on the wards or via the emergency care centre. Some patients were transferred from overseas ITUs for additional medical care and rehabilitation. Full admission route statistics were not monitored by the department, however we saw evidence demonstrating 71% of admissions from February to July 2015 were planned.
- Senior staff told us this type of patient cohort made service planning relatively straight forward as the patient flow could be anticipated.
- Most patients admitted to ITU required L2 support (higher levels of care and more detailed observation or intervention, including post-operative care). Between

February and July 2015, just 8% of patients were admitted requiring L3 support (advanced respiratory support alone or basic respiratory support along with support of at least two other organ systems).

- Data provided by the hospital demonstrated there were an average of 19 ITU admissions cancelled each month between February and July 2015 for various reasons. Staff told us cancellations usually occurred because patients recovered well after their procedures and did not require admission to ITU, although this was not formally monitored.
- ITU beds were booked in advance by the surgical administrative team, who liaised closely with the ITU ward manager. ITU staff told us their surgical colleagues had a low threshold for booking ITU beds, which meant many surgical admissions to ITU were cancelled as the patient was well enough to return to the surgical ward rather than go to ITU. There was no set criteria in place to guide when a patient should have an ITU bed booked in advance.
- During our unannounced inspection, we were told one patient should be admitted to ITU that day but was cancelled, and so no admissions were expected. Later on, the unit was preparing for three patients who had not been recorded as booked for admission. This did not cause a problem on this occasion as the unit was quiet and there were enough staff members available to receive the patients. It was unclear where the error in the booking process occurred, but staff told us this did not happen frequently.
- There was no critical care follow up clinic available for patients once they had been discharged from hospital; this was not compliant with ITU core standards. Most patients had a follow up appointment with their surgeon or medical consultant to discuss their progress but there was no involvement from the ITU team.

Meeting people's individual needs

- Patient visiting times were from 12pm until 4pm and 8pm until 9:30pm daily and visits were limited to two people per bed space. Staff told us there was flexibility with visiting times according to the specific needs of each individual patient, such as a relative working shifts which would mean they were unable to visit during the allocated times.
- Staff told us grieving relatives were able to stay with their loved one for periods outside of the visiting hours, with support provided by a nurse if needed.

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- There was a designated 'privacy room' adjacent to ITU which was used by staff to discuss patient care with relatives or as a waiting area for visitors. There was a sign on the door to the room indicating if the room was in use or not, so relatives were not disturbed inappropriately. The room had basic furnishings, including three sofas and a coffee table, and there was a large window in the room with a view overlooking a built up rooftop area. The curtains were seen to be hanging off the curtain tracks in several places. The room smelt musty and was not clean.
- Visitors told us they were offered hot drinks by staff while waiting and were kept informed if they had to wait outside the unit before seeing their relative.
- Relatives were able to book accommodation within the hospital if they wished to stay overnight, although they would be charged for this.
- An overseas liaison nurse was available to assist patients admitted from other countries. The liaison nurse worked closely with various administrative teams within the hospital and coordinated with overseas organisations providing funding for patient care. The nurse also attended ward rounds if required. We observed the overseas liaison nurse updating the ITU team about the funding status of a particular piece of equipment for an overseas patient.
- The hospital had an Arabic translator available onsite during the daytimes and ITU patients could access this service via the nursing staff if required. Some ITU staff could also speak Arabic and had been used to translate in the past.
- Staff told us other translators could be booked via an external company if needed, although they tried to find a hospital worker to translate in the first instance.
- Some written information was available for patients on ITU; however this was only available in English despite a significant Arabic-speaking patient population.
- Menus were provided for patients who were able to eat and a selection of food was available, including vegetarian and gluten free options. The menu stated Asian, Arabic and kosher food was also available on request, and patients could ask for food not on the menu which would be made for them if possible.
- A mixed sex breach occurs when level one or level zero patients were on an open ward area with a member of the opposite sex. Staff told us mixed sex breaches never occur on ITU, because patients are discharged from the unit as soon as they are considered to be level one.
- Patients were not routinely asked if they objected to having a staff member of the opposite sex caring for them. Staff told us they would try to accommodate a patient's wishes if they were aware a preference had been expressed but that this would depend on staffing at the time.
- There were no formal processes in place on ITU to identify or support patients with a learning disability or living with dementia. Staff told us they would use the patient's family to assist during their admission and flexible visiting times for these patient groups was accommodated. There was a dementia care plan available within the hospital but ITU staff were not aware of this.
- Patients on ITU were not assessed for delirium during their ITU admission which was not compliant with best practice guidance, although staff told us of plans to introduce this type of assessment at a later date.

Access and flow

- ITU had six beds available in total; four beds enclosed in the main unit and two side rooms on an adjacent corridor. The occupancy of ITU fluctuated considerably; between February and July 2015, average occupancy ranged from 49% to 89%.
- If patients deteriorated on the wards or post-operatively, they could usually access an ITU bed without delay as hospital data showed the unit at full capacity for only 18% of the time from February to July 2015.
- Staff told us forward planning by the ward manager helped make sure there was always beds available for elective patients who needed them. Since January 2014 there had only been two cases of elective surgery being cancelled due to lack of ITU bed availability.
- Staff told us ITU was able to accept a maximum of three L3 patients at any one time. There were two occasions between February and June 2015 when there were three L3 patients on the unit, meaning no more L3 patients could have been admitted. In July, there were 17 days in a row with three L3 patients on the unit, which staff told us was an anomaly due to the patients being long stays.
- Staff told us of plans to increase specific types of surgical activity at the hospital and the increase in ITU workload this would entail. Senior staff were aware that additional capacity would be required to maintain suitable ITU access for patients and expansion plans were in place to address this.

Critical care

- Staff told us patients did not experience delays in being discharged from ITU as their ward room was usually reserved for them throughout their admission. This was not audited and therefore there was no supporting information to corroborate this.
- There were no patients transferred from ITU to the wards out of hours. Staff told us this was because expected admissions occurred during the daytime and so there was no pressure for ITU beds overnight.

Learning from complaints and concerns

- There was no information about ITU, how to make complaints, or the performance of ITU available for visitors within the privacy room. Feedback questionnaires were available but there was no allocated place to leave them once completed.
- Complaints and negative patient feedback was noted on the Comm Cell documentation and displayed in the ITU office. This allowed all staff members to see the comments received.
- There were three formal complaints involving ITU from February to July 2015. We saw evidence of full complaint investigations and responses in collaboration with the patient complaints team and Executive Director. All complaints were seen to contain apologies and points learned.
- Informal complaints received by ITU were not officially recorded. Staff told us they tried to address complaints as soon as they had been made aware of an issue.
- Recent negative comments received from patients included the use of lights at night and excessive noise levels. To address these issues, during the ITU team day, staff were reminded to use lights on dim where possible and to maintain an awareness of the noise level in the department. Additionally, patients were to be offered earplugs during their ITU stay. It was unclear how the unit would review staff compliance with these reminders.

Are critical care services well-led?

Requires improvement



The leadership of ITU requires improvement. There had been many changes made on ITU in recent months and improvements made were recognised by all levels of staff, however further progress was needed. A culture of

under-reporting incidents was acknowledged, but had not been addressed, and there were other significant gaps in quality measures, such as auditing key safety areas like VTE assessment. We noted some oversights in day to day management issues which had not been identified as problems. Awareness and maintenance of the departmental risk register by senior ITU staff was not apparent.

Management staff had short and long term visions for developing the unit and formal plans were in place to support these improvements, including structural changes and developing a permanent staff base. The culture on ITU was positive and permanent staff valued their agency colleagues. Staff told us the immediate ITU management staff and the senior management team were visible, supportive and approachable.

Vision and strategy for this service

- Senior staff recognised the developing relationship between the hospital and overseas clients. They acknowledged this relationship was likely to increase the intake of the overseas ITU patients which was already stretched due to only having isolation facilities for two patients.
- In response to the demand for isolation facilities, ITU management made a short term plan and obtained approval to convert two of the open plan bed spaces into single patient 'pods'; the pods construction was planned for September 2015. This would mean they could accept four isolation patients and two patients cohorted in the open ward bay.
- Senior staff identified there could be four long stay overseas patients on ITU, which would leave only two beds available for other patients, including emergency admissions. Staff were unable to identify a plan to mitigate the risk to elective surgical patients and the income stream associated with these activities.
- Long term plans to build a new 12-bedded ITU, replacing the six beds currently available, were in place at the time of our inspection. The new unit would allow isolation of all patients on the unit. Estimated completion for this development was late 2017.
- Senior staff told us along with an increase in overseas patients, they envisage the planned ITU development at the hospital would increase colorectal and spinal surgery, as well as potentially the re-introduction of oncology services.

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- Staff were aware of the need to establish a team of permanent ITU nurses to staff the new unit. Senior staff told us some of the current vacancies on ITU were due to new roles being funded to work towards recruitment for the larger unit.
- There were attempts to retain current staff including improvements to the staffing structure to provide support and on the job training, as well as a breadth of development opportunities, including mentorship training, completion of an ITU course and other specialist courses.

Governance, risk management and quality measurement

- The unit was engaged with governance activity within the hospital, through attendance at the daily head of department Comm Cell meeting and representation at relevant meeting across the organisation including the MAC.
- Feedback and 'learns' from hospital-wide issues were provided to staff via the ITU manager. Key issues were also communicated via the ITU Comm Cell display board including incidents. No formal ITU Comm Cell meeting took place as staff needed to remain on the unit with patients.
- ITU management were aware of staff under reporting incidents and near-misses. They told us staff on the unit were very busy and they did not want to add to the workload. They did not feel the number of agency staff working on the unit had a direct impact on the number of incidents reported as all agency staff were told how to report incidents during their induction training.
- Senior ITU staff told us the main risk register for ITU was held and maintained by the Risk and Quality Manager within the hospital although senior hospital staff told us the register was maintained and updated locally. Nonetheless, ITU staff were unsure how to access the register and unable to identify risks that may be recorded. When we raised concerns with senior ITU staff, we were told these issues were "unlikely" to be on the departmental risk register. Some issues we identified, such as high use of agency nurses, was recorded as a risk but others, for example the cleanliness of ITU, were not.
- An additional departmental risk register outlining environmental risk assessments was maintained by the blue team charge nurse. This was reviewed at departmental level on an 'as needed' basis.

- ITU management told us the unit completed regular basic audits, for example on documentation and hand hygiene; other important information, such as VTE assessment, was not audited. Senior staff told us the division of nursing staff into specific teams, with allocated responsibilities, would facilitate the completion of relevant audits on the unit. It was anticipated that the roll out of a monthly audit programme on ITU would happen in September 2015.
- ITU did not contribute data to a national database for adult critical care, such as ICNARC, as recommended by the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units. This meant their performance was not benchmarked against other units and so direct comparison of patient outcomes was not possible.
- The ITU department was not involved in a regional critical care network, although consultants who worked on the unit were involved as part of their work through an NHS organisation. Critical care networks facilitate shared learning across the region, as well as providing peer support for clinical and managerial strategies. Membership to a critical care network is not compulsory but is good practice.

Leadership of service

- There was a unit manager responsible for overseeing ITU with support from the Deputy Director of Nursing and Director of Nursing. They reported to the Executive Director.
- Senior management told us the new unit manager had been brought in to make significant changes in the overall running of ITU. They described the unit as much improved, despite some changes and improvements still to be made.
- Staff told us many changes had been implemented on the unit since the new ward manager started in March 2015. They told us changes were necessary, had been implemented effectively and they felt positive about the new ward leadership.
- Staff told us they received good support from the ITU management team and felt valued in their roles. They told us they would feel comfortable raising concerns with any of the ITU management staff as they were all approachable.

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- Staff spoke positively about the senior management team (SMT), describing them as ‘friendly’ and ‘interested in the work we do’. They told us the SMT were regularly seen on the ward during their daily walk around the hospital.
- One member of the SMT in particular was identified by all levels of staff as being a ‘fantastic leader’ and ‘inspirational’. One member of senior staff described this person as ‘the reason I took the job’.
- Despite executive support for proposed development of the ITU department and the service it provides, a senior member of staff described how the executive team “still don’t get ITU”. This member of staff believed support in the daily function of the unit was poor and the lack of leadership at head of department level (due to no senior head of department post for ITU above the unit manager) was contributing to this.
- We noted some managerial oversights on the unit, such as tasks which were not completed appropriately and had not been identified as potential issues. For example checking patient transfer bags and running taps to reduce the risk of pseudomonas aeruginosa.
- Clinical guidance was provided to the unit by the Medical Advisory Committee (MAC). An ITU consultant represented the unit at the MAC meetings and provided feedback to senior nursing staff on ITU.
- ITU RMOs told us they felt supported by the ITU consultants despite the inconsistent nature of their relationship and the consultant not being based onsite other than during ward rounds and other patient reviews. They told us it was ‘never a problem’ to call the consultant for advice or assistance.

Culture within the service

- Permanent staff valued their agency colleagues and recognised the support they provided in terms of staffing on ITU. Permanent and agency staff told us they worked together as a team and that it did not matter who worked for an agency and who worked for the hospital.
- We observed good working relationships between staff, as they assisted each other in checking medicines, collecting equipment and completing patient care tasks. Staff treated each other with respect and spoke appropriately to one another on the unit.
- Staff told us they enjoyed their work because of the care they provided to patients, but also because of the people they worked with.

- Each week one of the hospital values was identified as being the theme of the week, for example care or commitment. At the end of the week, heads of departments could nominate individuals who had embodied the value and the individuals nominated received certificates in recognition of this. Staff on ITU told us they had received certificates and liked having hard work acknowledged.
- In order to provide incentives to staff to perform well, ITU management introduced a feedback system known as ‘Whispers’. This allowed staff to provide feedback, which had standardised wording, and score their colleagues after working a shift with them. Whichever staff member had scored the most points at the end of the month was rewarded with an additional day off.

Public and staff engagement

- Changes on ITU were discussed with staff before being implemented, for example dividing into the four nursing teams. ITU management told us they were keen to engage staff further and encourage them to come forward with ideas as well as provide feedback about changes which had already been made. Staff were able to do this during the ITU Team Day and told us they valued this opportunity and felt they were listened to.
- Bi-monthly team meetings, which included the ITU consultants, had been recently introduced to encourage two-way communication with staff and help improve staff engagement. Staff were positive about this opportunity.
- Patients were given a hospital-wide feedback questionnaire to capture their opinions, but no methods were used to get specific comments about ITU. Staff explained they were told if there had been comments made about ITU in the hospital-wide forms and so it was not necessary to do a unit-specific feedback questionnaire. Senior staff told us work was being completed on this to produce an ITU specific form by the charge nurse responsible for maintaining quality on the unit.
- No other methods of public engagement on ITU were identified during our inspection.

Innovation, improvement and sustainability







- The need for additional ITU isolation facilities had been identified and staff described the plans for new individual patient pods as the most recent example of

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innovation on the unit. Staff told us creating these pods would increase the volume of overseas patients who could be admitted, and therefore generate additional income for the department.

- There had been several changes made to the day to day running of ITU in recent months which had provided a stable structure on which future improvements could be based. Senior staff told us dividing ward staff into designated teams had formalised the management structure, facilitating the staff development and appraisal system.
- The creation of teams and subsequent allocation of specific responsibilities was intended to ensure all important tasks on the unit were completed. The system was still in its infancy and so, while progress had been made, there were clear gaps which still need addressing; for example there were many important audits, spanning several clinical remits, which were not completed on a regular basis. Senior staff told us plans were in place to implement a monthly audit programme and was due to begin in September 2015.
- Senior ITU staff acknowledged that not participating in quality benchmarking was not compliant with ITU core standards. They told us the unit was intending to begin collating information to be submitted to a national database for adult critical care, such as ICNARC, once the ITU training nurse was in post. They told us this would allow them to benchmark their performance against other similar units and help them identify where improvements needed to be made.
- Senior staff felt the ITU consultant involvement in the regional critical care network was sufficient and there were no plans for formal involvement of the unit at the time of our inspection.
- Plans were in place to develop a patient feedback questionnaire unique to ITU so that specific unit feedback could be obtained. It was hoped this would be approved and in place by the end of the year.
- Staff competency documents were not stored in a central place and were not always readily accessible, which made it difficult to know which members were due specific training updates. Senior staff had begun to accumulate competency documents for staff members in specific folders for ease of access. Staff told us this would make it easier to maintain staff competencies.
- Staff told us the sustainability of ITU was not in question while the hospital continued to complete its current wealth of surgical procedures, as a back-up ITU would always be required for this.
- Senior ITU staff were aware of the significant costs associated with high levels of agency staff usage on ITU. They recognised that having more permanent staff members in place would create a significant cost saving, as well as promote consistency in patient care.
- The need for a sound nursing staff base for ITU was also identified by senior staff to ensure the unit's sustainability with the expansion project in the next couple of years in mind. The management identified the need to recruit and retain staff with this development in consideration.
- Plans to recruit staff from overseas via recruitment agencies were in place and senior staff were aware of the processes related to this. They described using the organisation's overseas nurse programme to support staff in obtaining a Nursing and Midwifery Council personal identification number (PIN), which was required to work as a nurse in England.

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

Information about the service

The main outpatient department is located on the ground floor of a two storey building and has 23 consulting rooms. From April 2014 to March 2015 the outpatient department saw 82,367 patients, of which, 12,722 were NHS patients and 69,645 were private patients. The outpatient department provides a number of specialist services, such as breast surgery, dermatology, gastroenterology, gynaecology and spinal surgery. There is a specialist cardiology clinic which included a cardiology laboratory and a specialist audiology clinic. There is a small phlebotomy service based on the ground floor of the hospital which is located next to the diagnostic imaging and physiotherapy services. The diagnostic imaging services provided a range of radiological services, including x-ray, magnetic resonance imaging (MRI), ultrasound and computerised tomography (CT) scanning, Dual Energy X-ray Absorptiometry (DEXA) scanning, O-Arm and mammography. The physiotherapy service has a large room to treat patients, a gym area and hydrotherapy pool.

The Clementine Churchill Hospital see young people from birth upwards for non-interventional outpatient services, including physiotherapy across a differing range of specialities.

We inspected the outpatient, phlebotomy, diagnostic imaging and physiotherapy services. We spoke with 11 patients, six family members and one carer as well as received 13 comment cards. In addition we spoke with three consultants, 10 registered nurses, nine healthcare assistants, nine allied healthcare professionals of all levels

and including radiographers, physiotherapists, a cardiology technicians, phlebotomists and audiologists; and seven administrative/support services staff of all levels including porters and receptionists.

We observed care and treatment and looked at care records. Prior to our inspection we reviewed performance information from and about the hospital.

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Summary of findings

We found that the Outpatients and Diagnostic Imaging service (OPD) at the BMI Clementine Churchill Hospital was well-led, caring and responsive to patients' needs. However some parts of the service require improvement to ensure patient and staff safety such as equipment checks.

We found sufficient levels of cleanliness, infection control and hygiene across the OPD service. There was adequate staffing and completion of mandatory training. There were also effective systems in place to report incidents and manage concerns and complaints. We saw examples of patient feedback being used to improve services.

Patients in OPD received effective care and treatment that met their needs and there was evidence of positive feedback from patients. Their care and treatment was planned and delivered in line with national and local guidelines. Patients were treated with compassion, dignity and respect. All of the patients we spoke with praised the staff for the care they provided and said that they would recommend the hospital and outpatient services.

Flexibility, personal choice and continuity of care were embedded in OPD services. There was a flexible and easy to arrange appointment system and patients did not experience long waiting times. Services were planned in a way that met the different needs of patients using the hospital and staff in OPD were aware of the different cultural backgrounds and needs of patients. The OPD service saw few children or people living with dementia or patients with learning difficulties; we found that staff required further guidance and training to meet the needs of these particular patient groups.

The leadership, governance and culture of the OPD service promoted the delivery of high quality, person centred care. The hospital had a clear vision and values, driven particularly by quality. Staff were focussed on providing the best service they could for all patients whether they were privately or NHS funded. Staff told us they were supported by their departmental managers and there was a culture of openness to learn and

develop services. Performance information was shared within the department and there was clarity of responsibility for clinical and non-clinical performance. Staff were given opportunities to provide feedback and inform service development. They were also supported by managers to develop their knowledge and skills to improve the quality of care provided to patients.

We had some safety concerns, particularly within the phlebotomy services and the electrical testing and calibration of equipment used for tests and in emergencies. The phlebotomy administrative office was cramped and there were frequent interruptions while staff were checking and booking in the samples, which could lead to delayed or incorrect blood test results. We also found the phlebotomy staff did not follow hygiene procedures consistently. Equipment such as defibrillators, electronic scales and blood glucose machines were available; however most of what we inspected did not have current portable appliance test (PAT) certificates or been regularly calibrated.

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Are outpatients and diagnostic imaging services safe?

Requires improvement



We found some safety processes within the outpatient and diagnostic imaging services required improvement. Equipment such as defibrillators, electronic scales and blood glucose machines were available; however most of what we inspected did not have current portable appliance test (PAT) certificates or had been regularly calibrated. The office space the phlebotomy staff used for the clerking/booking in of patients' specimen samples was not fit for use because it was small and did not provide enough room to un-pack samples for labelling without opening them over a non-medical computer keyboard, which would be hard to clean in the event of a spillage. Phlebotomy staff did not follow hand hygiene procedures consistently. They were regularly interrupted by other staff delivering samples and consultants requesting results; this broke their concentration while booking the samples onto the computer system and could cause mistakes in recording tests requested against the patients' details.

There were effective systems in place to report incidents. Staff told us they felt confident to report incidents and they received feedback on investigations.

There were enough staff available to work in each of the departments. Chaperones were available on request. Most staff had completed their mandatory training in line with the hospital's policy. Staff had received training in safeguarding and most staff were able to describe their role in safeguarding. All staff we spoke with knew who the safeguarding lead at the hospital was and said they would speak to their manager about any concerns.

The departments were visibly clean. Cleanliness, infection control and hygiene were audited regularly. There was a cleaning rota which staff signed to show they had cleaned their designated area. We observed gaps on the rotas, but we saw meeting minutes reminding staff of the need to sign the rota to show that cleaning had been completed.

Staff were aware of their role should an emergency occur within the departments.

Incidents

- No 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.) were recorded in the last 12 months in outpatients. The hospital were unable to provide us a breakdown of how many incidents had occurred within OPD in the last 12 months due to the way incidents were categorised.
- Each week day the hospital's incidents from the previous day were discussed at the senior management 'comm cell' meeting. These incidents could be as simple as a patient being recalled to attend OPD which caused an inconvenience to them, to more serious incidents such as injury to a patient. This information was printed out and placed on the 'comm cell' boards in each department as well as discussed at the departmental 'comm cells' which was also held each day.
- We observed that the communication of incidents within OPD could be dependent on who was present at the meeting. For example during the midday 'comm cell' no incidents relating to the department had been identified from the risk and quality department's daily incident report or by asking staff about any incidents they were aware of. The board was then marked as an incident free day. However the sister who came late to the meeting then reported an incident that had occurred the previous day and the board was corrected. Had the sister not been at the midday department 'comm cell' the incident, outcome and learning from it would not have been discussed that day. This incident had not been included in the risk and quality department's 'daily incident report' as it had not reached them prior to printing out the report, however it had been discussed at the senior managers 'comm cell' that morning.
- Staff completed incident forms which were reviewed by the nursing sister or most senior registered nurse (RN) on duty. Incident forms were taken to the comm cell the following day where they would be outlined. Non-clinical incident forms were passed to the health and safety staff within quality and risk and clinical incident forms given to the clinical staff within the risk and quality department. The back page of the form was kept as a log in the reporting department. It was the

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responsibility of the risk and quality department to input the information on the corporate electronic reporting system for actioning, monitoring and auditing purposes.

- The hospital staff told us the diagnostics departments carried out a programme of Ionising Radiation (Medical Exposure) Regulations (IRMER). The minutes from the annual radiation protection meeting minutes indicated there had been no radiation related incidents to patients in the last few months however one member of staff was accidentally exposed by walking into a room. All radiation badges were within limits although several staff were recording zero levels which meant they either had not been exposed to any radiation or had forgotten to wear them when imaging patients. Staff were observed to ensure they were all wearing their radiation recording badges.
- The imaging department's monthly meeting minutes noted any incidents, actions such as reporting incidents of harm to the Care Quality Commission (CQC) or Health and Safety Executive (HSE), learning and changes to procedures as a result of the incident.
- Staff were able to articulate the most recent incidents relating to the hospital and their own department. They were able to describe the circumstances, how it was acted upon, whether an apology had been given, the learning from it and how it was disseminated to other staff.
- Staff in the imaging department told us there had been nine incidents in recent months where a venflon (a small flexible plastic tube that is inserted through the skin into one of your veins, also called a cannula) produced a slight extravasation (accidental administration of intravenously (IV) infused medications into the extravascular space/tissue around infusion sites). The patients were informed verbally at the time that contrasting fluid had entered the surrounding tissue and none of them reported any major reactions. Investigations found the incorrect venflons had been used. The problem was rectified once the appropriate ones were sourced. Under the Health and Social Care Act 2008 regulations 2014, providers are required to apologise for any incidents that either require a moderate increase in treatment and significant, but not permanent harm and share their investigation with the affected patient. The level of harm the venflon incident caused did not require the hospital to provide a formal apology, however it would be good practice to do so.

- Staff understood their responsibility around openness and candour in relation to incident management.

Cleanliness, infection control and hygiene

- The hospitals infection prevention and control (IPC) annual report written in January 2015 for the period October 2014 to September 2015 indicated that the OPD scored 94% against the cleaning standards expected for the area. The IPC monthly audit for June 2015 showed:
 - OPD: 90% for hand hygiene, 80% for cleaning and decontamination and 98% for sharp bins
 - X-ray: 80% for hand hygiene, 80% for cannula insertion, 97% for sharp bins
 - Pathology: 100% for hand hygiene, 100% for sharp bins
 - Physiotherapy: 100% for hand hygiene, 40% cleaning and decontamination, 99% for sharp bins. IPC was a standing item on the department's agenda but the July meeting had not taken place since this audit.
- Personal protective equipment (PPE) such as gloves and aprons were available to all staff.
- The nursing staff and HCAs were responsible for wiping down surfaces and equipment in the consulting rooms after every session. They described how they always wore gloves and wiped everything down using anti-bacterial wipes. Each member of staff was allocated a room or items such as children's toys to clean thoroughly each week. A weekly cleaning sheet was signed to show it had been completed. We observed that there were a number of gaps on the weekly signing sheets, but we were unable to ascertain whether the lack of signing was an oversight or meant the cleaning had not been completed. Nursing staff assured us that any gaps were identified during their daily lunchtime meeting however we were unable to ascertain how the sister was assured that cleaning was completed as they were not available on the day of our unannounced visit.
- The environment and equipment we observed was visibly clean. The department did not use 'I am clean stickers'. We were told these had fallen out of use as staff and consultants were raising concerns about the cleanliness of equipment which was used infrequently but had a sticker to indicate it was clean.
- Each consultation room had a hand basin with soap, alcohol gel and paper towels. Patients we spoke with said they had seen consultants wash their hands.

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- Sharps bins were appropriately labelled, however the safety closures were not in place on all the bins we checked. In the OPD we noted one out of three was not closed appropriately. The sharps bins in the phlebotomy rooms were not closed appropriately and were stored in an unlocked cupboard when the room was not in use. We observed that the sharp bins in phlebotomy also contained a large amount of paper wrapping which could have been thrown in a normal waste bin.
 - Disposable curtains were used in the consultation rooms in OPD. The policy was to change them every six months. All the rooms we reviewed showed the curtains to be within date.
 - We observed the hospital's clerking/checking process for all specimens prior to them being sent to the laboratory. We noted that all specimen samples and used blood transfusion bags were being double handled prior to going to the laboratory. This could result in cross infection and risk of more staff being open to infectious diseases.
 - Phlebotomy staff did not always wear gloves when handling specimen bottles during the clerking process. One member of staff said, "I have to be honest but we don't always wear gloves when dealing with blood [samples], however we always wear gloves when dealing with micro-biology [samples], and usually check them last."
 - We observed that, when phlebotomy staff did wear gloves, they did not always follow hand-hygiene best practice by using gel or wash their hands between each use of gloves or sample checked. We also saw used gloves were not disposed of in the clinical waste bin immediately after use and were left on the work surface while other specimens were checked and booked in.
 - As is good practice, blood samples from patients with known viruses were not labelled as infectious in front of them. Once a sample was checked in by the phlebotomist, it was labelled as infectious prior to being sent to the laboratory, so staff there were aware of any potential risks.
 - Used blood transfusion bags were returned to the phlebotomy office. These bags were returned in a BMI branded plastic carrier bag. Staff removed the used bags from the carrier bags to remove the labels which were then bagged and given to the laboratory in the next door office for tracking purposes. The used blood bags and carrier bags were then placed in the clinical waste bin. We asked why these bags were not returned directly to the laboratory for them to remove the tracking labels thus reducing the number of times the bags were handled by the phlebotomy staff in a small office environment. There was no rationale to this apart from it being the process they had adopted.
 - The small work surface in the room had equipment such as computers, a telephone and boxes used to store samples during processing. This cramped area and the standard computer keyboard would be hard to clean quickly and without minimal disruption if a spillage occurred.
 - We found boxes with phlebotomy consumables such as bottles and tubes stored on the floor of the room which housed the samples fridge. The floor could not be cleaned adequately and there was dust and empty wrappers found behind and under the boxes. Staff told us the boxes remained in the room as there was no racking or shelves to store the consumable on. Items should be raised from the floor by at least 30mm to allow air circulation and ease of cleaning according to infection control guidelines.
 - The lead aprons used in the imaging department for radiation protection were checked annually for cracks. They were cleaned weekly with detergent wipes. We found one apron was split and damaged, which was disposed of as soon as we pointed it out to the manager.
 - If a patient was known to have an infectious disease such as tuberculosis (TB), the imaging department would schedule their appointment at the end of the day in non-urgent cases. This would allow them more time to deep clean the room and equipment afterwards.
 - Patient information leaflets on infection prevention and control were available in the OPD.
- ## Environment and equipment
- The OPD, imaging, physiotherapy and diagnostics environment was well maintained and there were no obvious hazards. Controlled and restricted areas were clearly identified.
 - Resuscitation equipment in the clinic areas had been regularly checked. The oxygen cylinders were in date and full. However, the regulators on two of the oxygen cylinders we checked required reconditioning in 2012. These were removed immediately when we informed staff and were replaced with complete oxygen cylinder units.

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- The defibrillators were 'self-tested' each week. We observed evidence of these tests and nursing staff were able to access guidance should the test identify any concerns.
- We found equipment was checked and visibly clean. Staff told us there was generally adequate equipment available in all outpatient areas. A member of staff told us they had a shortage of nasopharyngeal scopes in the department. Although they had an alternative make and model of scope, the consultants preferred make and model was breaking at regular intervals. We noted that this concern had been placed on the hospital's risk register in October 2012 and in July 2015 replacements for the preferred choice of equipment had been approved with expected delivery in August 2015. In the meantime, consultants were able to use a different type of scope.
- We observed the majority of the portable electrical equipment in all the departments we visited did not hold current portable appliance testing (PAT) stickers and/or had not been calibrated as it should have been. Although the sticker on the baby scale indicated it should have been calibrated in June 2015 and had been, the plaster room blood pressure machine sticker indicated the date of the last service and PAT check was on 20 September 2010. The suction machine on the resuscitation trolley in the imaging department was due for testing in February 2009.
- The Cobas blood glucose machine had not been serviced since 7 July 2012. The reagents for the machine were not dated after opening. We spoke with a member of staff who confirmed these should have been dated for quality assurance. The outpatient sister was also made aware of this concern. Information from the machine was downloaded remotely by the on-site laboratory. The machine automatically 'locked out' if this procedure did not happen on a daily basis.
- We discussed our findings with the senior managers of the hospital and some department leads. It transpired that this was once the responsibility of the engineering department, however due to financial cut back some years previously it became the department heads' responsibility to ensure equipment was tested and calibrated. No one was able to tell us why this had been omitted on the smaller pieces of equipment such as blood pressure machines and defibrillators. All heads of staff were immediately requested to identify all equipment that required PAT testing and submit their findings to the executive team. Identification of the out of date PAT tests was still on-going during our unannounced inspection.
- Each consultant had a lockable storage cupboard for equipment they used for their clinics. These cupboards were only unlocked when the consultant was on duty. This prevented equipment being removed for other clinics and potentially mislaying items the consultant required.
- The phlebotomy department staff used a small office area to receive specimen samples to check correct labelling and to book them onto the hospital electronic system before sending them to the appropriate laboratory for the tests to be completed. We found this space was cramped; the desk areas were high and required extra tall desk chairs for them to work in a seated position. There were regular interruptions at the door although there was a letter box to post specimen bags through. The frequent interruptions could lead to specimen samples being incorrectly labelled. However, staff assured us any incorrect labelling was noticed by staff in the on-site laboratory prior to tests being performed or the sample being sent to another laboratory.
- We observed samples and used blood transfusion bags being unwrapped on top of computer keyboards due to insufficient workspace. These bags and the tubes contained some blood which could be spilt over the standard office keyboard, which would be hard to clean, and the desk. Staff had to pass each other and stretch awkwardly when passing samples for testing through a window hatch in the wall to the laboratory next door, this caused their colleague to be interrupted while they were processing samples, furthering the opportunity to lose concentration. We found the environment was not fit for purpose.
- The phlebotomy department had a fridge that was used for samples collected out of hours. The fridge room was accessed via a security number on the door. The fridge temperatures were recorded in the morning each day. The records we reviewed showed the temperatures were within the tolerance of two to eight degrees required. Staff we spoke with were unable to articulate what to do if it went out of tolerance or whether the fridge was alarmed to indicate a problem. However the manager reassured us that an audible and visual alarm was triggered until it was attended to.

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- In the radiology department we found appropriate changing facilities and clothing for patients to change into for their procedure. Radiology staff had access to appropriate protective clothing to prevent harmful exposure to radiation.
- There were two phlebotomy rooms available. The chairs were comfortable and clean. The rooms were very warm and we were told by a staff member that patients had been known to faint. All consumables within the department were within date and disposable items, such as tourniquets were used.
- The patient waiting area was in a glass roofed atrium. Some of the patients we spoke with told us the area could become unbearably hot. This was on the hospital risk register and the hospital had recently added window films to the glass to reflect the heat and they were waiting for a costing to repair the air conditioning.
- The imaging department's staff performed a daily paediatric environmental check. This included visual checks such as waste management, sharp bins security, trailing cables and emergency equipment checks. All of the safety checks were appropriate for people of all ages.
- There were emergency call buttons within the outpatient's areas. The alarm went through to the main reception desk at the hospital.
- For the safety of patients using the hydrotherapy pool, one member of the physiotherapy team always remained on the outside of the pool while another member of staff was in the pool.

Medicines

- The outpatient's department did not hold any controlled drugs (CD). The medicines they did hold were stored in a cabinet in a locked room in the department. Staff were required to sign the key to the room in and out. It was the responsibility of the last member of staff on duty to ensure all keys had been returned.
- Medicines used in the OPD were ordered by staff through the hospital's pharmacy.
- All medicines were administered by clinicians. Private prescription pads were locked in the room where drugs were stored. Staff were required to sign the pads in and out. The prescriptions identification numbers were recorded for security purposes.
- The pharmacy department performed regular CD audits. Any concerns were identified and feedback to the departments through meetings or the 'comm cell'.

The resulting actions were recorded on the CD audit. The last audit showed there were issues with controlled drug register completion and some consultant sign offs. Records we checked showed controlled drugs in the radiology area were checked by staff on a daily basis and periodically by the pharmacy department. We observed that drugs were in date; the record book had been completed and signed in accordance with policy. Staff were trained in medication administration and were required to meet the competencies laid down in the hospital's controlled drugs policy.

- Pharmacy turnaround times for prescriptions were not currently monitored, however a time stamp for prescriptions was on order with the hospital's suppliers. Once they had received this they would be able to monitor the turnaround time. When we spoke with pharmacy staff, they said the average turnaround time for a prescription was 30 minutes.

Records

- We found two systems for keeping outpatient records at the hospital. The system used was dependent on whether a patient was NHS funded or privately funded. NHS patients' records were kept securely in filing cabinets within the main OPD administration office. Private patients' records were kept by the respective consultant. We were told by administrative staff that some consultants provided a copy of private patient records to be kept at the hospital; however they were sure that this happened in every case.
- The hospital reported that approximately 18% of appointments were NHS, therefore 18% of the patients had notes readily available at the point of consultation as records for NHS patients were held at the hospital. The hospital was looking at ways to implement outpatient notes and keep a copy of the records on site for private patients. Staff told us it was rare that private patients' records were not available at the time of their appointment although this was not audited. Staff also told us they could usually obtain notes from the consultants' secretary with little delay.
- The consultants we spoke with did not consider there were any problems with accessing patients' notes for their clinics. NHS patients' notes were prepared prior to the consultants' clinics and placed in the consultants' offices. We observed that notes were organised for morning clinics the previous evening and placed in the consulting room that the clinician was designated for

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their morning clinic. These rooms were locked and could only be entered by using a code; however this meant that anyone who knew the system code, such as other clinicians, administrators, cleaning or maintenance staff could access these files prior to the clinic starting.

- The imaging department received clinical history from the referring consultant. Images were passed to referring hospitals either via a secure portal or on an encrypted compact disk. Passwords were sent separately. Patients could have a copy of their images after the results consultation. Staff told us all imaging records were kept indefinitely on the local and corporate secure server, however the BMI policy for the retention of records stipulated x-rays were retained for eight years after conclusion of treatment or the death of the patient; radiographs and other image formats from all imaging techniques were considered to be of a transitory nature and not part of the permanent hospital patient case record and in general kept by the consultant or given directly to the patient.
- We observed the hospital's policy for the retention of records on their intranet; however staff we spoke with were not familiar with the hospital's guidelines and agreed that they would check the current policy.
- We found that it could be difficult to identify when a patient was discharged from the hospital. We saw an example of a patient who was due to have a procedure as an in-patient. However at the time of their admission they were ill and therefore unable to have the procedure. We spoke with the consultant responsible for the patient and they told us the patient went on to have the operation at another NHS hospital. However this information was not included with the notes at BMI Clementine Churchill. Staff were unable to confirm how patients who had procedures elsewhere were monitored so that they could be discharged from the hospital.
- We observed the clerking process that phlebotomy staff followed when entering specimen tests onto the computer system. This involved checking samples against the tests ordered and ensuring the samples were labelled correctly. However we noted that staff were regularly interrupted while performing their checks. Staff told us this was a recurring issue and had installed a post box for samples to be put through to avoid the interruptions. However this had not prevented individuals from knocking on the door as some

consultants preferred to deliver their patients' specimens personally. They also told us that some consultants came demanding their patient's results, although test results were always passed immediately to the consultant via email or email when they were available. Staff told us some consultants forgot that it could take some hours or days for some tests to be completed and were not always as fast as they assumed. We were shown a reported incident of a consultant shouting at imaging staff for the results of tests they had ordered through the phlebotomy department. The phlebotomy staff reassured us that any inputting or identification errors would be picked up by The Doctors Laboratory (TDL), an external provider, who performed the pathology tests and microbiology onsite.

- Audiology results were stored as an electronic record on the local IT system. Paper result records were given to the referring consultant to discuss with their patient. The audiology department was working towards allowing consultants to access the results on line through a local IT system.

Safeguarding

- Staff checked the identity of patients attending the OPD by asking questions such as their address and date of birth. The imaging department used a six point check to ensure they were performing the correct radiological scan on the right patient at the right time. This included medical history and examination requested. If any information was missing, they would not perform the scan.
- The department had up to date policies and procedures for both children and adults. The information included the adult and children's safeguarding leads in the hospital and the local authority and their contact details should staff need advice or guidance.
- Staff were encouraged to contact their manager or the safeguarding lead if they had any concerns about patients. Staff assured us they knew who the safeguarding lead was and how to contact them if needed.
- We requested but the hospital was unable to provide us with information as to which staff had acquired what level of safeguarding training. However, we were told that the e-learning training identified which level staff were required to complete dependent on the role they input at the start of training. For example, a radiologist

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should automatically complete level three safeguarding vulnerable adults and children training as per the hospital policy 'Local Procedure for Safeguarding Children & Vulnerable Adults' paragraph 4.3.

- Most staff working in the outpatients and diagnostic and imaging departments told us they had completed mandatory training in safeguarding to a level that was appropriate to their role. Some staff were able to talk to us about the insight and knowledge they had gained from their training. However, some staff demonstrated a poor understanding of their role and responsibility with regard to safeguarding, particularly in terms of children.
- Department meeting minutes highlighted the local authority safeguarding training days for any staff wishing to attend.
- The hospital had a chaperoning policy which was under review at the time of our inspection. There was also a policy for chaperoning children and young people which had recently been updated by the link nurse at the local hospital. To date, only five staff across the hospital had signed to say they had read the new policy. We observed posters in the OPD and consulting rooms advertising the availability of a chaperone. These posters were female centred and did not indicate that chaperoning applied whether or not the consultant was of the same gender as the patient, therefore a male could ask for a chaperone when they were receiving an intimate examination by a male doctor. Staff with chaperoning responsibilities were required to pass a competency assessment. Patient records showed when a chaperone had been offered and requested.
- Two members of phlebotomy staff, one of which was paediatric trained and a parent/carer were always present when children required blood tests.

Mandatory training

- We were told that all mandatory training core subjects were based on the grade and type of staff completing it. The information the hospital provided did not allow us to breakdown the compliance for each subject within each department despite requesting this. The mandatory training compliance summary provided by the hospital showed that 90% of staff across the whole hospital had achieved compliance. Staff in the consulting rooms (OPD) had achieved 92%, diagnostic imaging 93%, radiology 29%, MRI 94%, physiotherapy 89% and pathology 94%. When we asked staff why the

radiology figure was low, it was not explained why this was the case. At factual accuracy we were advised this was because all new starters had been inadvertently categorised under 'radiology' rather than 'imaging'.

- Staff were able to describe the mandatory training they had participated in such as health and safety, basic life support, paediatric life support, manual handling and infection prevention and control.
- Training was monitored on line and each member of staff had a training account. They received email alerts when training was due. However, not every member of staff had access to an email account. These staff had to be reminded in person and given access to a computer to update their training.
- Most of the mandatory training was provided on-line. There were some face-to-face modules such as basic life support. All the staff we spoke with told us they were given enough time to complete their mandatory training modules.

Assessing and responding to patient risk

- Staff told us that all patients who attended the clinic were seen by the receptionist when they arrived. If staff were concerned that someone was unwell or at risk of becoming more seriously ill or falling they would inform nursing staff immediately.
- If a patient appeared to be ill during their visit to OPD they were taken to the emergency care centre at the hospital for assessment, treatment and/or possible admission.
- The hospital did not have a paediatric trained member of staff on duty every day. All outpatient services were told which days a paediatric nurse was on site so they could arrange children's appointments in line with those days. The hospital had access to a link nurse based at a NHS hospital in the local area.
- As part of their mandatory training, all staff attended basic life support training annually. Staff were currently completing paediatric immediate life support (PILS) and it was expected that all identified staff would have completed this training by the end of September.
- A 'crash' team from across the hospital responded to emergency situations. The call was practiced twice daily to ensure the alarms were working and staff responded appropriately and were clear about their role in case any patient experienced respiratory or cardiac problems.

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- A cardiologist was always on duty in the hospital when patients were using a treadmill for any medical investigations.
- We saw evidence that radiology staff completed the World Health Organisation (WHO) surgical checklist prior to any scan although we did not receive a specific audit for this despite requesting all the hospital's WHO checklist audits. The completed paperwork was scanned onto the radiology information system (RIS) and filed with the patients records.

Nursing staffing

- There were 12.96 whole time equivalent (WTE) clinical staff, 6.68 WTE registered nurses (RNs) and 6.28 WTE healthcare assistants (HCAs). The OPD did not use agency staff and only covered staff shortages with regular bank staff. There was one nursing vacancy in OPD and a further vacancy for a phototherapy nurse was coming in the very near future. This was going to leave one phototherapy nurse in a busy department. This meant the service would have to close for two weeks when they went on annual leave. Senior staff expressed a doubt that a phototherapy nurse could be recruited and the plan was to 'skill up' a new or existing nurse on the next available course in November. There was a plan to recruit a bank member of staff to help cover this service however this was not going to be in place by September.
- The hospital reported low sickness rates and turnover of nurses and HCAs in the OPD. Staff worked on a four week roster and worked about one in six Saturdays. Allocation of clinics was done by the last registered nurse on duty the night before to ensure the most appropriate staff worked within each clinic.
- At the time of our inspection there were no paediatric trained staff employed in the service. However, we noted that the department's minutes dated 2 July 2015 stated that a paediatric nurse will be starting to work in the consulting rooms on certain days. It noted that this was to ensure children under the age of three could be adequately cared for according to the BMI policy. The rota was to be confirmed.
- The nursing staff attended the OPD 'comm cell' and held a further meeting at 2pm each day to ensure staff who were unable to attend the earlier meeting were made aware of any nursing related updates or concerns.

Medical staffing

- All staff we spoke with told us they had a good relationship with the consultants. Some consultants liked to have specific nursing staff working with them as they would know how they liked to practice particularly when performing some treatments or procedures.
- Every clinic was run by a consultant who saw everyone on their specific list.
- Clinic records we reviewed showed that consultants were always available although on some occasions they were late. Incidents of lateness were monitored by the department. If a consultant was consistently late, the patient service manager in the first instance discussed ways in which they could support them in, such as early morning alarm calls or reminders. The executive director would speak with them if their lateness continued. This happened very rarely.

Allied Healthcare Professionals

- There were 15 whole time equivalent (WTE) and four part-time staff in the imaging services. Staff shortages were covered by regular bank staff. Two agency staff covered mammography services four times per week.
- The physiotherapy department had 24.1 WTE and a vacancy for 1.9 WTE and were recruiting at the time of our inspection. The department had a pool of 10 bank staff to cover staff absences or vacancies. The department manager told us they expected physiotherapy staff to utilise their time at 75% clinical work and 25% for non-clinical work such as training, administrative tasks and handovers.
- The phlebotomy department had 6 WTE phlebotomists, including the supervisor and pathology lead. There were 2.75 WTE bank phlebotomists. Each member of staff's duty was split between phlebotomy and administrative tasks according to their role.
- The cardiology department used regular bank staff for any staff absences.
- Pharmacy had eight pharmacists and six technicians. They did not use any agency and only required bank staff when there was leave or sickness. They felt the workload was manageable with this amount of staff.

Administration Staff

- There were 15.39 WTE administration staff supporting the outpatient department. Many of the staff had

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worked within the department for many years. We observed the OPD reception staff requesting help from the staff working within the OPD office when the desks became busy.

Major incident awareness and training

- Staff in the outpatients department, diagnostic imaging and pathology services were able to describe what to do in the event that the hospital lost total power. They drew on a past experience of a planned 'outage' and an unexpected incident resulting in power failure.
- Patient appointments were printed for the following day at the end of the previous day should they require a paper record of who was attending the hospital. Once systems were running again, the attendance information was entered onto the electronic system retrospectively.
- If the hospital had a planned power cut, the phlebotomy service had the ability to produce emergency patient identification (ID) numbers so that tests could still be performed and be tracked. However, if there was an unplanned power outage senior staff told us patients could be tested but it would be difficult to admit the patient as it was hard to tie the emergency patient ID numbers with their regular hospital ID number which meant any required follow up could potentially be missed.
- Staff had recently undergone anti-terrorism training as part of their mandatory e-learning course.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

Patients received effective care and treatment that met their needs. Patient's care and treatment was planned and delivered in line with national and local guidelines. The hospital participated in some national audits and in an inpatient satisfaction survey which provided evidence of how some of the services within outpatients were perceived.

Consultants and other staff followed the World Health Organisation (WHO), National Institute for Health and Care Excellence (NICE) and Royal College of Physicians best practice. Staff were expected to achieve competencies

within the area they worked in and were encouraged to develop and learn through yearly staff appraisals. Staff told us they were supported by managers to develop and attend training relevant to their role.

Staff had received training in Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Senior managers told us a majority of staff had completed the training however they were unable to ascertain exact numbers through the BMI learning system. Most clinical staff we spoke with were able to demonstrate an understanding of the principles and legislation. Those that were unsure told us they would seek their manager's advice.

Evidence-based care and treatment

- Clinical staff we spoke with were aware of national and local guidelines relevant to their specialist areas.
- The policies and procedures we checked on the hospital's intranet were in date or identified as currently being reviewed. Policies referred to national guidelines appropriately. However we observed that not all hard copy folders of the policies and procedures were in date. For example we found the infection control policy for allied professionals was last reviewed in April 2013. Although staff were expected to refer to the most recent policy on the hospital's intranet, the hard copies files were available if the system failed which meant they could refer to old guidance if the file was not kept up to date.
- The hospital followed the World Health Organisation (WHO) and Royal College of Radiologists guidelines for interventional radiology. The guidelines were easy to access and displayed for reference.
- We found clinical equipment such as ultrasound and laser devices had been subject to regular and recent audit. Any concerns were recorded and rectified before patient use and staff were reminded of procedures if they were found to be lacking. Monthly audits were carried out on health and safety and infection control issues.
- Staff told us the diagnostics department carried out a programme of Ionising Radiation (Medical Exposure) Regulations (IRMER). Local radiation protection rules were evident on the walls in the imaging rooms.

Pain relief

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- As per the hospital policy, staff in OPD and radiology were not authorised to prescribe or administer pain relief. However, if a patient was in pain they would take them to the emergency care centre at the hospital where they would be able to provide appropriate medication to the patient.

Patient outcomes

- Hospitals across BMI had been asked to volunteer to pilot the 'Imaging Services Accreditation Scheme (ISAS)'. BMI Clementine Churchill had expressed an interest and was currently waiting for further information and instruction.
- The hospital participated in the Medicines and Healthcare products Regulatory Agency (MHRA) national audits for pathology and Ionising Radiation Medical Exposure Regulations (IRMER) for radiology. There had been no reported incident of patients receiving inappropriate exposure to ionising radiation.
- The hospital did not participate in the 'Improving Quality in Physiological Services (IQIPS) accreditation scheme'.
- Staff reported that children may receive disjointed care as a result of paediatric inpatient services recently ceasing at the hospital. We were told that children may be required to attend multiple sites for pre and post consultations, tests and results with the potential for care not being seamless. This was a recent change and the hospital was not monitoring the effect of this change in service.

Competent staff

- Less experienced staff were supported by a mentor. A HCA told us they found their mentor's support invaluable and helpful and there was a comfortable pace of learning.
- Nursing staff within OPD tended to be generalist nurses and operate in all of the specialist areas; this allowed them to cover any of the outpatient clinics. All staff completed competency assessments and an induction to the OPD when they first started. Staff told us there was a comfortable pace of learning.
- The OPD sister had initiated HCA competencies and formulated use of the 'Benner's Stages of Clinical Competence'. With the support of the practice

development nurse (PDN), the OPD sister had planned that all HCAs complete local induction documentation and then were put forward for the BMI HCA training modules.

- We reviewed twelve individual staff training folders, which included HCAs and registered nurses (RN). These folders had been in place for approximately two months and were a work in progress. They were used to collate staff training in one place so as to keep a complete record of their competencies and evidence for revalidation in the case of RNs. Training compliance could be seen on 'BMI Learn' or tracked manually for subjects not included on BMI Learn such as the Mental Capacity Act and Deprivation of Liberties training
- Most of the staff we spoke with told us they had received an annual appraisal and those that had worked for the hospital for less than one year were aware that they would have one in the coming months.
- Staff did not receive regular formal one to one supervision. However, senior staff regularly checked on how individuals were performing and if they required extra support or learning worked with the PDN to further their development. Staff reported told us they felt supported and could always approach senior staff to discuss any training gaps or further their learning.
- Consultants reported favourably about the nursing team in the outpatients department. They were described as "very good" and as having a good working relationship with consultants. Some nursing staff worked regularly for specific consultants' clinics as they had developed expertise in some areas.
- Departmental meeting minutes noted reminders to staff to complete their competency booklet and present themselves for assessment when key reading or practice had been undertaken; of the importance to keep records of their training and work records for re-validation purposes; and to refresh their knowledge of policies and procedures.
- The practice development nurse ran regular training sessions in a variety of subjects such as documentation, care of the dying and medical pathway. All staff were invited to sign up to the sessions, this included administrative and housekeeping staff if they considered the topic was relevant to their role. If staff were unable to attend, the practice development nurse could take the training to the wards. The PDN told us

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they were in discussion about how to provide training for the permanent night staff. They were considering doing night duties and providing the training on the wards.

- Two staff had attended a 'breaking bad news' workshop and further staff members were expected to attend the study day.
- All the staff we spoke with reported an improvement in study leave since the new director of nursing had started the hospital. Nurses were asked to sign a learning agreement which meant they could not leave their post for two years after undertaking a course relating to their work that was financially supported by the hospital. This meant the hospital benefitted from their new skills or knowledge.
- Nursing staff received a barcode card once they had completed training on the Cobas blood glucose machine provided by the on-site laboratory. They were unable to access the machine until training had been completed.
- Some nursing staff had undergone a three month leg ulcer training course to support this growing area of work at the hospital.
- Physiotherapy staff who supported patients in the hydrotherapy pool took part in aqua-therapy rescue training so that they could evacuate patients from the water should they have an accident. At the time of our inspection, all staff had completed the assessment.
- All diagnostic imaging staff were assessed on a range of competencies, such as CT scanning, full field digital mammography and MRI on an annual basis.
- Consultants were required to have practising privileges at the hospital to conduct outpatient clinics. We found the MAC reviewed these on a biannual or annual basis and we saw evidence that paperwork relating to their competency such as annual appraisals and indemnity insurance was reviewed.

Multidisciplinary working

- We saw examples of multidisciplinary working within the OPD. For example orthopaedic surgeons who consulted in the clinic were assisted by a registered nurse in removal of plaster and fitting orthopaedic aids.
- BMI Clementine Churchill had a small on site pathology laboratory, but all pathology tests and microbiology

were provided through The Doctor's Laboratory (TDL). Histopathology services were provided by London North West Healthcare NHS Trust, with Unilabs HIS supporting the Hospital's NHS histology requirements.

- The hospital had a service level agreement (SLA) with TDL to turn tests around within specific timescales, dependent on the test performed. TDL completed 31,288 tests in the three months up to June 2015. 99.6% of tests were received within the SLA's targeted timescale over the three months.
- The hospital had a service level agreement with the Consultant Microbiologist at London North West Healthcare NHS Trust for 24 hour access to a microbiologist / Infection Control Doctor

Seven-day services

- The OPD (Consulting Rooms) was open from 7.30am to 10pm Monday to Friday, 8am to midday on Saturdays, and very occasionally on a Sunday if a consultant requested it.
- The phototherapy service was open on Monday, Wednesday and Friday and the leg ulcer clinic ran from Monday to Friday. The hospital team reported positive patient feedback in relation to these services; this had been shown through recommendation of the service to other patients, some of whom travelled quite a distance.
- MRI services were open Monday to Friday from 7am to 10pm, Saturday 9am to 8pm and Sunday 10am to 6pm. The department was 97% booked each day. However, they aimed to perform urgent scans on the day a consultant referred a patient if they could; there was a three to four day wait for non-urgent MRI scans.
- X-ray, CT and ultrasound imaging were available Monday to Friday 8am to 10pm and on Saturday 8.30am to 2pm. Patients were referred and seen immediately most times. There were four protected slots for inpatients during the day, plus one at the end of the day.
- Outside of these hours diagnostic imaging was available through an on-call system. The on-call radiographer lived no more than 30 minutes away from the hospital. The hospital had a protocol for scans that did not require a radiologist to be present, this meant patients that required urgent CT or MRI scans could be seen quickly. The images were sent to the radiologist via a secure portal to report on and discuss with the consultant. The diagnostic and imaging department also monitored theatre lists and if there was a large

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work load an extra radiographer was rotated to work within the theatre so that other patients attending the department as an inpatient or outpatient were not left waiting.

- Physiotherapy services were available to outpatients Monday to Friday from 7.30am to 8pm and Saturday 8.30am to 2pm. Inpatient services were available from 8am to 8pm Monday to Friday. On Saturday, Sunday and bank holidays a weekend coordinator arranged support for patients with physiotherapy needs from 8.30am.
- The phlebotomy services were available for inpatient and outpatient services Monday to Friday from 8am to 9pm and Saturday 8am to 5pm, and for inpatient services only on 9am to 12pm. We observed there was little waiting time for patients who required any tests following an outpatient consultation or GP referral. Phlebotomy staff collected the samples taken by ward staff twice per day. Outside of these hours, specimen samples were stored in a secure fridge within the diagnostics department. These were checked and sent to the laboratory for processing first thing the following morning.

Access to information

- The radiology service used a picture archiving and communication system (PACS). This was a central off-site server that clinicians with appropriate secure access could view images from. Report results were available promptly from the radiology management computer system where the report was typed
- Private patients' healthcare records were kept by consultants who brought them to each appointment. NHS patients' records were held at the hospital.
- All results were sent to the patients referring GP to discuss with their patient. Results were not sent directly to patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was mandatory for all staff. The practice development nurse ran a one hour course on a regular basis. Attendance was recorded in the staff learning passport. The department managers were unable to ascertain who and how many people had

attended this course through the electronic BMI learn system. We were told by a senior member of staff that a majority of staff had completed training in the Mental Capacity Act.

- Most clinical staff were able to demonstrate an understanding of the principles and legislation. Those who were unsure told us they would seek their manager's advice.
- The hospital policy stated children were assessed to decide if they had the capacity to consent although parents were able to give consent on behalf of children up to the age of 18. Staff told us they would ask the person with parental responsibility to consent on behalf of a child who was unable to consent themselves.

Are outpatients and diagnostic imaging services caring?

Good



Patients were treated with compassion, dignity and respect. Most of the patients we spoke with told us their experience in the department was positive. Patients told us the nursing and administrative staff were "friendly, cheerful and welcoming"; and they were confident in the diagnosis and advice given by the consultants.

All the patients we spoke with praised the staff for the care they were given. One person said, "I cannot speak highly enough of the care from the [staff in the] physio[therapy] department here." A relative told us that staff in the leg ulcer clinic had remembered their family member even though they had not been to the hospital for over three years. All the patients we spoke with said they would recommend the hospital and outpatient services.

Compassionate care

- All the patients we spoke with in the OPD told us they were treated with kindness, dignity, respect and compassion while they received care and/or treatment. We observed staff being polite and taking time to explain the processes to patients and people close to them.
- We observed staff greet patients and spend time greeting to those that they saw regularly.

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- Patient consultations took place in private rooms and we noted that sensitive information was not discussed in public areas.
- We observed that reception staff called out to patients across the waiting area when their consultant was ready to see them. Staff told us that some patients had complained about this as they did not like their name being called out. There had been discussions about using signage to indicate to patients when their consultant was ready and which room to go to (similar to systems used in many GP surgeries) but the patients they had discussed this with did not think it was appropriate for a private, more personal service.
- The hospital produced a patient satisfaction survey every three months. This showed 91.2% were satisfied with imaging, 86.7% were satisfied with pharmacy and 92.4% were satisfied with physiotherapy in the three months up to May 2015. These were based on response rates of over 20% for pharmacy but over 40% for physiotherapy and imaging. There was no specific survey just for outpatients and we were not given the benchmarking figures although, across the hospital, they were in the bottom 11 hospitals of the BMI group although had improved from second from bottom.

Understanding and involvement of patients and those close to them

- Patients and those who were close to them told us they felt involved in their care. One patient we spoke with said “they explained everything and I had plenty of time to ask questions.” Another patient told us they were “put at ease” as they understood everything that would happen.
- One patient told us how the physiotherapy department had helped them to achieve their personal goal of playing nine holes of golf after not being able to walk due to extensive surgery and oncology treatments. The patient’s therapy plan included exercises to practice at home. They discussed targets and ticked them off as the patient achieved them and after two and half years the patient was able to walk almost totally unaided and had realised their ambition.

Emotional support

- We noted a number of thank you cards to the physiotherapy team for their support and care.
- Phlebotomy staff were able to describe how they supported children and their parents and nervous

patients when taking blood. We were told that if the phlebotomy team won any corporate awards, it was usually for the way they were able to take blood from children without upsetting them. This was corroborated by the OPD staff who told us how impressed they were with how the staff could keep children calm and support the concerned or upset parents.

- A parent told us their child completely trusted the nurses and had complete faith in them.
- There were staff that had been specially trained to support patients when consultants were breaking bad news. Staff told us the consultant would inform them if they were about to break bad news to a patient so they would be available to support them. They spent as much time as was needed with the patient and those close to them. They provided support and gave them guidance on where to get further help.
- One member of bank staff was a former Macmillan breast nurse and was also available to support patients when requested. We were also told the director of nursing had also supported patients receiving bad news on two occasions in the OPD.

Are outpatients and diagnostic imaging services responsive?

Good



We found the outpatient and diagnostic imaging services were, in the main, responsive. The importance of flexibility, choice and continuity of care was reflected in the service. NHS and privately funded patients reported a “flexible” and “easy to arrange” appointment system. Patients did not experience long waiting times to see a consultant.

Services were planned in a way that met the differing needs of the patients using the hospital. They looked at ways to expand services supported by flexing staff numbers and providing specialist services such as leg wound care and phototherapy services. They were culturally aware as there were a large number of international patients using the service.

We found there was limited focus on the needs of children, people living with dementia and those with learning difficulties. There was some ambiguity about children’s outpatient services and what age and who could see them although their website described seeing children of all

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ages; staff had recently requested clarification from the management team. There was a heavy reliance on relatives or carers to support hospital staff with patients living with dementia or learning difficulties, however the hospital had recently started raising staff awareness in dementia.

The facilities within the outpatient department had a small play area for children and designated consulting room for children. There was nothing child-centred available in the imaging department, however we were told that children waited for such a short period of time that there was little need to entertain them for long and most parents brought their children's favourite toys with them.

Information on how to complain was available in the waiting area. Most complaints were about treatment costs; as a result of this the hospital had recently provided an information leaflet in relation to this. Complaints were taken seriously and managers tried to resolve them immediately. They considered complaints a learning opportunity and a way to improve services.

Service planning and delivery to meet the needs of local people

- Staff reported that there was a growing demand for wound care clinics at the hospital. As a result staff were supported to take a course in leg ulcer and wound care to support the outpatient clinics.
- The hospital saw a high number of international patients. Staff we spoke with were culturally aware and had a flexible approach to cater for patients' individual needs such as their religious/spiritual celebrations or fitting in around visitors who may have travelled some distance.
- There was one consulting room designated for children. The room's interior decoration was not specifically child centred and had the same wall colouring and curtains as the other consultation rooms. However there was a round table as opposed to a desk to sit at and a children's table with chairs. There was also one box of toys and one box of books in the room. A children's height chart and two sizes of paediatric blood pressure cuffs were available.
- The OPD had a large number of patient information leaflets available. These included information about the hospital and certain medical conditions but not

regarding infection prevention and control. Leaflets were supplied by the organisation's marketing department. We observed IPC leaflets were available at our unannounced inspection.

- One of the main complaints the service received was regarding charging. We found that leaflets regarding possible charges (but not the costs) was available once you booked in at the hospital for your appointment but not with the appointment letter prior to an appointment. At the time of our inspection the department was waiting for written information to give patients with appointment letters with regard to what charges (not the costs) they could expect to receive from the consultants and hospital. We saw these leaflets were available at the time of our unannounced inspection.

Access and flow

- Patients accessed services via a GP referral through the NHS e-Referral Service (previously known as Choose and Book), or via self-referral and self-funding or via their health care insurer.
- Access to appointments was fast and patients told us that they were satisfied with the length of time it had taken for them to be seen. One of the CQC comment cards said "fantastic service, flexible appointments".
- NHS patients were managed in line with other NHS patients who should start their treatment within 18 weeks of being referred by their GP. The Patient Referral to Treatment (RTT) pathway was monitored by BMI's information management team.
- The hospital met the RTT target of 95% of non-admitted patients beginning treatment within 18 weeks of referral for each month we had data for in the reporting period April 2014 to March 2015. Eight out of 12 months was at 100%.
- We were told that privately funded patients waited on average up to one week to be seen in OPD from their referral date.
- The hospital had a very low rate of patients not attending booked appointments. The average rate was 3.6%. Patients were not penalised for failing to attend booked appointments; they were able to re-book/re-arrange appointments as many times as they needed to.
- The hospital did not monitor how long patients waited to see their consultant once they arrived at the department. Although they did monitor late running clinics and consultants. Most of the patients we spoke

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with told us they usually saw their consultant on time. However, one patient and their family were upset they had been waiting for over an hour to see the consultant although they were very happy with the service once the consultant arrived. Another patient wrote on a CQC comment card that they had waited an hour to see their consultant and received no apology from them.

- The OPD staff told us they informed patients personally when clinics were running behind; they offered them refreshments while they waited or arranged a new appointment if more convenient. If patients were unhappy, they explained why there was a delay, such as breaking bad news to the previous patient. In the past staff called or sent a text message to patients to advise them of delays. However, this system had not proved successful as patients had often already started their journey to the hospital or the consultant caught up on the time and was left waiting for patients to arrive.
- The physiotherapy department told us they could offer an appointment within 48 hours of referral if appropriate for the patient. They reported their outpatient productivity was 40% higher than the budgeted figure and they had seen a growth of 30-40% in NHS funded patients. Staffing levels were increased to support this.
- The phlebotomy service performed around 300-350 full blood counts per month. From 1 January to 1 June 2015 27,691 tests had been completed.
- We observed good practice in the reception area where patients checked into their appointments became busy. Staff rang for assistance and it was given promptly. However we noted that one of the CQC patient feedback cards indicated that the booking-in process was slow and they would have appreciated some warning of this to allow extra time prior to their appointment.
- Consultants referred patients to the cardiology and audiology departments. Completed test results were made available as soon as the cardiologist/audiologist had compiled their report. This could be on the same day as the test. Results were given directly to the consultant or left in their pigeon hole if not urgent.

Meeting people's individual needs

- Staff completed equality and diversity training as part of their mandatory training. We found staff to be culturally aware, particularly as a high number of international patients attended the hospital..

- Translation services were available through 'Language Line'. There was an in-house Arabic translation service to meet the needs of the high number of Arabic speaking patients. A number of staff also spoke other languages and their details were kept on an internal register so they could be called upon if required. We were told by staff the relatives or friend of patients were used as interpreters at times which is not appropriate.
- There was good access to the outpatient department for people with physical disabilities although we noted a relative's complaint highlighted in meeting minutes about the small changing facilities in the imaging area. The patient required assistance from their relative to change into a gown and there was not enough room for the patient, their wheelchair and their relatives. Staff told us that patients could change within the room they were having their image taken if they preferred to.
- Very few patients with learning difficulties or living with dementia attended the hospital. Staff told us they would always try to ensure these patient groups were not left waiting long and would offer a separate room for privacy and dignity if needed. Staff lent heavily on relatives or carers to support these patient groups.
- Dementia and Alzheimer study days were implemented just prior to our inspection. We asked staff if they had received any training in this subject through any other sources. Reception staff told us they had not had specific dementia training however they had watched Barbara's story, a video to raise awareness of dementia amongst hospital staff. However, when we asked a member of administration staff how they would respond to someone living with dementia they told us they "would speak more clearly and ensure the patient understands."
- The nursing team had developed an ulcer service which had become a full tissue viability service.
- There was a phototherapy service available for patients with psoriasis and eczema.
- Consultants told us the physiotherapy service at the hospital was very good, they said there had been good service development to meet the needs of the patients such as the hydrotherapy pool and the 'Holistic Empowering Lifestyle Programme' for patients living with chronic pain.

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- Children's surgical procedures did not take place at BMI Clementine Churchill. Children requiring surgical treatment were referred to a NHS hospital appropriate to their needs. However, they could have their pre or post outpatient appointments at BMI.
- Administrative staff told us they felt seeing and treating children in the OPD was an ambiguous area and had recently asked the DoN and Executive Director for clarity. Children from new born could be seen within OPD however we were told by a consultant that no children under the age of three attended. The administration staff told us that under threes were only seen by a paediatrician and children between the age of three and under 16 could be seen but could not receive any interventions, such as injections or investigations with equipment such as scopes. They told us there had been a recent occurrence where a consultant was unable to see a child over the age of three as they were not trained in safeguarding children. This meant the child had to attend another local hospital to be seen by an appropriate doctor.
- The imaging department told us they could see new-born children however they were more likely to see children from four or five months old, usually for chest or pelvis x-rays. They assured us they only arranged appointments for children on the days when a paediatric trained member of staff was available in the OPD.
- The cardiology unit saw children from the age of three for tests such as an echocardiogram (ECG).
- The audiology department saw children from the age of three. They received 2-3 referrals per month.
- We found there were a few toys for children to play with in the corner of the OPD waiting area and in consulting room designated to children. There were no toys or books in the imaging department. There were plenty of toys for all ages in the audiology department. There was no access to play specialists to help children who may be required to have treatment as an outpatient or diagnostic procedures. There was nothing available for teenagers to distract them while they were waiting, however we observed that the few children or teenagers who attended the hospital as a patient or with a parent usually had toys or electronic gadgets to entertain themselves with.
- Imaging services flexed the number of staff on duty in-line with the theatre lists. For example an extra radiographer was rostered as part of the theatre team to ensure patients were left waiting for images in relation to their procedure.
- The imaging department's changing facilities had disabled access.
- There was a multi-faith prayer room available at the hospital.

Learning from complaints and concerns

- There were few complaints about the quality of care and treatment. The manager told us most complaints related to treatment charges. As a result of this the department had introduced a leaflet explaining what the consultants and hospital charged for. This did not include the amount charged as this varied vastly between the different consultants and tests. This information was provided on request.
- Informal complaints were managed by the patient services manager. If they were unable to resolve the complaint satisfactorily, they would undertake a full formal investigation, liaising with all the parties involved.
- The staff were able to describe examples of how the OPD and diagnostic imaging departments had listened to patients' complaints. For example, in the past the radiology department put fresh gowns in each changing cubicle but patients complained that they would not know if the gowns left in the rooms were fresh and that no other patient had used it. Staff changed the process so that all the gowns were stored in another location and a set was given to each patient on an individual basis.
- The Patient Services Manager told us recently they had a complaint from a patient who regularly used the service. They had asked the patient if they would like to meet when they come to their next appointment to discuss their issues and see if they could come up with an innovative way to rectify the matter.

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services well-led?

Good



We found the leadership, governance and culture promoted the delivery of high quality person centred care. The hospital had a clear vision and values, driven particularly by quality. Staff were focussed on providing the best service they could for all patients whether they were privately or NHS funded.

The board and other levels of governance within the organisation functioned effectively and interacted with each other appropriately. Staff told us they were supported by their departmental managers and had confidence in the Executive Director and Director of Nursing; all of them were described as having an open door policy. All staff described there being a no blame culture and everyone was encouraged to be open and honest in order to learn and develop services.

Daily meetings were held with the most senior member of staff in each department to ensure they had the opportunity to keep up to date with any changes, incidents and to add their own views as well as keep up to date with the department's status. Information from these meetings was disseminated throughout the hospital within each department. There was clarity about who was responsible for clinical and non-clinical performance.

The department's performance was monitored by the hospital. Patients and staff were asked their opinion of the services and environment and ideas were acted on.

Vision and strategy for this service

- All staff told us the vision for the hospital was to provide a first class service for all patients. Several members of staff told us it was their aim to be the best they could be.
- Senior managers in the department were clear that the OPD was the "shop front" for the hospital and "the first impression of the service was patients' lasting impression". Therefore it was imperative the service was efficient.

Governance, risk management and quality measurement

- The senior staff had clear roles as to who was responsible for clinical and non-clinical performance in the department. For example the patient services manager was clear it was their responsibility to ensure the smooth running of the OPD in relation to teamwork between clinical and non-clinical staff and keeping consultants running to time and patients informed when appointments were running behind.
- Clinical governance was part of the Medical Advisory Committee (MAC) agenda. Any concerns or issues related to outpatient and diagnostic imaging services were discussed at the bi-monthly meeting. Meeting minutes showed the discussions held and outcomes.
- The most senior member of staff on duty within each department attended the senior staff 'comm cell' every morning. This meeting was an opportunity to share information relating to the hospital and across each department. As well as general hospital business it included complaints, incidents, concerns and compliments. Each department had the opportunity to report on things relating to their area. The information from this meeting was shared at departmental 'comm cells'.
- The outpatient department held a 'comm cell' in the department each day. This was a joint meeting between clinical and non-clinical staff. The clinical staff held a further meeting prior to the afternoon clinics starting. Both meetings allowed staff to share any concerns or observations with the team. The outpatients' team took it in turns to lead the 'comm cell' meeting.
- Each department had a 'comm cell' board of information and statistics. The boards were uniform across the whole hospital and displayed amongst other things the department's activity, incidents and staffing. It was updated daily.
- Staff reported very positively about the 'comm cell' board and meetings. They told us it gave them the opportunity to see at a glance how the department was doing. For example, they could see compliments, concerns or updates, late running consultants/clinics, the number of patients seen. We found it easy to navigate.
- In OPD a further short meeting was held for nursing staff that came on duty late and were not available for the meeting held at midday. This ensured key messages reached all staff.

Outpatients and diagnostic imaging

- Many of the staff we spoke with were able to describe how they could access policies and procedures however many of them told us there were too many and they were complicated.
- Senior staff were able to identify the risks on their local risk register and knew what progress was being made in order to manage the risk until a solution had been sought. However, they reported that addressing some relatively easy situations could take a while due to the organisation processes. For example, of the three Olympus nasopharyngeal scopes, one was broken and two were old and requiring repair regularly. This was raised in October 2012 and acknowledged and two scopes were purchased which consultants did not want. The consultants continued to use the old ones as they preferred them. The consultants raised their concerns again about the scopes in May 2014 and the issues were placed on the risk register again in September 2014. A different brand of scope was trialled in June 2015 for seven weeks, which was reported to alleviate some pressure, however the consultants still preferred the original brand. According to the current risk register, the consultants' preferred choice of scope is due to be delivered in August 2015.
- We saw evidence dated October 2012 of pathology staff raising concerns to senior management in relation to the environment used by the phlebotomy staff. This included the area being too cramped, the hatch between BMI and TDL being too high, the fridge being located in a different room, staff potentially getting repetitive strain injury due to their work station height and regular interruptions to staff concentration. A risk assessment was completed and had been put in place. This was seen as being a locally managed risk and did not appear on the hospital's risk register. We raised this with the ED and management team and they told us they were unaware of the situation as it was not on the main risk register and no one had raised the issue since the current ED came to position.
- Senior staff also told us the risk rating/level of risk was subjective and they felt that some risks were rated lower than they should be. We also found that the speed at which a risk was assessed and rectified could depend on the individual pushing it through while other risks sat on the risk register being managed/controlled for years.
- Staff within the outpatients department reported that they were supported well by their immediate managers and the senior management team.
- All the staff we spoke with in outpatient and diagnostic services, including the consultants told us they had seen an improvement in their relationship with the senior management since the change of Executive Director (ED).
- Staff told us they knew who the ED and DoN were and had seen them visiting the OPD. Staff felt confident they could raise any concerns or ideas with them if they wished to.
- Managers within the imaging and diagnostic services were visible to all staff and continued their clinical practice regularly if their role allowed. For example the physiotherapy manager worked every other Saturday as a clinician.

Culture within the service

- The team was visibly enthusiastic about the outpatient and diagnostic imaging services. Many of them had worked in the service for many years. Some bank staff told us they enjoyed working at the hospital and in the department so much they were going to apply for a permanent role when one became available.
- Shift patterns were designed to ensure all clinics were covered and to provide staff with a fair and amenable work life balance. Staff told us they were happy having a four week rota as they could plan their home lives around it. There was a degree of flexibility but all staff knew that the only proviso was that every clinic must be covered by appropriate skill mix and number of staff.
- We found the clinical and non-clinical teams gelled well together and were supportive of one another. They acknowledged each other's skills and recognised the value of teamwork.
- Every week one of the hospital values was identified as being the theme of the week, for example care or compassion. Staff in each department were asked to nominate their colleagues with the reason they thought the individual had embodied the value. We heard the managers encourage nominations from non-clinical as well as clinical staff. At the end of the week the head of departments identified the nominated individuals at the 'comm cell'. The staff received certificates acknowledging their hard work.

Leadership of service

Outpatients and diagnostic imaging

- Staff reported an open no blame culture. All the staff we spoke with were aware of the hospital's whistleblowing policy. Staff were encouraged to feedback any thoughts to their peers and managers. The staff we spoke with reported positively about this culture.

Public and staff engagement

- Patients attending the OPD were able to provide feedback by completing forms available in the waiting area. This feedback was analysed and the departments received the feedback relating to them. The patient services manager described how they invited patients who had concerns or ideas to a meeting to discuss any ideas they had to improve the service or environment.
- The diagnostic imaging and physiotherapy department regularly engaged with staff, including consultants, and patients by holding open evenings to showcase their service. For example they held a foot and ankle clinic prior to the London Marathon and have promoted the breast screening service. Staff reported that patients liked the opportunity to chat informally with consultants and nursing staff about things that might be concerning them. It on occasions resulted in patients arranging to see a consultant.
- The physiotherapy department manager gave us examples of how they had engaged with patients about improvements they could make to the department and service offered. Patients had suggested music playing in

the waiting area and disagreed with the staff's idea to have a mirrored wall in the physiotherapy gym area. As a result the department listened by providing music and did not install mirrors.

- Staff told us that managers had an open door policy and they felt comfortable approaching them about any concerns or ideas. They also had an opportunity to raise anything during the daily 'comm cell' meeting.
- Staff told us they were encouraged to develop new services in OPD. One member of staff told us they were keen to develop an urology clinic; however they were unsure how it would be staffed.

Innovation, improvement and sustainability

- We found the lead for the imaging department and physiotherapy department was keen to identify talent within the staff team. They were given the opportunity to develop their skills by taking part in projects. For example, staff could become part of a procurement team for a new piece of equipment. This required them to use their knowledge and skills in helping the team decide the most suitable piece of equipment for the hospital's needs by researching the different makes and models, visiting other sites using the equipment, testing it and writing a report on their findings to present to the board.
- The Clementine Churchill imaging department was the first BMI hospital to provide IV cannulation training for staff. They offered this course to other hospitals. All staff who attended and passed the course received a certificate from the University of Hertfordshire.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital had a good system of raising issues and concerns across the hospital in a timely manner through its 'comm cell' meetings and display boards. This meant that hospital staff could access up-to-date information about the hospital's performance and any concerns or changes in practice in a timely manner. This had been embedded throughout the hospital and staff spoke positively of how much communication had improved across the entire site.
- The ECC has introduced reflections about a year ago and a means to support staff when there had been a difficult shift and there was no one to talk to about it.

Staff are encouraged to write up what's happened, their feelings, what action they have taken and what difference they have made. We saw good examples which were open and honest, for example when a patient has fallen, where there had been staff shortages, concerns about a patient who deteriorated post discharge, and when there had been a busy shift. It gave staff an opportunity to express how they felt. Staff reported that this promoted discussion within the team and allowed the centre manager to support and guide them.

Areas for improvement

Action the hospital **MUST** take to improve

Ensure the ITU environment and equipment is clean and the hospital meets infection prevention and control guidance such as ensuring staff have clean hands and wear personal protective equipment when necessary.

Take action to ensure the phlebotomy administrative office and storage room is suitable for the purpose for which it is being used for and ensure floors in the area are clear of boxes and consumables to allow for appropriate cleaning.

Action the hospital **SHOULD** take to improve

- Consider reviewing all policies relating to children to denote the service now being provided at the hospital and provide staff with a clear policy and procedures in relation to children using outpatient services.
- Ensure that there is additional nursing cover available in the ECC when staff from the centre attend a cardiac arrest.

- Review the statement of purpose to reflect that post discharge reviews and all medical admissions are assessed and transfers from NHS and other providers are admitted via the ECC.
- Take action to ensure all equipment is safe to use.
- Ensure that the guidance from the College of Emergency Medicine is followed which states that a 'service should have a minimum of ST4 or equivalent working in the department when the service is open'.
- Ensure patient records are complete and up to date including care plans and nursing assessments.
- Ensure the ITU audits and benchmarks its performance so it can monitor and improve its service.
- Ensure there are sufficient staff available to cover any additional admissions from the ECC.
- Review the practising privileges policy regarding those consultants who have not practised at the hospital over a year to ensure they are still competent to work at the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

Diagnostic and screening procedures
Nursing care
Treatment of disease, disorder or injury

Regulation

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

The provider was not meeting regulation 12 (1) and (2) (h) as both the medical wards and ITU were not preventing and controlling the spread of infections including those that are health care associated as multiple members of staff were not observing infection prevention and control precautions such as hand washing between patients and using personal protective equipment.

Regulated activity

Diagnostic and screening procedures
Nursing care
Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

The provider was not meeting regulation 15 (1) (a) as the premises and equipment used by the service provider were not always clean.

This section is primarily information for the provider

Enforcement actions

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.